NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

GROUP BOARDS IN COMMON - PUBLIC

GROUP BOARDS IN COMMON - PUBLIC

12 December 2024

09:00 GMT Europe/London

Main Boardroom, Diana, Princess of Wales Hospital

AGENDA

1.1 - WELCOME, GROUP CHAIR'S OPENING REMARKS & APOLOGIES FOR ABSENCE

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

Agenda - HUTH NLaG Boards in Common Meeting - December 2024 - Public.pdf

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AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 12 December 2024 at 9.00 am to 1.00 pm in the Main Boardroom, Diana, Princess of Wales Hospital

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** Sean Lyons, Group Chair	Verbal	Information	**09:00**
1.2	**Staff Charter and Values** Sean Lyons, Group Chair	Attached	Information	
1.3	**Patient Story** Amanda Stanford, Group Chief Nurse	Verbal	Discussion / Assurance	
1.4	**Declarations of Interest** Sean Lyons, Group Chair	BIC(24)223 Attached	Assurance	
1.5	**Minutes of the Meeting held on Thursday, 10 October 2024** Sean Lyons, Group Chair	BIC(24)224 Attached	Approval	
1.6	**Minutes of the HUTH Annual General Meeting held on Wednesday, 16 October 2024** Sean Lyons, Group Chair	BIC(24)225 Attached	Approval	
1.7	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.8	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(24)226 Attached	Assurance	
1.9	**Group Chief Executive's Briefing** Jonathan Lofthouse, Group Chief Executive	BIC(24)227 Attached	Assurance	**09:20**
1.10	**Winter Plan** Clive Walsh, Interim Site Chief Executive (North Bank)	BIC(24)228 Attached	Assurance	**09:50**
2.	**GROUP DEVELOPMENT**			
2.1	**NHSE developments and updates including the 'Insightful Provider Board'** Jonathan Lofthouse, Group Chief Executive	BIC(24)229 Attached	Information	**10:05**
2.2	**Update on Group Strategy** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(24)230 Attached	Information	**10:25**
3.	**BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS**			
3.1	**Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge** Sue Liburd & Dr David Sulch, Non-Executive Directors Committee Chairs	BIC(24)231 Attached	Assurance	**10:35**

3.1.1	**Maternity Safety: CNST Maternity Incentive Scheme (MIS)** Amanda Stanford, Group Chief Nurse	BIC(24)232 Attached	Approval	**10:50**
3.1.2	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Stuart Hall & Sue Liburd, NED Maternity & Neonatal Safety Champions	BIC(24)233 Attached	Assurance	**11:00**
3.1.3	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Amanda Stanford, Group Chief Nurse	BIC(24)234 Attached	Assurance	**11:05**
BREAK – 11:15 – 11:30				
3.2	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)235 Attached	Assurance	**11:30**
3.3	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(24)236 Attached	Assurance	**11:45**
3.3.1	**Freedom to Speak Up Guardian (FTSUG) Report – Quarter Two** Liz Houchin & Fran Moverley, FTSUGs	BIC(24)237 Attached	Assurance	**12:00**
3.3.2	**Establishment Review of Safe Staffing Progress Update** Amanda Stanford, Group Chief Nurse	BIC(24)238 Attached	Information	**12:10**
3.4	**Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)239 Attached	Assurance	**12:20**
4. GOVERNANCE & ASSURANCE				
4.1	**Board Assurance Framework & Strategic Risk Register – NLaG and HUTH** David Sharif, Group Director of Assurance	BIC(24)240 Attached	Assurance	**12:30**
5. OTHER ITEMS FOR APPROVAL				
5.1	**Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report** Clive Walsh, Interim Site Chief Executive (North Bank)	BIC(24)241 Attached	Approval	**12:40**
5.2	**Health Tree Foundation Trustees' Committee Terms of Reference** David Sharif, Group Director of Assurance	BIC(24)242 Attached	Approval	**12:45**
6. ITEMS FOR INFORMATION / SUPPORTING PAPERS				
6.1	**Items for Information / Supporting Papers (as per Appendix A)** Sean Lyons, Group Chair	Verbal	Information / Assurance	
7. ANY OTHER URGENT BUSINESS				
7.1	**Any Other Urgent Business** Sean Lyons, Group Chair / All	Verbal		**12:50**
8. QUESTIONS FROM THE PUBLIC AND GOVERNORS				
8.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**12:55**

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** Sean Lyons, Group Chair / All	Verbal	Discussion	**13:00**
10.	**DATE OF THE NEXT MEETING**			
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 13 February 2025 at 9.00 am**			

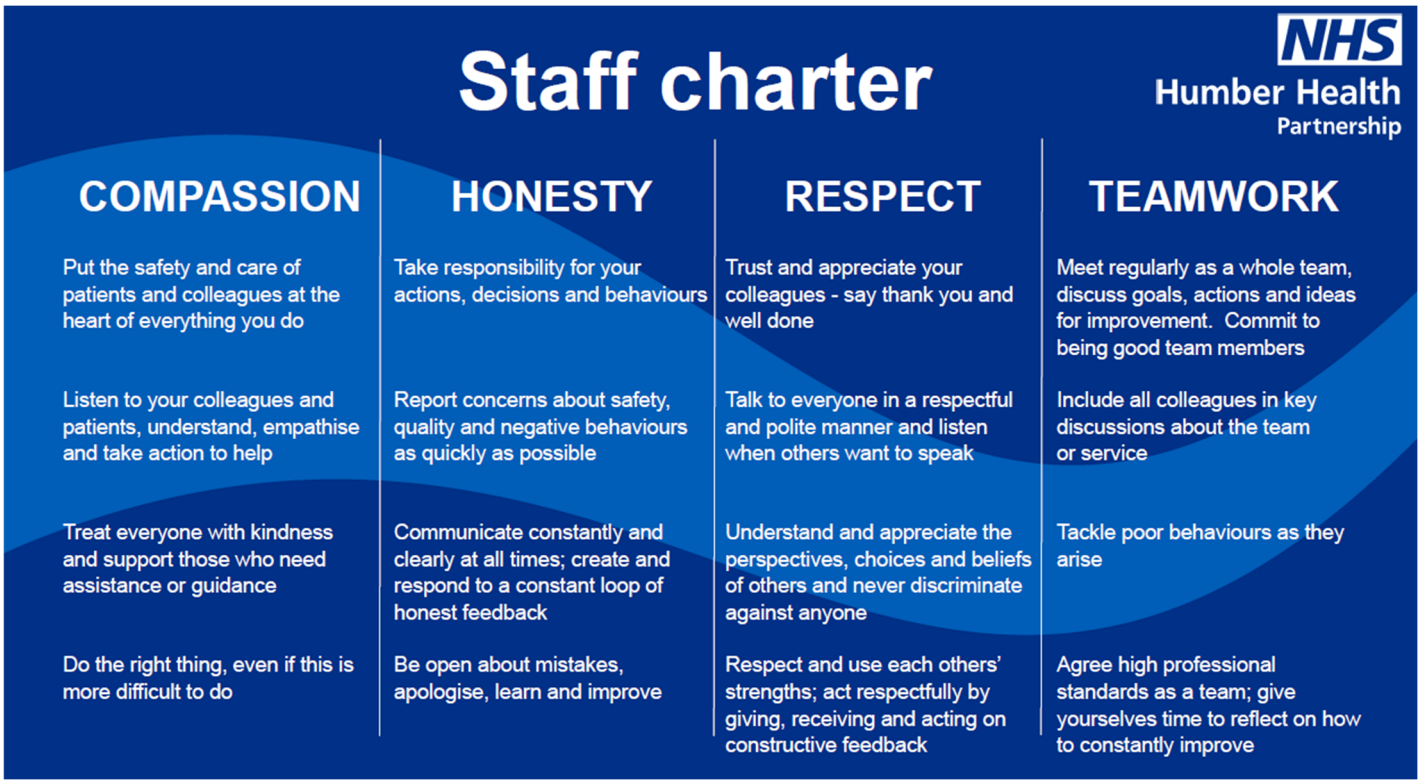
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – August 2024** Sue Liburd & David Sulch, Non-Executive Directors Committee Chairs	BIC(24)243 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Finance, Estates & Performance Committees-in-Common Minutes – September & October 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)247 Attached
6.3	**Workforce, Education & Culture Committees in Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – August & October 2024** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(24)248 Attached
6.3.2	**Guardian of Safe Working Hours Annual Report** Dr Kate Wood, Group Chief Medical Officer	BIC(24)249 Attached
6.3.3	**Guardian of Safe Working Hours Report – Quarter Two** Dr Kate Wood, Group Chief Medical Officer	BIC(24)260 Attached
6.4	**Capital & Major Projects Committees in Common**	
6.4.1	**Capital & Major Projects Committees-in-Common Minutes – June, August & October 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)250 Attached
6.5	**Other**	
6.5.1	**Integrated Performance Report – NLaG and HUTH** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(24)251 Attached
6.5.2	**Trust Boards & Committees Meeting Cycle – 2025 & 2026** David Sharif, Group Director of Assurance	BIC(24)252 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.



1.2 - STAFF CHARTER AND VALUES

Sean Lyons, Group Chair

1.3 - PATIENT STORY

Amanda Stanford, Group Chief Nurse

1.4 - DECLARATIONS OF INTEREST

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(24)223 - Declarations of Interest.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)223

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 December, 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Jonathan Darley (Corporate Governance Officer at NLAG) and Rebecca Thompson (Deputy Director of Assurance at HUTH)
Title of Report	Declaration of Interests
Executive Summary	**Non-Executive Directors, Executive Directors and Other Directors list of declarations of interest**
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Executive Directors and Other Directors Register of Interests At both the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH)	
Name and position	**Interests**
Amanda Stanford, Group Chief Nurse	None.
Andy Haywood, Group Chief Digital Information Officer	Previous employer was a digital health consultancy that could potentially bid for services within the Trust. Procurement steps in place to remove Andy from any decision making and to ensure full transparency.
Aswathi Shanker, South Bank Managing Director	None.
Clive Walsh, Interim Site Chief Executive - North	Yet to declare (start date 4 November 2024)
David Sharif, Group Director of Assurance	None.
Dr Kate Wood, Group Chief Medical Officer	Husband is Trust employee - Theatres Manager at Diana, Princess of Wales Hospital Grimsby (DPOWH). Associate for AQUA.
Emma Sayner, Group Chief Finance Officer	Yet to declare (start date 2 December 2024)
Ivan McConnell, Group Director of Strategy and Partnerships	None.
Jonathan Lofthouse, Group Chief Executive Officer	Group Chief Executive Officer for Northern Lincolnshire and Goole NHS Foundation Trust, as part of HUTH and NLAG working in a Group model. This includes attending the NLAG Council of Governors when requested. Wife Volunteers with the Look Good Feel Better work with the Queens Cancer Centre.
Neil Rogers, North Bank Managing Director	Director of own limited company – Neil Rogers Healthcare Management Solutions Ltd which is currently dormant.
Rob Chidlow, Interim Group Director of Quality Governance	None.
Sarah Tedford, Interim Site Chief Executive - South	Yet to declare (start date 2 December 2024)
Simon Nearney, Group Chief People Officer	Director at Cleethorpes Town FC / The Linden Club. Family members working at NLAG. Family member working at Hull City Council.

Non-Executive Directors at NLAG Register of Interests	
Name and position	**Interests**
Gillian Ponder, Non-Executive Director and Senior Independent Director	None.
Julie Beilby, Non-Executive Director	None.
Linda Jackson, Vice Chair/Non-Executive Director	Associate Non-Executive Director at HUTH. 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 Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Simon Parkes, Non-Executive Director	Director of Lincoln Science and Innovation Park (Unremunerated). Lay Canon and Chair of the Finance Committee of Lincoln Cathedral. Senior Independent Director of Lincolnshire Housing Partnership. Director of Visit Lincoln (unremunerated). Deputy Vice Chancellor and Chief Operating Officer of the University of Lincoln.
Stuart Hall, Associate Non-Executive Director	Non-Executive Director/Vice Chair HUTH. Partner is Lay Member of Yorkshire Clinical Senate. Member of Advisory Committee on Clinical Excellence Awards.
Susan Liburd, Non-Executive Director	Managing Director and Principal Consultant of Sage Blue. Director and Trustee of British West India Regiments Heritage Trust CIC.

Non-Executive Directors at HUTH Register of Interests	
Name and position	**Interests**
Dr Ashok Pathak, Associate Non-Executive Director	Works as a medical expert for Medical Appeals Tribunals. 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.
Helen Wright, Non-Executive Director	Permanent role as Group FD of Eltherington Group Ltd – 3 days per week commencing 1 September 2024
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. Both Sister and Sister-in-law work at Diana Princess of Wales Hospital, Grimsby (DPoWH) (in Family Services).
Professor Laura Treadgold, Non-Executive Director	As the Dean of the Faculty of Health Science at the University of Hull (since 2 January 2024 – ongoing), the Faculty has a large research portfolio which receives funding from external bodies to undertake research.
Sean Lyons, Group Chair at both NLAG and HUTH	Daughter is Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Stuart Hall, Vice Chair	Associate Non-Executive Director at NLAG. Partner is Lay Member of Yorkshire Clinical Senate. Member of Advisory Committee on Clinical Excellence Awards.
Tony Curry, Non-Executive Director	None

1.5 - MINUTES OF THE MEETING HELD ON THURSDAY, 10 OCTOBER 2024

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(24)224 - Minutes of the Meeting held on Thursday, 10 October 2024.pdf

TRUST BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 10 October 2024 at 9.00 am
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Mark Brearley	Interim Group Chief Financial Officer
Paul Bytheway	Interim Group Chief Delivery Officer
Amanda Stanford	Group Chief Nurse
Julie Beilby	Non-Executive Director (NLaG)
Tony Curry	Non-Executive Director (HUTH)
Stuart Hall	Vice Chair (HUTH)
Jane Hawkard	Non-Executive Director (HUTH)
Linda Jackson	Vice Chair (NLaG)
Simon Parkes	Non-Executive Director (NLaG)
Gill Ponder	Non-Executive Director (NLaG)
Dr David Sulch	Non-Executive Director (HUTH)
Prof Laura Treadgold	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Rachel Farmer	NHS Liaison
Hannah Horsfield	GE Healthcare
Myles Howell	Group Director of Communications
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Yvonne McGrath	Group Director of Midwifery (for item 3.1.3)
Simon Nearney	Group Chief People Officer
Ian Reekie	Lead Governor - NLaG
Mr Peter Sedman	Group Deputy Medical Officer (representing Dr Kate Wood)
David Sharif	Group Director of Assurance
Simon Treacher	Patient Experience Lead (for item 1.2)
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 referred colleagues to the new Staff

Charter and reminded Board members that all business should continue to be undertaken with those behaviours. It was important this was embedded from the leadership team. He asked that all Committees-in-Common added this to meetings going forward.

Sean Lyons was grateful for the commitment of the Committees-in-Common for receiving and reviewing papers that had been discussed prior to being shared at the Trust Boards-in-Common.

Sean Lyons introduced Mark Brearley as the Interim Group Chief Financial Officer and noted that Julie Beilby had been appointed as a Non-Executive Director (NED) at NLaG following the departure of Kate Truscott.

Sean Lyons paid tribute to Kate Truscott for her commitment during her time at NLaG and advised she had sent her best wishes to colleagues.

The following apologies for absence were noted:

Dr Kate Wood	Group Chief Medical Officer
Sue Liburd	Non-Executive Director (NLaG)
Dr Ashok Pathak	Associate Non-Executive Director (HUTH)

1.2 **Patient Story**

Simon Treacher shared his personal patient story due to a recent health issue as an inpatient. He wanted to praise all the staff that had been part of his care. One point to note was the positive impact of being able to see his family during his time in hospital. Simon Treacher wanted to also highlight that his line manager Melanie Sharp and his team had also been very supportive when he returned to his role at the organisation.

Linda Jackson appreciated that seeing family during his time in hospital had been important and the noticeable support that had been received by his team when he returned to work. It was noted that cardiac rehabilitation had also been supportive in his care journey. Paul Bytheway wanted to highlight that it showed the great work that the NHS undertake on a daily basis. Simon Parkes felt that the story showed how staff do care for their patients recognising for many it is not just a role they undertook. Helen Wright agreed and felt it showed how staff were embedding the current values of the organisation.

Dr David Sulch commented that it highlighted some patients do have to go through health issues without the support of families. He felt this had unfortunately, been one of the errors during covid where organisations had restricted visiting; it was now recognised how this had impacted on patients and their families. This was something that should be considered if this did happen in the future.

Simon Treacher advised this of course also impacted the patients' families not being able to see them during inpatient care. Gill Ponder felt the nurses that were part of Simon Treacher's journey needed to be aware of the positive impact they had at the time. Amanda Stanford commented that hearing such stories did highlight the issue of visiting times for patients it had been identified there was a

need to reset and work in partnership with families. The direction at this organisation in the future would be to work with patients and families by introducing an open door as they should be encouraged to see patients whilst they were in hospital.

Sean Lyons felt every contact a patient had counted as those patients did remember how they were made to feel at the time they were being cared for. Simon Parkes also wanted to pay tribute to Melanie Sharp for her support as Simon Treacher's line manager during this time and on his return to work. Melanie Sharp explained it had been recognised what support Simon Treacher required and it was vital that his health was the most important issue as he returned to work. It had been recognised that he also needed to be supported when returning to work on a phased return.

Sean Lyons thanked Simon Treacher for sharing his personal story.

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, 13 June 2024 – BIC(24)181**

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

- Simon Nearney referred to page seven, item 2.1, this referred to Simon Morris, however, this should read Morritt.

1.5 **Matters Arising**

Sean Lyons invited board members to raise any matters requiring discussion not captured on the agenda.

1.6 **Action Tracker – Public – BIC(24)182**

The following updates to the Action Tracker were noted:

NLaG

- 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. Sean Lyons reported that there was still no progress in respect of appointing a patron. Trust Board members were asked to advise Sue Liburd of any individuals that may be interested in the role.

Trust Boards-in-Common

- Item 3.3.1, 13 June 2024 – Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH. Amanda Stanford reported that the team had undertaken

work in respect of this issue, no further concerns had been identified. It was agreed this item would be closed.

- Item 1.5, 8 August 2024 - Quality & Safety Committees-in-Common Highlight Report - Never Event. Amanda Stanford reported that the Never Event was still ongoing with a Police investigation.
- Item 1.5, 8 August 2024 - Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Perinatal Mortality Review Case. Amanda Stanford advised that this had now been included within the required report. It was agreed this item would be closed.
- Item 3.1.1, 8 August 2024 - Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports - NLaG & HUTH. Amanda Stanford advised that this had now been included within the required report. It was agreed this item would be closed.

1.7 **Group Chief Executive's Briefing – BIC(24)183**

Jonathan Lofthouse referred to the report shared. It was reported that the organisation was one of two Trusts in the country to receive Getting It Right First Time (GIRFT) support. This would mean the organisations would have additional national expert support. Further details in respect of this would be shared at the Finance, Estates and Performance Committees-in-Common once they were received.

Jonathan Lofthouse wanted to highlight the recent golden stars awards ceremony that had taken place on the 13 September 2024 this had been a fantastic celebration. Thanks were given to the Communications Team for organising the event.

Amanda Stanford advised of an Integrated Care Board (ICB) visit that had been undertaken within the Emergency and Acute Care provision at Diana, Princess of Wales Hospital (DPoWH), Scunthorpe General Hospital (SGH) and Hull Royal Infirmary (HRI) in September 2024. This had been with the senior leadership team as referred to within the report. Positive comments had been received following the visit. Staff had engaged well and positively on the challenges they faced. On the South Bank the staff had demonstrated the effective streaming of patients and how they worked collaboratively with colleagues. It had been highlighted how difficult it was on the HRI site and staff were able to show how they cohort patients at the front door. It had also shown how the patient safety risk increased as the department became busier and how the organisation responded to this escalating risk. The team were currently working on this to review how they escalate and maintain safety.

Paul Bytheway referred to the 65-week waits and confirmed these were on track to eliminate them by the end of October 2024. There were some that required intense management, however, there was confidence that those patients had an appointment. Focus was now being undertaken in respect of the 52-week wait patients.

Ivan McConnell explained the opening of the two Community Diagnostic Centres (CDCs) on the South Bank would be delayed. The site at Grimsby had encountered some issues in terms of fire regulations, this site would now open on a phased basis. This would mean the Ophthalmology service would not be opened until

quarter four of 2024/25. The site at Scunthorpe was delayed due to issues with the power connection and the local authority in terms of access to the site. The CDC at Hull was currently on track for opening.

Simon Nearney reported it was Black History month and Freedom to Speak Up (FTSU) month. Discussions were being undertaken with the Black, Asian & Minority Ethnic (BAME) Network and Equality, Diversity & Inclusion (EDI) teams around how to support and celebrate individuals. Some stories had already been celebrated on Bridget. A session would also be held to highlight individual stories and challenges currently faced.

Jonathan Lofthouse explained the flow campaign was receiving positive feedback with prizes being awarded of £5,000 for new schemes.

Linda Jackson referred to the referral to treatment (RTT) on the North Bank in terms of those patients that had not had their first appointment and queried what was in place to ensure those patients did not deteriorate whilst on the waiting list. Jonathan Lofthouse advised that in terms of national standard those patients were subject to revalidation every 12 weeks, however, this was undertaken as a paper-based exercise rather than by a clinician. Mr Peter Sedman advised that it was difficult from a clinical perspective, however, a checklist was in place to review whether there had been any harm to those patients.

Stuart Hall queried how the organisations were tackling the issues around patients not attending for appointments. Jonathan Lofthouse advised this was part of the outpatient improvement work being undertaken. This would include pre-alerts to patients notifying of an upcoming appointment, this would be shared more widely across the group by April 2025. It was hoped this would then reduce the amount of Did Not Attends (DNAs) by around 2% to 4%. It was noted this would also include a link allowing patients to cancel appointments that they were unable to attend.

Tony Curry referred to the emergency care achievement for this month and queried where the organisation was in terms of this. Jonathan Lofthouse explained that when the formal operational planning commenced for HUTH it had historically been a low performing unit, therefore, the national team were aware that it would not achieve the national standard within the one year. However, until this month it had been on the recovery trajectory and was slightly ahead. Since the beginning of October this had dropped in performance along with neighbouring Trusts. It was felt that the General Practitioner (GP) strikes had contributed to this.

Helen Wright queried whether the option of opening the centre for a longer period had been considered as previously raised. Paul Bytheway advised that the centre was currently open for 16 hours a day, and although it had been considered, it currently operated with the initial contact being from a City Health Care Partnership (CHCP) nurse that redirected patients. Rather than extend the hours it opened further, the nurse would try to direct patients earlier in the day rather than towards the end of the opening hours. It was hoped this would then help alleviate any issues. The issues at both Trusts in terms of the Emergency Department (ED) were due to overcrowding, at NLaG this was also impacted by discharge problems.

Sean Lyons referred to the 62-day cancer performance as there had been a compliance reduction. Jonathan Lofthouse explained this had been investigated by the operational team and the findings were that this was due to the reductions in

activity during holiday periods. It was reported that this should have been identified earlier, however, this had now improved. Gill Ponder advised this had previously been discussed at the Performance, Estates & Finance Committees-in-Common as it was recognised this happened during holiday periods over the year. As these were periods of leave that occurred every year it suggested that this be planned for to in the future to avoid such issues.

Sean Lyons referred to the issues that had arisen due to recent riots in Hull and queried whether there was an update in terms of how BAME staff were now feeling. Jonathan Lofthouse advised structured pre-communications were shared prior to the planned riots that recently took place. It had been reported that staff were more assured that there was support in place during this time. On the day the riots were planned there was also additional external support from the Police along with enhanced Security from the Trust. It was noted that whilst staff were concerned it had been recognised that additional support was in place. Myles Howell commented that due to early conversations for the planned riots this had supported the plans in place prior to the day. Simon Nearney added that in addition to the communications being in place early there had also been contact with management teams to highlight what would be required of them to support staff. Team meetings had been in place and BAME staff were able to highlight concerns prior to the day, this had included support for staff that needed transport to work and a change in working hours where required. Although, it had been shown as a peaceful demonstration it was recognised that for those staff involved there would be concerns. Jane Hawkard commented that feedback through the BAME Network had been positive that support arrangements were in place. Sean Lyons queried whether there had been intelligence on further riots being planned. Simon Parkes advised he was aware of planned days of action around the current conflict in the middle east due to be held on the 17 October 2024 at universities. Professor Laura Treadgold explained she was aware of this taking place at the Hull University Campus, an open space had been allocated for this to take place peacefully.

2. GROUP DEVELOPMENT

2.1 Jonathan Lofthouse provided updates in relation to this item within the Group Chief Executive Briefing.

3. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS

3.1 Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)185

Dr David Sulch referred to the report and noted key highlights. It was reported the meeting in September was a Time Out session. Items were discussed as detailed within the report.

Jane Hawkard referred to the issue around hygiene and queried how this would be alleviated. Amanda Stanford advised this issue was not unique to the organisations and had been a wider issue following the pandemic. There needed to be more consistency in respect of what basic infection prevention and control (IPC) requirements were. Issues had highlighted were that staff needed to be more aware of the bare below the elbow standard. There were also some differences between the two organisations in respect to how specific outbreaks were responded to. This

would be addressed going forward. It was noted that the metrics for both organisations had flagged red for some time, some of those issues on the South Bank were also contributed to by the poor estate. A piece of work would be undertaken around cleaning standards which would include revisiting the five stars that had been awarded. The professional standards would need to be shared with heads of departments and chiefs of staff overall. The IPC Steering Group had also been re-established to review what was being undertaken. Jonathan Lofthouse added that in respect of HRI some of the concerns were legacy issues as the tower block had insufficient hand basins. Dr David Sulch queried whether a NED champion should be considered in terms of IPC due to current issues. Simon Parkes referred to the data quality issues and queried whether the issue required referral to the Audit, Risk & Governance Committees-in-Common to review assurance. Jonathan Lofthouse advised there had been commitment provided to this in terms of additional staff and improvements with the data warehouse.

Action: Discussion required as to whether a NED Champion was required in terms of IPC

Stuart Hall felt NED visibility was an issue that needed to be reviewed particularly around how they could interact with staff. Amanda Stanford explained a piece of work was being undertaken around engagement of Executive Directors and NEDs, this would be shared at a future Board Development session.

Action: NED and Executive visibility to be added to Board Development timetable

Linda Jackson explained there was a strong directive in terms of issues being dealt with by committees rather than having too many NED champion roles in place, however, there was of course expertise within the current NEDs that could provide support with such issues.

3.1.1 **Establishment Review of Safe Staffing – BIC(24)186**

Amanda Stanford highlighted key points from the paper and advised a more detailed report would be provided at the December 2024 Trust Boards-in-Common meeting.

Amanda Stanford advised policies across the group would be merged to ensure safer staffing. She added that clear processes were in place for setting establishments with human resources and finance colleagues. Particular roles would also be in place within both organisations that were needed to ensure consistency. Reports in respect of nursing establishments would be shared with the Trust Boards-in-Common twice a year which would highlight any gaps in staffing with risks identified. Both organisations would form part of a review to highlight rosters including any efficiencies that should be considered. A report for Advanced Health Professionals (AHPs) would also be shared.

3.1.2 **Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports – NLaG and HUTH – BIC(24)187**

Stuart Hall referred to the report and noted key highlights. It was noted a credible candidate had been appointed for the Head of Midwifery at HUTH.

3.1.3 **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(24)188**

Yvonne McGrath referred to the report and noted key highlights.

Yvonne McGrath advised that in respect of the Clinical Negligence Scheme for Trusts (CNST) some aspects had changed slightly from the detailed report due to a recent external visit where evidence had been reviewed.

In respect of safety action one there were some risks due to some detail that should be included within the Trust Boards-in-Common minutes prior to April 2024 the Board was referred to the Perinatal Mortality Review Tool (PMRT) quarterly reports for both HUTH and NLaG included within the agenda item.

In respect of safety action two the Boards were informed of the progress of submitting 10 out of the 11 Maternity Services Data Set (MSDS) clinical quality metrics. The launch of Badgernet at NLaG had been successful and had not presented a risk for the submission period.

In terms of safety action two at HUTH, there was a potential risk of compliance with the standard due to the transfer of Badgernet as there had been some manual inputting of data, this would mean that this may not be compliant on the first run due to the information not being transferred. NHS Resolution had agreed an additional later submission in order to be able to resolve the data quality issues.

In respect of safety action three there were no concerns highlighted for HUTH or NLAG, the quality improvement (QI) project had also commenced, and the transitional care pathway was also in place.

In respect of Safety action four the Boards were assured HUTH and NLAG were compliant against the Royal College of Obstetricians & Gynaecologist (RCOG) Guidance for the employment of long and short term locums. Yvonne McGrath informed the Board of compensatory rest position and an agreement of action plan in place for NLAG. The HUTH Neonatal medical workforce were compliant with British Association of Perinatal Medicine (BAPM) Standards, however the Neonatal Nursing Workforce Standards were not met and the action plan was in place, evidenced and approved. NLAG did not currently meet the BAPM standards for both the Neonatal medical and Neonatal nursing workforce therefore action plans were still in place, evidenced and ratified by the Board.

Yvonne McGrath reported that in respect of safety action five this was out of sync slightly in respect of reporting, however, this would be aligned for the December 2024 Trust Boards-in-Common meeting. In respect of NLaG they were compliant in birth rate plus, however, HUTH were not so an action plan had been agreed in respect of this to show this was being worked towards.

In addition, the Group had commissioned a refreshed Birthrate+ for both NLAG and HUTH. The data collection had commenced with a full report being shared in January 2025.

In respect of safety action six the ICB had been happy that the organisations had made best endeavours to achieve this. A further meeting would be held in November 2024 to show where progress was required.

For safety action seven there were no concerns, the infrastructure was in place for the Maternity and Neonatal Voices Partnerships (MNVPs).

It was reported for safety action eight that nothing was to be raised specifically, there was recognition that training compliance was still a risk, and mitigations were in place in respect of this with staff booked on to required training.

In respect of safety action nine, it was noted that the Perinatal Quality Surveillance Model (PQSM) dashboard was included within the Board report. A meeting was also being held with the Maternity and Neonatal Safety Champions on a monthly basis. Feedback from those meetings would also be included within the report going forward.

Yvonne McGrath confirmed compliance with Duty of Candour requirements for both sites, with one residual case being confirmed at HUTH.

In summary, the highest risk was safety action one, however, conversations were being undertaken with NHS Resolution in light of this.

Simon Parkes referred to a recent discussion where it had been highlighted that actions improved whilst they were being focussed on, however, this was not always the case when they were not being monitored. He queried whether all the Standards actually improved patient safety or whether focus should be channelled elsewhere where more was required. Yvonne McGrath agreed with the point made and advised that in terms of training this would be undertaken differently in the future as it would be over a week-long period. It was noted this was already in place at NLaG. It was also hoped that meetings in respect of CNST would reduce over the next year as improvements were made.

Action: Board Development Session to be held to review what the organisations were required to complete in terms of statutory requirements and what this did to improve patient care

Gill Ponder highlighted that it stated that the organisations were unable to demonstrate progress due to financial restrictions, she queried why this had not been built into financial budgets for year five if that was the case so that it was better built into the Business Cases. Amanda Stanford explained there needed to be better linking in with the action plan in terms of business planning. That specific action was being discussed as to how that was being managed and how that this would need to be implemented in the future as there may need to be changes made.

Yvonne McGrath continued to refer to points within the report. Sean Lyons referred to the Head of Maternity role as this had recently been advertised. Yvonne McGrath confirmed interviews were due to be held shortly.

Sean Lyons thanked Yvonne McGrath for the update provided.

3.2 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)189**

Helen Wright referred to the report and noted key highlights.

Dr David Sulch highlighted that the Quality & Safety Committees-in-Common had not had sight of any quality impacts. Considering the financial challenges, he queried whether there was a view on this. Amanda Stanford felt there was a gap in respect of this and that there should be more information shared. A meeting had been held with the QI team to ensure there would be more assurance going forward. There would then be two stages to the Equality Impact Assessment (EqIA), the QI team would undertake the first part. Amanda Stanford and Dr Kate Wood would then share a quarterly report with the Quality & Safety Committees-in-Common to show the summary of what the EqIAs had triggered when they had been through other relevant areas. It was agreed Amanda Stanford would share a report with the Trust Boards-in-Common and that this would then be shared on a six-monthly basis.

Action: Amanda Stanford agreed to share a report with the Trust Boards-in-Common on EqIA

Jane Hawkard queried whether other Trusts in the area were discussing the possible gaps. Jonathan Lofthouse explained a discussion had been held in respect of this at the ICB Board the previous day. A further update on this would be provided in the private board session.

Sean Lyons referred to the data quality issue at NLaG as detailed within the report. Helen Wright explained that when the issue was referred the data had then been revised and was now on track. The feedback had been commended for being highlighted to the team to allow them to correct this.

Sean Lyons referred to the late theatre starts and performance issues around length of stay, he queried what had been implemented in terms of this. Helen Wright advised there was more work to be undertaken within the care groups particularly around holding to account those that were not performing. Paul Bytheway explained that in terms of late theatre starts these unfortunately registered as a late start even if this was only one second past the scheduled time, 85% of theatre lists started within 10 minutes. There was a need to review how this was reported in the future as the organisations were in a positive position in respect of this. He then referred to the point made around follow ups and explained this would be supported by the DrDoctor system that would be implemented. It was recognised follow ups needed to be reduced and slow progress was being made with this, unfortunately, it would take some time to achieve the required outcome.

Linda Jackson referred to the data quality issues and advised it had previously been highlighted that issues had arisen due to the Lorenzo roll out at NLaG, however, it had been confirmed in the committee that the issue had now been resolved.

3.2.1 **Winter Plan Update – BIC(24)190**

Paul Bytheway referred to the report and drew the Boards attention to key highlights. He added that he was seeking approval from the Trust Boards-in-Common to delegate authority to the Performance, Estates & Finance Committees-in-Common at the October 2024 meeting to approve the Plan for submission.

Paul Bytheway advised that in respect of no criteria to reside (NCTR) there would be focus on three areas, one was surgical assessment. A review had been undertaken the previous day with the Get It Right First Time (GIRFT) team and actions had been agreed at that meeting. This would mean improvements when patients were moved from the ED more quickly including discharge. There would also be an increased frailty presence at the front door on the North Bank that would be supported by additional staff in an assessment area with extended hours. The long length of stays on the North Bank had also increased, however, reviews would start to support a reduction in numbers.

In terms of the South Bank, the occupancy in ED was an issue, however, this was also due to discharge issues. An external review would be undertaken through NHS England to look at discharge process and also reinvent the safer care bundle. There would also be enhancement in the Urgent Care Co-ordination Centre to support issues. Although the issues were relatively the same on both banks they were being addressed differently.

There would also be the implementation of an Urgent Care Co-ordination Centre on the North Bank. This would be hosted by colleagues at Yorkshire Ambulance Service (YAS).

Jonathan Lofthouse advised that investment for the North Bank had previously been agreed with national colleagues, however, the offer had unfortunately been withdrawn due to being allocated elsewhere.

Simon Parkes commented that he had been surprised at the amount of negotiating there was to move a patient to a bed and felt this could be improved. Paul Bytheway advised that Nick Cross was undertaking a piece of work in accordance with Internal Professional Standards which would redefine the way this was undertaken. On the North Bank the care groups managed the beds, however, the process was different on the South Bank. Paul Bytheway explained there were not many wards available to be reopened due to this already happening. Mark Brearley commented that although there was an awareness around required capacity those areas of course needed to be staffed appropriately which had caused issues.

Julie Beilby queried how this sat alongside the business continuity planning in respect of what would happen when there was adverse weather. Paul Bytheway explained there was an Adverse Weather Policy that was in place for those incidents, if required this would be escalated as a critical incident. He added that those processes were tested throughout the year. It was noted this should be included within future reports to highlight it was in place.

Stuart Hall queried whether first point of contact testing would be in place for the winter period. A second query related to whether there would be development for criteria led discharge as referred to in another paper. Thirdly, was around pathway zeros as there would be a need for a unit to ensure this was supported. Paul Bytheway advised that zero pathways had already been added into some pathways. Amanda Stanford advised point of contact testing would not be put in place, however, those patients would be managed in terms of those with respiratory health issues. Paul Bytheway referred to the query in respect of criteria led discharge and explained this was aimed at medicine. This was easier in respect of surgical patients, however, there were more complex issues with medical patients.

Linda Jackson was concerned at how this would be co-ordinated and felt the Trust Boards-in-Common should be provided with assurance by further sharing of the Winter Plan at the November Board Development session. Paul Bytheway advised the site triumvirates would have oversight of this going forward.

Action: Winter Plan to be provided at Board Development session in November 2024

The Trust Boards-in-Common agreed to delegate the sign-off of the Winter Plan to the Performance, Estates & Finance Committees-in-Common. The final version would then be shared with the Trust Boards-in-Common.

3.3 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)191**

Tony Curry referred to the report and noted key highlights. In respect of the issues raised around staffing of the CDCs, it was noted that the committee would focus on early operational days to ensure this did not become an issue. Ivan McConnell advised the clinical staffing for the CDC would be on a rotation between the CDC and hospital sites. Additional clinical staff had been recruited to those roles and admin staff had been recruited that would only work at the CDC.

Tony Curry explained that BAME appointments and promotions continued to be disproportionately adverse within the organisation, this would be addressed in terms of reviewing what else could be put in place. The Committee had a scheduled Time Out session due to be held in December 2024. In respect of Care Quality Commission (CQC) actions Amanda Stanford advised that this was being reviewed in terms of how it reported into the Committees-in-Common.

3.3.1 **Workforce Disability Equality Standard (WDES) Report – BIC(24)192**

Simon Nearney shared the report and advised that both reports still needed to be progressed in terms of how they reported. This would progress with work from the organisational development (OD) teams. It was noted that the reports had been approved through the Workforce, Education & Culture Committees-in-Common.

Simon Nearney advised that the Group continued to focus on zero tolerance including the strengthening of networks, both the North and South Bank were working together to implement those improvements. He added that leadership training was also developing as a Group, however, it was recognised more focus was required around recruitment. Simon Nearney continued to highlight key points from the report for both organisations.

Gill Ponder commented that the HUTH report was more confusing to read in respect of some of the narrative, for example at 4a(i) it stated that the numbers had increased, however, the data provided was a decrease. Simon Nearney highlighted what this referred to and that there had been improvements made. He agreed there should be more clarification provided in the narrative as to what this referred to. It was agreed this would be reviewed in future reports.

The Trust Boards-in-Common approved the Workforce Disability Equality Standard (WDES) Report.

3.3.2 **Workforce Race Equality Standards (WRES) Report – BIC(24)193**

Simon Nearney shared the report and highlighted key points to note.

Two points to note related to the low numbers of BAME staff being appointed to roles that were Agenda for Change 8a and above. The second point was in relation to more BAME staff entering formal disciplinary than white staff. Simon Nearney added that in terms of recruitment training at NLaG, it did not include unconscious bias, however, this was included on the Equality, Diversity & Inclusion training. It was felt there needed to be more focus on this to ensure that there was more consistency. This was also not included in any of the leadership training. At HUTH the unconscious bias training was included in all aspects. There had been some work around this on the South Bank, but it should also be included in other training sessions. A new leadership network was due to be launched towards the end of the year and this would be included within that as well as Group wide recruitment processes. Other aspects had been put in place as the human resources (HR) teams had been advised of this information to ensure they do challenge this going forward. A 'Just Learning' Framework had also recently been launched at NLaG and this continued to be embedded as it had been previously at HUTH. In respect of disciplinaries, new guidelines had been introduced to ensure there would be a BAME representative when required on those specific panels. Other framework policies would also be reviewed to be more supportive of BAME colleagues.

In respect of recruitment, Jonathan Lofthouse had had discussions with network leaders about how to adopt a different approach. One option being considered was to ensure any roles interviewed above a band seven would have a mixed panel in terms of race.

Dr David Sulch queried whether there was any evidence to show that white people where English was not their first language were disadvantaged. Simon Nearney advised the data was not provided in terms of this.

Simon Parkes added that processes for both white and BAME staff needed to be considered in terms of whether white staff were being treated with more leniency than BAME staff in circumstances such as disciplinaries. Jane Hawkard felt that there needed to be more proactive work in terms of attracting BAME staff to apply for such roles.

Sean Lyons agreed as there was access to various groups in terms of attracting staff to certain roles. Simon Nearney agreed and highlighted that some proactive measures had been put in place in respect of interview skills being available to BAME staff and mentoring of those staff. Gill Ponder queried whether consideration had been given to reverse mentoring as this was a good way of breaking down barriers. Simon Nearney advised this had previously been undertaken on the North Bank and consideration could be given as to whether it had been on the South Bank. Gill Ponder added that the Board should also be included in this. Simon Parkes commented that there should also be awareness that all BAME staff were also not the same so needed to be treated as required.

The Trust Boards-in-Common approved the Workforce Race Equality Standards (WRES) Report.

Action: Commit to training as a Board in respect of unconscious bias

3.4 **Capital & Major Projects Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)194**

Helen Wright referred to the report and noted key highlights. It was noted that although the capital spend of £6.6 million had been approved assurance had been sought in respect of this. The Committee would also ensure that plans were delivered as it had been noted that there had been some slippage in terms of the estates and capital plan. In terms of the strategic planning process, there had been recognition that it was important to understand the replacement programme for equipment as this would be significant over the next three to five years.

It had also been highlighted that when large projects were undertaken with complicated business cases, they were not revisited to see where they may have gone wrong. A schedule had, therefore, been put in place to review this going forward. Jonathan Lofthouse advised there were schemes that would still need to be reviewed by Cabinet. He added that there was a large risk in respect of the management of the service for complex radiology equipment.

3.5 **Audit, Risk & Governance Committees-in-Common Highlight Report & Board Challenge – BIC(24)217**

Simon Parkes referred to the report and noted key highlights. Simon Parkes referred to the point made in respect of recommendations that were received by Internal Audit as it had been recognised that when they were made there needed to be a realisation of when those recommendations could be responded to in terms of timelines. The auditors had, therefore, been asked to focus on issues that were the most important when reporting rather than including everything to ensure there was clear focus on those issues that mattered. He added that the Committee had been grateful to Executive colleagues that they had been honest and transparent in respect of the plans that were in place to lead the organisations to improvement. It was positive that there was a lot of good working that was being undertaken.

4. GOVERNANCE & ASSURANCE

4.1 **Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(24)195**

David Sharif shared the BAF and highlighted comments within the report.

Sean Lyons noted appreciation for the work undertaken with the report.

5. OTHER ITEMS FOR APPROVAL

5.1 There were no other items for approval at the meeting.

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 **Items for Information / Supporting Papers**

- Quality & Safety CiC Minutes –July 2024
- Infection Control & Prevention Annual Report

- Audit, Risk & Governance CiC Minutes – July & August 2024
- Performance, Estates & Finance CiC Minutes – July & August 2024
- Fire Annual Report & Work Plan
- Security / LSMS Annual Report & Work Plan
- Workforce, Education & Culture CiC Minutes – July 2024
- Guardian of Safe Working Hours Quarter One Report
- Capital & Major Projects CiC Minutes – February & April 2024
- Integrated Performance Report (IPR)
- Documents Signed Under Seal – NLaG & HUTH
- Trust Boards & Committees Meeting Cycle 2024 & 2025

7. ANY OTHER URGENT BUSINESS

Sean Lyons sought items of any urgent business from Board members, none were received.

Amanda Stanford wanted to highlight that the IPC Annual Report was included in the items for information.

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Sean Lyons sought questions from the public and Governors.

Ian Reekie referred to the highlights earlier in the meeting in respect of further discussion around the financial plan; he sought assurance on behalf of the Governors and asked that consideration was given to patients' services when this was being discussed to ensure those services were not impacted due to any savings. He further queried whether any of that information would be shared at the Council of Governors (CoG) meeting in October 2024. Jonathan Lofthouse advised he would be happy to share information once it was available, however, it may not be ready to be shared at that meeting.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 It was noted the data quality point would be raised through the Audit, Risk & Governance Committees-in-Common as discussed earlier in the meeting.

10. DATE AND TIME OF THE NEXT MEETING

10.1 **Date and Time of the next Boards in Common meeting:**

Thursday, 12 December 2024 at 9.00 am in the Main Boardroom, Diana, Princess of Wales Hospital.

The meeting closed at 12:30 hrs.

Cumulative Record of Board Director's Attendance 2024/25

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	4	4	Ashok Pathak	4	2
Jonathan Lofthouse	4	4	Simon Parkes	4	2
Julie Beilby	4	4	Gill Ponder	4	4
Lee Bond	3	3	Mike Robson	1	1
Paul Bytheway	3	3	David Sharif	4	4
Tony Curry	4	4	David Sulch	4	4
Stuart Hall	4	4	Shaun Stacey	1	1
Linda Jackson	4	3	Amanda Stanford	3	3
Jane Hawkard	4	4	Laura Treadgold	2	2
Sue Liburd	4	3	Kate Truscott	3	1
Ivan McConnell	4	4	Kate Wood	4	3
Simon Nearney	4	4	Helen Wright	3	3

1.6 - MINUTES OF THE HUTH ANNUAL GENERAL MEETING HELD ON WEDNESDAY, 16 OCTOBER 2024

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(24)225 - Minutes of the HUTH Annual General Meeting held on Wednesday, 16 October 2024.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

HULL UNIVERSITY TEACHING HOSPITAL NHS TRUST
ANNUAL GENERAL MEETING

Minutes of the meeting held on Wednesday, 16 October 2024 at 9.00 am
By MS Teams

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Mark Brearley	Interim Group Chief Financial Officer
Amanda Stanford	Group Chief Nurse
Tony Curry	Non-Executive Director (HUTH)
Prof Laura Treadgold	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Myles Howell	Group Director of Communications
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Simon Nearney	Group Chief People Officer
Dr Ashok Pathak	Associate Non-Executive Director (HUTH)
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

KEY
HUTH - Hull University Teaching Hospitals NHS 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. He emphasized the importance of accountability to the public. In addition, he went on to express his gratitude to the staff for their dedication and hard work. It was recognised staff created conditions of care to be proud of.

The following apologies for absence were noted:

Paul Bytheway	Interim Group Chief Delivery Officer
Dr Kate Wood	Group Chief Medical Officer
David Sharif	Group Director of Assurance
Stuart Hall	Vice Chair (HUTH)
Jane Hawkard	Non-Executive Director (HUTH)
Dr David Sulch	Non-Executive Director (HUTH)
Dr Ashok Pathak	Associate Non-Executive Director (HUTH)

1.2 **Declarations of Interest**

Sean Lyons sought declarations of interest; none were declared.

1.3 **Review of 2023/24**

Jonathan Lofthouse introduced himself and shared the presentation with attendees.

Sean Lyons thanked Jonathan Lofthouse for his presentation and the overview of the last year.

1.4 **Financial Review and Annual Accounts 2023/24**

Mark Brearley shared the presentation with attendees.

Sean Lyons thanked Mark Brearley for his presentation.

Sean Lyons opened up the conversation for questions from attendees, however, none were received.

Sean Lyons again wanted to thank all staff for how they looked after patients. He advised he felt privileged to be in a position of leadership. He felt that through living the organisations values he was optimistic there would be improvements and engagement with staff in a positive way.

2. ANY OTHER URGENT BUSINESS

2.1 There were no items of any other business.

3. QUESTIONS FROM THE PUBLIC

3.1 There were no questions raised from members of the public.

Sean Lyons closed the meeting at 10.00 am.

1.7 - MATTERS ARISING

Sean Lyons, Group Chair

1.8 - ACTION TRACKER - PUBLIC

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(24)226 - Action Tracker - Public.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(24)226

BOARDS-IN-COMMON ACTION TRACKER

2024

ACTION TRACKER - CURRENT ACTIONS - 12 DECEMBER 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	December 2024	It was agreed a further update would be provided at the December 2024 meeting.		
Boards-in-Common ACTION									
3.1.3	13.06.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Growth Scans		Amanda Stanford to provide further information regarding growth scans being reported	Amanda Stanford	October 2024	Update to be provided at the October 2024 meeting.		Detail included within the report.
1.5	08.08.24	Quality & Safety Committees-in-Common Highlight Report - Never Event		Dr Kate Wood to provide update on Never Event once details are available	Dr Kate Wood	December 2024	Update to be provided at the December 2024 meeting.		
1.7	08.08.24	Group Chief Executive's Briefing - Flow Campaign		Simon Nearney to share a flow campaign report at a future board meeting	Simon Nearney	April 2025	The Flow Campaign was launched in September 2024. A further Campaign Report will be shared at the April 2025 meeting.		
3.1.1	08.08.24	Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports - NLaG & HUTH		Comments around leadership and mitigations to be included in reporting by Yvonne McGrath	Amanda Stanford / Yvonne McGrath	October 2024	It was agreed further details would be included with the reporting.		Detail included within the report.
3.1	10.10.24	Quality & Safety Committees-in-Common Highlight Report - Infection Control NED Champion		Discussion required as to whether a NED Champion was required in terms of IPC	Amanda Stanford	December 2024	Update to be provided at the December 2024 meeting.		
3.1	10.10.24	Quality & Safety Committees-in-Common Highlight Report - NED Visibility		NED visibility to be added to Board Development timetable session	Amanda Stanford	January 2025	A session was provided at the November 2024 Board Development session on Executive and Non-Executive Director visibility. Further updates would be provided		
3.1.3	10.10.24	Maternity & Neonatal Safety Assurance Reports - NLaG & HUTH - Board Development Session		Board Development Session to be held to review what the organisations were required to complete in terms of statutory requirements and what this did to improvement patient care	Amanda Stanford	January 2025	Update to be shared at the February 2025 meeting		
3.2	10.10.24	Performance, Estates & Finance Committees-in-Common Highlight Report - EqIA Report		Amanda Stanford to share an example report with the Trust Boards-in-Common on EqIA	Amanda Stanford	December 2024	Update to be shared at the December 2024 meeting		
3.2.1	10.10.24	Winter Plan		Winter Plan to be shared at November 2024 Board Development Session	Clive Walsh	December 2024	Winter Plan to now be shared at the December 2024 formal meeting		
3.3.2	10.10.24	Workforce Race Equality Standards (WDES) Report - Unconscious Bias		Board Development Session to be held on Unconscious Bias	Simon Nearney	November 2024	Session held at the November 2024 Board Development		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
1.7	11.04.24	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	Information was to be shared with the Performance, Estates & Finance Committees-in-Common		
3.3.1	13.06.24	Freedom to Speak Up Guardian Annual Report		Fran Moverley & Liz Houchin to provide information on Senior Leaders training	Fran Moverley & Liz Houchin	August 2024	Information was circulated to Board Members		
1.5	08.08.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Perinatal Mortality Review Case		Amanda Stanford to confirm if the NLaG PMRT case had been missed from the report.	Amanda Stanford	August 2024	Amanda Stanford confirmed this case had not been ommitted from the reporting.		

Key:

Green	Completed - can be closed following meeting

1.9 - GROUP CHIEF EXECUTIVE'S BRIEFING

Jonathan Lofthouse, Group Chief Executive

REFERENCES

Only PDFs are attached

BIC(24)227 - Group Chief Executive's Briefing.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)227

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 December 2024
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer / Author	Jonathan Lofthouse, Group Chief Executive
Title of Report	Group Chief Executive's Briefing
Executive Summary	This report updates the Trust Boards in Common on: • Changes in the Executive team, welcoming three colleagues and giving thanks to three interim colleagues • Key outputs from the latest system-level GIRFT review by Professor Tim Briggs, which highlighted examples of best practice in our patch as well as some opportunities to go further • Our current Group performance on patient safety, access targets and finance, which are subject to scrutiny by our Trust Board Committees in Common • The current position on the two devolution deals covering our footprint and the networking opportunities these offer • Our highly successful Digital Hackathon event on 28 November 2024 • Positive progress with the Paediatric Day Surgery development at Castle Hill Hospital • Good news stories, including our new Shining Lights programme, which has seen 118 nominations since launch, about the great work of our staff
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Group Chief Executive Officer

Briefing to the Trust Boards in Common
Thursday 12 December 2024

1. Introduction

1.1 I am very pleased to welcome Emma Sayner as our substantive Group Chief Finance Officer. Emma joined us on Monday 2 December 2024 from her role as Acting Executive Director of Finance and Investment at Humber and North Yorkshire ICB. I know that all Board members are looking forward to working with Emma and we warmly welcome her to our Group. I would also like to offer my sincere thanks to Mark Brearley for filling the role of interim Group Chief Finance Officer so well over the past few months.

1.2 As discussed previously with the Trust Boards in Common, we have taken our next steps around the operational structure at Executive level. Paul Bytheway completed his interim role as Group Chief Delivery Officer on 31 October 2024 and we send our sincere thanks for his hard work as part of the Humber Acute Services programme as well as in the interim Group Chief Delivery Officer role. We welcomed Clive Walsh as Interim Group Chief Delivery Officer on 4 November 2024. On Monday 2 December 2024, the Site Chief Executive roles started on an interim basis. Clive Walsh has moved over to the Interim Site Chief Executive role on the north bank as of this date. I am very pleased to welcome Sarah Tedford, who also started with us on 2 December 2024, as Interim Site Chief Executive for the south bank. These roles will be pivotal in bringing operational delivery of our patient services closer to the Cabinet and enable a direct line of accountability to the Care Group leadership teams. Following the announcement of this change at the most recent Top 100 Leaders' event in November 2024, the feedback I have received from our leadership teams is that our colleagues welcome this change and the more direct accountability between the Cabinet and our clinical teams that this enables.

1.3 My sincere thanks go to Rob Chidlow, who completed his tenure as interim Group Director of Quality Governance on 30 November 2024. Rob has been instrumental in responding to regulatory requirements as well as starting the processes for Group quality governance systems and teams during his time with the Group.

2. Patient Safety, Quality Governance and Patient Experience

2.1 I was honoured to welcome Dr Prem Premachandran MBE to our November 2024 Top 100 Leaders' event. Prem is the Medical Director at the Care Quality Commission and an ED Consultant at Frimley Health NHS Foundation Trust. Prem shared his valuable insights, both as a clinical leader who has made significant improvements in patient safety, as well as from a CQC leadership perspective. I was particularly struck by his encouragement to all of our leaders to have professional curiosity and courage. It is part of our new Group staff charter to *do the right thing, even if it hard to do* and Prem's words of wisdom on active listening and leading with compassion really resonated with the room.

2.2 I am also very grateful for Prem's presentation regarding the Care Quality Commission's re-positioning of the hospital inspection framework. I am very keen to continue to work in partnership with the Care Quality Commission as we deliver on our strategic objectives to improve health outcomes and narrow health inequalities for our patients and have offered for our Group to be an early adopter of the re-based hospital inspection framework.

2.3 A big thank you to Dr Kate Wood and Amanda Stanford for inviting me to speak at the Group Consultants' and the Group Nursing, Midwifery and Health Professionals' Conferences that have both taken place in the last two months. Having an opportunity to link our strategic objectives to the operational delivery of our services, and to share our passion with our clinicians to be ambitious for our patients' health and well-being has been a privilege and the feedback has been positive.

2.4 On Monday 2 December 2024, I chaired a meeting with colleagues across our ICB for our system-level GIRFT review with Professor Tim Briggs. This is a follow-up session to a review visit last year and has given a real sense of the progress we have made across our system to adopt best national practice on productivity and clinical outcomes.

2.5 Professor Briggs highlighted in particular that our system is in line with the requirement to return to full compliance with the 18-week elective standard by the end of this Parliamentary term.

2.6 In addition, with our system focus on paediatric waiting times, our new ICB trajectory is to be under 40-weeks by July 2025, with the majority of patients already seen within 18 weeks. Our excellent collective work has enabled our use of independent sector capacity to be reduced by £1.7m in the last 12 months. We have much to be proud of as a system and we are well positioned to embrace the Further Faster 20 support from the centre as part of the Secretary of State for Health and Social Care's focused programme for heathcare's role in national economic recovery.

2.7 We continue to work closely with the CQC and colleagues in the ICB and NHS England on our position on patient safety and quality, particularly on the areas highlighted on the north bank in the CQC inspections in 2022 and 2023. I am very grateful to our clinical teams for continuing to make progress in key areas and to our quality governance teams in supporting the collation and submissions of evidence to external bodies. The Trust Board Quality Committees in Common receive the details of all of this work and will be highlighting key areas in their update to the Trust Boards in Common today.

2.8 We are making good progress on the upgrade works to the Daisy Day Surgery Centre at Castle Hill Hospital. This is on track to open as a dedicated paediatric day surgery unit at the beginning of January 2025. I am delighted that we will be meeting the needs of our young patients in a bespoke facility following the conversion of the Duchess of Kent Day Surgery Centre at Hull Royal Infirmary to the Urgent Treatment Centre. We have had positive discussions with Sheffield Children's Hospital NHS Foundation Trust to understand national best practice and potential partnership opportunities, on which I will keep the Trust Boards in Common appraised.

3. Urgent and Emergency Care and Planned Care

3.1 The headline data position for Urgent and Emergency Care and Planned Care are included in today's Integrated Performance Report at agenda item BIC(24)251. Starting with our Group organisation's performance on ambulance handover and the four-hour Emergency Department standard, our performance for October 2024 is set out below.

3.2 The four-hour standard is 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 On a 'footprint' basis, the north bank collective four-hour performance for October 2024 was 70.3.1%, which is a small deterioration. The plan requirement was a performance of 76.3%. The Unplanned Care Board has received short-and medium-term recovery plans co-produced at Place level, with final assurance and acceptance of plans underway at system level. This delivery has been broken down in the constituent parts of the 'footprint' to understand changes: there has been a downturn in performance in all modalities, requiring actions from all partners including our Group, for improvement.

3.4 The ambulance handover position for the north bank in October 2024 saw a performance deterioration, linked with crowding in ED and lack of flow through the acute bed base. Actions for flow at Hull Royal Infirmary have been prioritised, with the aim of improving processes for Expected Discharge Dates, SAFER and discharge flow. There has also been increased attendances for non-admitted patients, with a resulting mis-alignment of medical staffing resources to demand. This is also being reviewed.

3.5 The south bank 'footprint' performance in August 2024 for all Type 1 and Type 3 activity, including the UTC in Goole, was 76.3% against a plan position of 73%, which is an improvement in the last two months.

3.6 We have seen an upturn in the number of Type 3 attendances on both banks of the river. This is impacting on the north bank in particular and appears to be a result of unmet need having some system capacity through the Urgent Treatment Centre at Hull Royal Infirmary to be seen. We are also seeing a number of patients needing urgent review, particularly within specific clinical specialties, which we believe is linked to the national GP collective action.

3.7 Nationally, October 2024 was the busiest month this year for Urgent and Emergency Care activity, which was mirrored in our geography. While both of our sovereign organisations are in Tier 2 for Urgent and Emergency Care with NHS England, we were called to a system meeting on Tuesday 3 December 2024 to discuss our fluctuations in performance in recent weeks, in particular ambulance handover times as well as ED performance.

3.8 The ambulance handover position for the south bank in October 2024 saw a small deterioration however remains within normal operating range. Improvement actions continue on flow continue, particularly ensuring assessment space is available in a timely manner to enable ambulance handovers, with a standard of zero tolerance to over 45-minute handovers being the aim.

3.9 In respect of elective care, the 65-week position remains under significant scrutiny. Our Group continues to perform well in this regard, with specialty-specific action plans being put in place where there are volumes of patients at risk of breaching 65-weeks each month. The north bank October 2024 position was 13 breaches of the standard, which was a reduction of 2 from the previous month. Specific action are being put in place for ENT and Plastic Surgery, which are the two key specialties under pressure in HUTH. For the south bank, a new control total of 8 breaches of the standard by end of December 2024 has been agreed, with specific actions for reducing 52-week volumes being reported to the Performance and Finance Committees in Common in November 2024.

4. Strategy and partnership developments

4.1 As briefed in my last report to the Trust Boards in Common, two devolution deals in our footprint were authorised by HM Government in September 2024. We have been updated as to the current progress and next steps of these deals by our partners in North East Lincolnshire Council.

4.2 In respect of the Greater Lincolnshire County Combined Authority (GLCCA), which covers North Lincolnshire, North East Lincolnshire and Lincolnshire, each of these Local Authorities are working towards the necessary enabling processes for the first Mayoral elections in May 2025. A working group is established, focused on governance. This will be the work necessary to establish, operate and govern the GLCCA. This includes the development of the GLCCAs constitution, its structure, financial procedures and assurance framework.

4.3 A number of working groups with cross-constituent council membership are focusing on the work necessary to implement the devolution deal – for example, Transport, Employment and Skills, Housing, and Business and Trade. We will network with these groups as would be helpful to maximise the impact of the devolution deal. The immediate priorities that have been earmarked are housing in North Lincolnshire, low carbon brownfield and industrial sites in Lincolnshire and transport in North East Lincolnshire. There is a stated priority for economic development and skilled jobs through the region from the devolution investment funds.

4.4 The work and the delivery of statutory responsibilities of the three individual Local Authorities continues; the devolution deal brings long-term investment that is locally prioritised through the GLCCA. When the GLCCA is formed, two councillors (including the Leader) from the Cabinet of each constituent council will have a place on the Board, chaired by the elected Mayor. The District Councils within Lincolnshire will have 4 seats on the Board. They will be joined by the Police and Crime Commissioner and a business representative. The GLCCA will meet to discuss and make key decisions on where best to invest the money and exercise the range of powers that will be devolved by the Government and develop the necessary enabling strategies.

4.5 The Mayor will be elected by the people of Greater Lincolnshire and will hold office for four years. The GLCCA Mayor does not replace any of the civil mayors or council chairs in any of the Local Authorities, rather is the locally elected figurehead locally and nationally for the investment and devolved powers that the GLCCA will be granted in the new year.

4.6 The devolution deal for the north bank, which covers Hull City Council and East Riding of Yorkshire Council, is undertaking similar steps. The Hull and East Riding Mayoral Combined Authority is a separate devolution deal to the GLCCA. The links to the industrial development taking place on both sides of the estuary and particularly the energy transition to low and zero carbon technologies means that job creation and potential economic growth arising from this is likely to be large scale.

4.7 There is an existing Humber Leadership Board (HLB), which has been in place for around 10 years. This is a Joint Committee of the four councils around the Humber estuary. The aim is that the HLB will transition into a Joint Committee of both combined authorities, bringing the two elected Mayors and all constituent councils together to focus on matters of mutual strategic and economic interest. I will keep the Trust Boards in Committee updated on progress and our involvement in particular in the enabling strategies for the devolution deals.

4.8 On 28th November 2024, the Group hosted its first ever Digital Hackathon. The event invited 130 members of our staff from all teams and backgrounds to innovate with two groundbreaking new digital products made available by NHS England and Microsoft. Co-Pilot uses AI to support everyday tasks within Office 365 and PowerApps allow people who don't have a background in software development to build applications and automate processes without being able to code. The Group has access to trial licenses for each until 31 March 2025 to test their value and ability to boost productivity. Working in teams at the Aura innovation centre at the Humber Bridge, our people built a variety of applications with uses such as document control and clinical audit, as well as using Co-Pilot to create an AI powered trainer for major incidents, and to independently compile a discharge summary. In all, the teams worked up 19 fantastic Co-Pilot automations and 9 prototype applications. However, one of the major benefits fed back by all was the value of having a mix of our people together with a full day to focus on problems and innovate solutions. The Digital team are now working with Microsoft and their partners, Bytes and Digpacks, to see which applications are suitable to take forward at pace and get them into live use.

5. Financial Performance and Estates and Facilities updates

5.1 In respect of the Group financial position, the Month 7 position was reported to the Performance, Estates and Finance Committee in November 2024 and the assurance and escalations report at agenda item BIC(24)235.

5.2 The Month 7 position is that: the Group's in-month deficit was £3.8m, circa £1.5m adverse to plan. Group Capital spend was £20.6m, which was £16.5m behind plan, largely due to some slippage on the Community Diagnostic Centres. Capital spending plans have been reviewed in detail to ensure the full capital budget is utilised this year.

5.3 The Group reported delivery of £41.3m in cost improvements against a year-to-date target of £35.7m, which was £5.6m better than plan. Our cash balance was rated green at £71.8m and will continue to be monitored closely. The Group spent £7m less on agency, bank and overtime costs than the same period in 2023/24. This is now below the NHS England 3.2% target of total pay expenditure, at 2.9%

5.4 We are slightly behind on activity levels to ensure Elective Recovery Performance income, however, with activity projections as currently profiled, this should still recover by year-end.

5.5 Work continues at pace on our capital developments, particularly those at Castle Hill Hospital and the Community Diagnostic Centres. As noted above, there has been some slippage on these capital schemes, however clinical activity has started to be provided and planned in other community settings. I will provide further information about this at the Trust Boards in Common meeting.

6. Workforce Update

6.1 We have fully refreshed our induction programme and will be launching our new Group induction this month with all new starters. This is a full day programme to onboard our new colleagues with our Group vision, values and staff charter, provide staff with their mandatory training in one set and get them mission ready with NHS Humber Health Partnership. I am grateful to colleagues across the Group, particularly the Organisational Development and Education teams, for coordinating this effort and taking a fresh approach to induction.

7. Equality, Diversity and Inclusion (EDI)

7.1 I was humbled to share the story of one of our neurodiverse colleagues at this year's Group Staff Disability network conference. Our colleague had really struggled in her apprenticeship programme placement, despite being really open and clear about her support needs and having successfully been a volunteer in one of our wards before this. Hearing our disabled staff's experiences at this year's conference as well as having time to put forward ideas for real improvements made for an excellent conference session.

7.2 I am really pleased to be asked to speak at tomorrow's Group Black, Minority and Minority Ethnic (BAME) Staff Leadership conference, which is on the theme of 'Challenging and Overcoming Racial Discrimination in Healthcare'. We have recently launched our Group-wide Zero Tolerance to Racism reporting tool and I am grateful to our colleagues across the Group who support the Circle groups and support systems whenever a colleague reports unacceptable behaviour from staff or from a patient.

8. Good News Stories and Communications Updates

8.1 Hull leading the way in neonatal care after £1.3 million investment

Physical expansion of the neonatal unit within Hull Women and Children's Hospital began in October 2023 to accommodate more intensive care and high dependency cots, improved parent and family facilities, additional equipment and a dedicated staff training suite.

8.2 Funded by a £1.2 million grant from NHS England plus local contractor donations and £100,000 from the hospital charity's "Space to Grow Appeal", the centre is now one of the leading providers of Level 3 intensive care in the country for babies as young as 22 weeks.

8.3 Liver health project has potential to save lives

Funding of £500,000 over two years from NHS England and the Humber and North Yorkshire Cancer Alliance has been secured to pilot Liver Health Checks in a number of community locations across Hull, East Yorkshire, North and North East Lincolnshire.

8.4 Initially starting in Hull and East Yorkshire in April 2023, the project was extended after 12 months to encompass Scunthorpe, Grimsby and surrounding areas, and parts of Scarborough too. The region is one of just 18 sites across the country conducting the liver health checks project and this is based on high levels of deprivation and poor health outcomes from liver disease.

8.5 By working with healthcare and service providers, local authorities, local employers, community groups and taking scans out to those who might benefit most, the team is seeking to identify liver disease and begin treatment at a much earlier stage.

8.6 Regional first as hospital bids to deliver green patient transport

The facilities team at Castle Hill Hospital in Cottingham has just taken delivery of its first ever, all-electric, non-emergency ambulance.

8.7 Representing investment of over £86,000, the ambulance will be used to transport patients needing tests and scans, as well as those requiring admission to or transfer between wards, around the 168-acre (683,000 m²) site – equivalent to 106 football pitches.

8.8 This is the first fully electric patient transport ambulance to be used at a hospital across North Yorkshire and the Humber; it is also believed to be the first of its kind in the country.

8.9 Hundreds of patients benefiting from new hospital project

A team of 16 MSK physios, supported by hospital admin staff, have seen, treated and supported almost 300 patients with bad backs, shoulder injuries or leg, knee or ankle pain and other MSK issues at three special Community Appointment Days (CAD) since June.

8.10 Waiting times for appointments have fallen from the longest wait of 26 weeks to just over 10 weeks in four months, non-attendance rates have almost halved, almost a quarter of patients receive pain management support on the day and almost 20 per cent are joining initiatives to support healthier lifestyles.

8.11 Community staff receive prestigious title

Three of our community staff have received a top honour, recognising their commitment to our patients.

8.12 Claire Clarke, Garry Cowling and Claire Hebden have been awarded the title of Queen's Nurse (QN). This is a formal recognition by the Queen's Nursing Institute (QNI) that they're part of a professional network of nurses committed to delivering and leading outstanding care in the community.

8.13 Shining Lights

The Shining Lights recognition scheme allows staff and patients to nominate our workforce for recognition, celebrating those who go the extra mile to brighten the days of patients, staff, and visitors. Whether it is a kind word, a thoughtful gesture, or simply easing someone's anxiety, these small acts make a huge difference.

8.14 In October and November 2024 we received 118 nominations. Board members have each committed to visiting one nominee every month to say thank you and well done and pass on a Shining Lights card and badge. In the past two weeks these have included Sean Lyons, who dropped in on Sallie Longman, Radiotherapy and Chemotherapy Booking Coordinator and Julie Beilby who visited ED consultant Dr Sergio Sawh at Diana, Princess of Wales Hospital. I met and chatted with Nursing Auxiliary, Emma Tymon, on Ward 90 at Hull Royal Infirmary, who was really pleased to receive her card and badge. Well done to everyone who has received a Shining Light nomination.

Jonathan Lofthouse
Group Chief Executive
4 December 2024

1.10 - WINTER PLAN

Clive Walsh, Interim Site Chief Executive (North Bank)

REFERENCES

Only PDFs are attached

BIC(24)228 - Winter Plan.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)228

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 December 2024
Director Lead	Clive Walsh, Interim Site Chief Executive - North
Contact Officer / Author	Clive Walsh, Interim Site Chief Executive - North
Title of Report	Winter Plan 2024/25
Executive Summary	HUTH and NLaG plans in 24/25 were led by the Care Groups and Site Teams, with a strong link to the Financial Planning and Improvement Programme (supported by PA Consulting) which incorporates the improvement in the flow of patients through ambulatory and inpatient units. The main elements of the Winter Plan are: ▪ Objectives ▪ Multi Agency Discharge Event (MADE) ▪ Improvement in Flow ▪ Virtual Wards ▪ Schemes to provide capacity and increase safety ▪ Management of capacity and escalation ▪ Monitoring and prediction of increasing congestion ▪ Issues and risks The MADE event commence on 25 Nov 2024, and the outputs will be incorporated into the Flow Programme, which will require a significant commitment of staff time in order to effect change. National funding is not available in 24/25 for winter initiatives, and the Trust has committed to a range of non-recurring intiatives. These will be subject to approval and evaluation through a “mini business case” process, overseen by the CFO. A range of governance and assurance processes are in place to ensure the monitoring and delivery of the plan. The next iteration of the Winter Plan will include an offer on staff Health & Well-being. For 2025/26, it has been agreed that the Winter Plan will be developed as part of the Operational Planning process. The organisation will use the opportunity to pilot and evaluate proposals that would improve flow and reduce congestion. Early decisions on plans will allow physical moves to take place in preparation for the Winter period. The Board is asked to consider the report and the assurance provided through the PEF CiC.
Background Information and/or Supporting Document(s) (if applicable)	The latest draft of the Winter Plan is included
Prior Approval Process	Consideration at Cabinet on three occasions Consideration at PEF CiC on 27 Nov 2024
Financial Implication(s) (if applicable)	Investment of c. £1.03M in non-recurring improvement schemes

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The effective management of emergency services is likely to reduce inequality in access to healthcare.	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other – please detail below:

NHS
Humber Health
Partnership

Winter Plan

4 Dec 2024
Version 3

Name - Clive Walsh
Position - Interim Site Chief
Executive - North

NHS
Humber Health
Partnership

Contents

- Objectives
- Multi Agency Discharge Event (MADE)
- Improvement in Flow
- Virtual Wards
- Schemes to provide capacity and increase safety
- Management of capacity and escalation
- Monitoring and prediction of increasing congestion
- Issues and risks

Humber Health Partnership

Objectives

- Improve flow to allow timely access to the most appropriate In-Patient care
- Maintain & improve ambulance handover times to deliver the impact of HO 45
- Mitigate IPC issues in adults and children's services
- Maintain elective and outpatient care for patients
- Improve 4hr A&E performance to meet the agreed standard (local agreement)
- Deliver 30% of ED attendances through SDEC service
- Mitigation of risk of 12hr trolley waits
- Take care of staff Health & Wellbeing
- Identify risks & enact mitigations

- The national framework for drivers of quality in Urgent & Emergency Care

Overall aim	Primary drivers	Secondary drivers	Change ideas	
Increase the quality and productivity of urgent and emergency care resources by improving flow and reducing variation and waste	**Right place:** Ensure patients are cared for in the most appropriate setting for their needs	**Optimising admissions** Adopt criteria driven approach regarding decision to admit	Run **Criteria to Admit** as a live tool for confirming patient admissions	**Team job plans** that support early review of patients by senior clinician
			Extend **CTA to residents** & other HCPs with senior oversight	Ensure use of CTA by senior decision maker **at the point of attendance**
			Use **CTA audits** to confirm capacity required in alternatives to admission	Run CTA for admitted patients at 24hr to determine **fitness for discharge**
		Alternatives to admission Reduce reliance on admitted care by increasing the use and impact of alternative care models	Implement 10 core components of the **Virtual Wards Operational Framework**	Ensure virtual wards link with **SPoAs/ ICC, SDEC, UCR, 999/111, care homes**
			Scale virtual ward capacity to deliver efficiencies and meet UEC demand	Establish a **virtual hub** to manage referrals & outreach to specialist teams
			Local **profiling of SDEC demand** to ensure core service meets demand	Establish **acceptance criteria** & Include SDEC and VW on DoS
			Ensure **job plans and resource** support SDEC delivery	**Co-locate SDECs** with the emergency department
			Use self-assessment tools to benchmark & address gaps in SDEC	
	Right process: Optimise processes, making best use of resources & minimising waste	**Standardised process** Increase the use and optimise the impact of Internal Professional Standards (IPS) 7-days a week, across all services and specialities	**Establish, measure and hold** to account IPS delivery	Test IPSs during times of **crowding and increased pressure in ED**
			Implement changes to **rostering and job planning** to ensure the right resource	Use **telephone** to refer allowing conversations rather than electronic referrals
			Ensure consistent **access to diagnostics** 7 days a week	**Minimise ward moves**
			Deliver networked **rotas** to access speciality advice in low volume specialities	
	Right pathway: Ensure patients have an appropriate plan, know about it & it is enacted	**Care & discharge planning** Create and enact comprehensive care and discharge plans in partnership with patients and carers	Deliver **100% coverage of comprehensive care plans**	Ensure all appropriate patients can answer the **four patient questions** every day
			Deliver **comprehensive discharge planning**	Implement **criteria led discharge** (CLD) with a focus on facilitating weekend discharge
			Implement **reconditioning / get up get dressed** initiatives	Ensure a **'home first'** approach
			Establish **team job plans** which support early review of all patients	Implement best practice, **evidence based clinical pathways**
			Embed the **flow principles** throughout the patient pathway	Maximise use of **step-down virtual wards**
	Right people: Securing greatest value from our people	**Workforce planning and transformation**	**Job planning:** e-job planning, job planning toolkit & demand / capacity planning	**Retention:** deploy the national retention guide and toolkit
			Workforce transformation: use best practice models like CLEAR & HEE tools	**Consider new roles:** access workforce transformation case studies
		Workforce deployment	**E-rostering and e-job planning:** as an enabler for flexible working	Consider the establishment of a **digital staff passport**
			Use the nationally developed **agency rules toolkit**	
		Governance & measurement	Deploy the national **safe sustainable and productive staffing guidance**	Adopt the national **e-rostering & e-job planning meaningful use standards**
			Utilise national **workforce measurement tools, including model hospital**	

Measures

Outcome measures (Quality)	Balancing measures	Outcome measures (Productivity)
Reduction in 12-hour+ stays in ED	Readmission within 30-days	Reduction in number of NEL admissions
Reduction in time after discharge ready date for P0 patients	Re-attendance at ED within 7 days	Reduction in number of patients with 7+ day LoS
		Reduction in number of patients with 14+ day LoS
		Reduction in number of patients with 21+ day LoS

Humber Health Partnership

Multi Agency Discharge Event

Humber Health Partnership

As part of the Winter Plan, the Trust will undertake a 2-week Multi Agency Discharge Event (MADE), commencing 25 November 2024.

KEY AIMS:

- Zero tolerance to 45-mins ambulance delays – including timely bed moves and handover plans, overboarding for planned discharges, identifying ‘golden discharges’ for the next day
- Improved estimated date of discharge (EDD)
- Longer length of stay (LLoS) rounds daily - increase no criteria to reside (NCT) patients identified and discharge to assess (D2A) referrals
- Increased utilisation of the Discharge Lounge
- Increased weekend discharges
- Increase number of discharges identified daily from community beds
- Support discharges from ED for low level social requirements (South Bank)

Programme: Pathway 0s – Improve flow

SRO: Jenny Hinchcliffe Lead: Anne-Marie Hall Implementation Date: 25/11/24 Impact: In patient flow

Humber Health Partnership

Action	Owner	Completion Date	Project Impact
Initiate new governance structure	Jenny H	06/12/24	Affirms ownership and accountability
Create RACI's to support the new governance structure	PA	10/12/24	To ensure compliance with governance and accountability for workstreams
Create communicates plan for the newly revised programme	Bev/Corrin and Comms	13/12/24	Ensure all stakeholders are aligned and sighted on the newly revised programme
Develop tactical discharge focussed board pack	QI Team/Wards	13/12/24	Standardise processes across the Group
Launch pilot wards for discharge focussed board rounds (AMU/H500)	QI Team	06/12/24	Ensure validity of the programme and have golden standard
Consolidate learning from pilot wards	QI Team	13/12/24	To ensure best practice
Agree approach for roll out	Jenny H/Anne-Marie Hall	13/12/24	Identify best approach for project plan that supports rapid roll out
Agree named clinician and nurse lead for each ward to support roll out	Divisional Tris	06/12/24	Affirms ownership and accountability
Review Discharge and going home policy (north bank)	Anne-Marie Hall	10/01/25	To ensure policy is up to date and fit for purpose
Review Discharge Policies – south bank	Anne-Marie Hall	10/01/25	To ensure policy is up to date and fit for purpose
Decision for Discharge Lounge options paper for interim and long-term plan implemented with supporting SOP	Anne-Marie Hall/Tracy Campbell	20/12/24 10/01/25 - SOP	To drive success of the project targets
Capture learning from MADE events and ensure priorities to be embedded are incorporated into programme	Anne-Marie Hall	13/12/24	To drive success of the project's targets
Review data post MADE event to understand impact on the measures identified for the programme	Anne-Marie Hall	13/12/24	To understand the impact on project targets

Measurables

Outcome Measure - Increase the pathway 0 discharges
Reduce LoS for pathway 0
Process Measures :
Improve AM discharges
Improve utilisation of discharge lounge

Improve weekend discharges
Improve EED process (meaningful EDD's)

Balancing Measure :
Readmission within 30 days

Risk/Issue	Description	Mitigation Strategy
Risk	No Permanent environment for the discharge lounge HRI	Options paper being developed for agreement with cabinet (Cost circa 1m)
Risk	Clinical engagement	Care Groups to identify leads to ensure ownership and accountability
Risk	Data not readily available from the south bank for some measures	Work with Power BI on timelines for reports

Programme: Pathways 123 – Improve Flow

SRO: Nick Cross Lead: Anthony Rosevear Implementation Date: 25/11/24 Impact: Inpatient Flow

NHS Humber Health Partnership

Action	Implementation Date	Project Impact
North Bank [Hull/ER] – System Single Coordinator: Rachel Kemp		
Same day discharge wherever possible delivered via single multi-disciplinary and multi-organisational Integrated Discharge Team – Phase two including TARF removal	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Enhanced intermediate home care capacity (c.83FTE / 3000 care hours per week) delivered via c.£2m financial investment	Q3	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Improved discharge performance delivered through enhanced intermediate bedded care capacity, VCSE sector support, continuation of MADE initiatives, and maximised utilisation of step-down capacity via c.£4m winter scheme additional discharge funding	Q1	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Real time reporting of acute delays and community-based capacity via implementation of the OPTICA single system dashboard	Q2	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Expedite nursing and residential placements through review of the brokerage process for hospital discharge support	Q3	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Improved hospital discharge lounge utilisation supporting flow through identification of an appropriate discharge lounge environment and resourcing	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Standardisation of hospital discharge processes via training and resource support for ward-based teams	Q3	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Enhanced Home First team capacity via NR investment in CHCP Be at Home service (15FTE) and alignment of therapies resources with shift of D2A activity	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Development of support and comprehensive planning for High Intensity Users via ICB review of current provision and business case for Place HIU leads	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Confirm system governance and reporting structures to ensure Group Executive oversight of progress against actions, performance against measures, and mitigation of risks to programme delivery	Q3	Oversight and assurance of oversight of progress against actions, performance against measures, and mitigation of risks

Programme: Pathways 123 – Improve Flow

SRO: Nick Cross Lead: Anthony Rosevear Implementation Date: 25/11/24 Impact: Inpatient Flow

Action	Implementation Date	Project Impact
South Bank [NL/NEL] – System Single Coordinator: Emma Owen		
Real time reporting of acute delays and community-based capacity via implementation of the OPTICA single system dashboard	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Improved patient flow through optimising the Discharge to Assess (D2A) Model, reducing LOS, enhancing coordination among HCPs, and supporting timely interventions	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Address deconditioning during short hospital stay via VCSE support (Get Up Get Dressed Get Moving) improving patient outcomes, reducing readmission rates, and enhancing recovery	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Standardisation of hospital discharge processes via training and resource support for ward-based teams	Q3	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Reduced delays in transfer of care or discharges via Choice Policy implementation achieving early engagement and support, and efficient implementation of the Choice Directive	Q1	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Enhanced intermediate home and bedded care capacity delivered via stocktake review of flow management processes, reablement and intermediate care service provision opportunities, and Home First recruitment and retention activities	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Improved NCTR discharge turnaround through Integrated Discharge Team (IDT) improvements including further development of the trusted assessor model, targeted home care provider work, demand analysis, workforce needs assessment, and tech enablement	Q3	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Development of support and comprehensive planning for High Intensity Users via ICB review of current provision and business case for Place HIU leads	Q4	Reduction in NCTR P123 Reduced LOS post NCTR P123 Improved 7-, 14- and 21-day stranded patient performance
Confirm system governance and reporting structures to ensure Group Executive oversight of progress against actions, performance against measures, and mitigation of risks to programme delivery	Q3	Oversight and assurance of oversight of progress against actions, performance against measures, and mitigation of risks

Virtual wards

Humber Health Partnership

HHP SRO: Nick Cross PA Lead: Scott McBride

Immediate Focus Areas

- Consolidate learning from pilots - favourable outcome data to date:
  - ✓ Proven patient safety
  - ✓ Low re-admission rates consistent with national benchmarking
  - ✓ Strong patient feedback
  - ✓ Consistent / slightly above NL virtual ward utilisation against national average (68.7%)
  - ✓ Data from SGH and DPOWH showing reduced average length of stay from Aug 23 – Aug 24 (7 down to 3 days and 4.5 down to 3.5 days respectively)
  - ✓ Cost effective - £70 per bed day virtual vs £400 inpatient
- Scale-up from c. 25 to 50 virtual ward beds in total to aid in winter planning

Enablers

- 'Command centre' concept – will require resource
- Expand virtual ward model to 24/7 (currently 8am – 8pm)
- Agree single platform for use across HHT
- Agreement for funding / expansion of respiratory virtual ward North Bank (Lenus Health)
- Raising awareness and improved confidence amongst clinicians re: virtual ward incl / excl criteria, criteria to admit to virtual ward prior to inpatient bed

Long term

- Develop relationships with Yorkshire Ambulance Service (YAS) and East Midlands Ambulance Service (EMAS) regarding admission avoidance
- Additional scaling as required to eventually include supporting management of long term conditions, working with primary care / GP
- Expansion of number of specialties actively involved
- Encourage evaluation and research opportunities, invite trainees into programme

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Schemes to provide capacity and increase safety

Schemes	Rationale
UTC scope and Capacity	Makes best use of existing physical capacity. Prove concept of primary care streaming
Pharmacy inreach	Proven across multiple providers. Earlier prescribing of TTO's. Advice to ward clinicians.
Portering	Reducing bed turnaround time.
Cleaning	Reducing bed turnaround time.
Virtual Ward Infrastructure	Priority workstream in Financial Planning and Improvement programme.
Paediatricians extended hours and Enhanced care capacity	Expected higher prevalence of RSV. Ad hoc cover could be more expensive.
Respiratory NIV Support and Critical Care	Managing this group of patients effectively can reduce LOS.
Extended Hours for Frailty SDEC	Turnaround of elderly patients can have substantial benefit in bed days used.
Enhanced hours and staffing for HRI site management	Current staffing levels insufficient to manage complex patient flow, Increase staff resilience

Management of capacity and escalation

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Daily planning for winter period:

- Ops Call meetings throughout the day with focus on escalation of operational pressures, identifying unmitigated risks and required actions
- OPEL levels and escalation focus on each Ops Call
- RAIDR app used as primary OPEL communication tool across the system
- Ambulance Rapid Handover Protocols in place with Ambulance Tactical Commanders invited to each Ops Call
- Any Temporary Escalation Spaces (TES) in use captured on each Ops Call
- Strategic and Tactical level on-call structure 24/7 for North and South Bank
- HNY System Coordination Centre (SCC) in operation between 08:00-20:00 with ICB Director On-Call outside of these hours
- HNY ICB daily Directors Call at 12:00 for system collaborative working and oversight
- Live reporting requirements for 12hr+ waits in ED and ambulance handover delays (3hr to ICB/SCC and 4hr+ via ICB to NHSE)

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Planning for winter period:

- Escalation and Surge Plans (including Full Capacity Protocols) have been reviewed and updated for North Bank and South Bank
- An Escalation and Surge Workshop took place to review OPEL 3 and 4 actions
- Operational Business Continuity Plans are being updated
- Adverse Weather Plan has been reviewed
- Incident Response Plan and ICC SOP reviewed to support decision making during an incident
- ICB workshops to commence in preparation to implement new national OPEL Framework 2024-26 including introduction of Community Services OPEL and update to Acute OPEL metrics
- HNY ICB System Resilience Framework
- 7-day national UEC reporting requirements commenced 1st November 2024

Monitoring and prediction of increasing congestion – Winter Pressure Tracker

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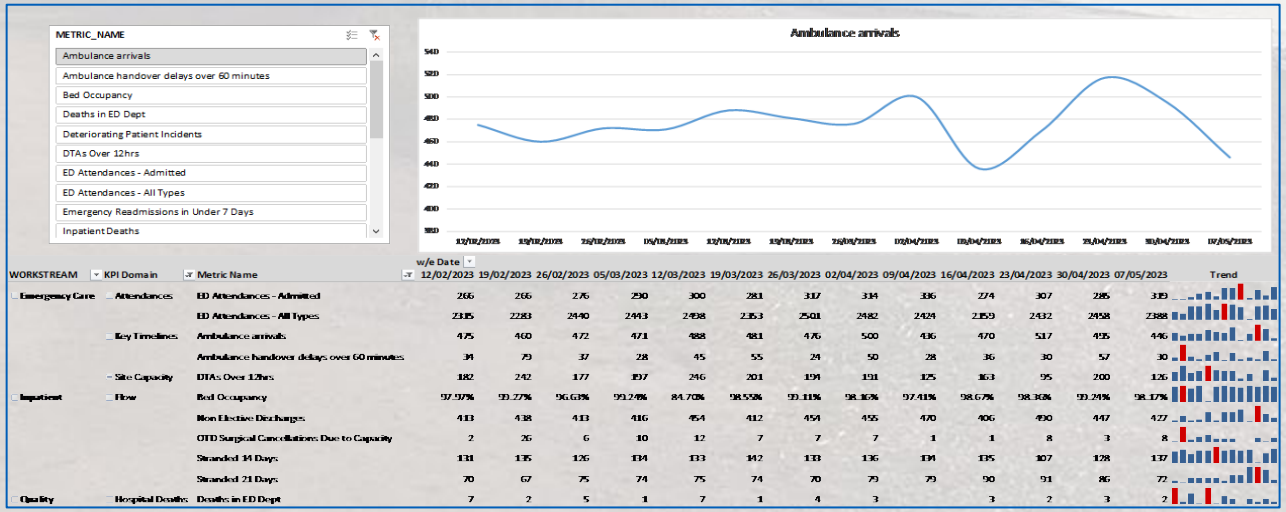
- Augmenting the suite of existing reporting tools a simplified Winter Pressure Tracker will be deployed to provide at-a-glance indication of emerging issues
- The tracker will allow user defined inter day trending and comparisons of core metrics.
- The tool will deploy Statistical Process Control to track in year delivery against control limits derived from 23/24 data to immediately identify any meaningful variance in delivery pressure.

Output



Core Metrics

Workstream	Metric	Currency
Emergency Care	ED Attendances - All Types	Value
	ED Attendances - Admitted	Value
	Median time to Treat (first clinician)	Value
	Median time in Dept	Value
	Ambulance arrivals	Value
	Ambulance handover delays over 60 minutes	Value
	DTAs Over 12hrs	Value
	Emergency Admissions	Value
	ED Admission Rate	%
	Breach reason: Awaiting Admission	Value
	Breach reason: Awaiting Diagnostic	Value
	Breach reason: Awaiting Specialtiy	Value
Flow	Beds Open	Value
	Bed Closed due to infection	Value
	Beds Occupancy	Value
	Number of DTAs in ED at 8 am with no bed allocated	Value
	Non Elective Discharges (total)	Value
	Non Elective Discharges before 11am	Value
	OTD Surgical Cancellations Due to Capacity	Value
	Stranded 14 Days	Value
	Stranded 21 Days	Value
	NCTR	Value
Quality	Deaths in ED Dept	Value
	Emergency Readmissions in Under 7 Days	%
	Leaving ED without being seen	%
Workforce	Short Term sickness	%

Issues and risks

Schemes	Risk	Likelihood	Impact	Score	Mitigation
Improve flow to allow timely access to the most appropriate Inpatient care	Demand will outstrip escalation capacity with lack of system winter escalation funding	5	4	20	Use of Full Capacity Protocol (including double FCP as required). Invest time in Flow element of Financial Planning and Improvement
	Lack of community/IDT capacity	4	4	16	Increased reliance on FCP and Escalation. Appraise CHCP and Locality Winter plans (when available) Pilot of Home First programme. Identify gaps through MADE
	Lack of resolved location for HRI Discharge Lounge	4	4	16	Use of Escalation capacity and FCP
	Higher levels of acuity driving challenges with LoS	4	4	16	Use of Escalation capacity and FCP. Expansion of respiratory NIV service
	Clinician Buy in and change in behaviours	4	4	16	
Maintain & improve ambulance handover times to deliver the impact of 45min Drop & Go	Insufficient bed/trolley availability due to extensive use of escalation and FCP implementation.	4	4	16	Ensure patients placed through FCP have suitable beds
	Increase in daily demand and surges outside of forecast, resulting in insufficient offload capacity	4	4	16	Explore ordering/loaning specialist cost.
Improve 4hr A&E performance to meet the agreed standard & Mitigation of risk of 12hr trolley waits	External factors driving up ED attendances e.g GP accessibility for the population, community pharmacy collective action	3	3	9	Redirect to UTC where possible. Use ICB localities to provide alternative pathways
	Athough recognition of additional staffing requirement, shifts may not be covered.	2	4	8	Shifts are likely to be covered given current restrictions.
	Surges in diagnostic demand which lead to delays in diagnosis	4	3	12	Early escalation and effective CDU use (where present)
Deliver 30% of ED attendances through SDEC service	Lack of footprint to support additional SDEC capacity	4	3	12	Exploring alternatives outside of bed-base e.g. OPAT moves.
	Overall bed deficit means high likelihood of SDEC utilised as escalation and impact SDEC numbers	5	3	15	Review of escalation guidance to ensure SDEC can function in the morning.
Other Internal Risks	Relative newness of Care Group management structures	3	4	12	Weekly operational Identification of gaps and interim solutions
	Delays in ability to act due to triple lock process	3	3	9	Early identification and escalation of areas of risk
	Balance of demands between financial performance, quality, structure and managing change during winter pressure	4	4	16	Cabinet to identify pressure points and support prioritisation by site Teams

2 - GROUP DEVELOPMENT

2.1 - NHSE DEVELOPMENTS AND UPDATES INCLUDING THE 'INSIGHTFUL PROVIDER BOARD '

Jonathan Lofthouse, Group Chief Executive

REFERENCES

Only PDFs are attached

BIC(24)229 - NHSE Developments & Updates including the Insightful Provider Board.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)229

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 December 2024
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer / Author	Jonathan Lofthouse, Group Chief Executive
Title of Report	NHS England developments and updates including the 'Insightful Provider Board'
Executive Summary	This paper provides an update on four national and regional areas of work: • NHS England's publication - *The Insightful Provider Board* • The national consultation from the Department of Health and Social Care - *Leading the NHS: proposals to regulate NHS managers* • An update on the Department for Health and Social Care's national consultation on the NHS 10 year plan • An update on the discussions around the future roles and reporting structures to NHS England and the Integrated Care Boards
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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Group Chief Executive Officer

NHS England developments and updates including the 'Insightful Provider Board'

Thursday 12 December 2024

1. Introduction

1.1 This paper provides an update on four national and regional areas of work:

- NHS England's publication - *The Insightful Provider Board*
- The national consultation from the Department of Health and Social Care - *Leading the NHS: proposals to regulate NHS managers*
- An update on the Department for Health and Social Care's national consultation on the NHS 10 year plan
- An update on the discussions around the future roles and reporting structures to NHS England and the Integrated Care Boards

2. The Insightful Provider Board

2.1 NHS England published *The Insightful Provider Board*, which is non-statutory guidance for NHS Trust Boards.

2.2 This guide is designed to help Boards to consider their approach to handling and acting on the information they receive. It reinforces the primary role of Trust Boards to set the organisation's strategy as well as the leadership behaviors and culture of the organisation. It also looks at how the culture of the Trust Board can affect the information it receives and the actions it takes. It provides an overview of metrics that can support the Board to better understand the organisation's performance.

2.3 The guidance is structured into four parts:

- **governance and culture:** the factors that make it challenging for the right information to flow to the Board and the role of effective governance in tackling this; how Boards should handle and act on information; and the importance of a curious, problem sensing and open culture
- **meaningful information:** the principles that govern the flow of information to the Board, and tools to report that information; and a strong focus on outcomes rather than actions and processes
- **Six domains for consideration:** these areas and illustrative metrics can be used by Boards to understand if their organisation has a sufficiently comprehensive framework for reviewing trust performance, making decisions and developing strategy. These domains are: strategy, quality, people, access and targets, productivity and finance
- **putting the framework into practice** including a sample integrated reporting framework to illustrate how information can be presented and used effectively.

2.4 The full guidance is available at:
https://www.england.nhs.uk/long-read/the-insightful-provider-Board/
(search NHS England Insightful Board for the direct link)

3. Leading the NHS: proposals to regulate NHS managers

3.1 The Department for Health and Social Care has launched a public consultation on the question of whether and how to regulate NHS Managers.

3.2 This includes a range of perspectives to consider, including what level (if any) below Trust Board level that any proposed framework should apply to, the intended benefits vs. the costs, the public and NHS confidence in such a system and to what extent such a process would provide solutions to key findings of national publications and inquiries, where the quality and accountability of NHS managers has been a direct or indirect finding (such as the National Infected Blood Inquiry).

3.3 The consultation was updated on 28 November 2024 and is open to all comments for 12 weeks, until 18 February 2025.

3.4 https://www.gov.uk/government/consultations/leading-the-nhs-proposals-to-regulate-nhs-managers/leading-the-nhs-proposals-to-regulate-nhs-managers
(search Department of Health NHS managers consultation for direct link)

4. NHS 10 year plan

4.1 The Department of Health and Social Care's national conversation on the 10 year plan for the NHS has increased its level of public, patient and staff engagement in recent weeks.

4.2 I have attended a number of sessions over the last two months facilitated by the ICB and NHS England, which have started to take up feedback from a senior leadership point of view. These have usefully also included discussion opportunities on the future relationship between NHS Trusts with NHS England and the ICB, which I will update on later in this paper.

4.3 The NHS Change website provides the main engagement portal for public, patients and staff engagement. Any member of the public and staff are welcome to submit their views now via on-line questionnaires, which are also available in other formats. A number of face-to-face engagement meetings are in the process of being arranged for the new year, and organisations will also be asked for their input in the new year, also.

4.4 The engagement portal is available at:
https://change.nhs.uk/en-GB/
(search NHS 10 year plan for direct link)

5. Update and Next Steps for NHS Operating Framework

5.1 There are current discussions within NHS England and with Integrated Care Boards around the next developments of the operating framework in the NHS.

5.2 This is seen as the key enabler to the stated aim from the Secretary of State for Health and Social Care, in which the NHS becomes a neighbourhood care service. The goal of the current work is for clearer accountability, for an NHS that delivers today and is fit for the future as a neighbourhood health model.

5.3 The clearer accountability element centres on the NHS Oversight and Assessment Framework as well as the NHS Performance Improvement and Regulation Framework and ensuring there is clarity between NHS England national and regional teams, and individual ICBs, as to the level of accountability and authority sitting with each team.

5.4 The focus for NHS England will be to partner with best-performing areas to share national best practice and inform policy making; to build NHS IMPACT to support 'mid-performing' systems and also to step in, with the ICB, to support rapid improvement

5.5 The focus for ICBs will be to be the strategic commissioner, to plan, secure, and manage services, ensure sustainable primary care (GP practices, dentistry, community pharmacy) are in place and to lead on neighbourhood health initiatives to reduce secondary care usage.

5.6 Both will use the NHS Oversight and Assessment Framework as well as the NHS Performance Improvement and Regulation framework to undertake their duties as well as to provide clarity to NHS Trusts on reporting lines.

5.7 The work is ongoing at present and there are as yet no immediate changes for 2024/25. There is a commitment to ongoing and extensive engagement, including a regular advisory group for implementation planning. This sits under the NHS System Development and Reform programme to co-create the implementation plan once any framework is agreed.

Jonathan Lofthouse
Group Chief Executive
2 December 2024

2.2 - UPDATE ON GROUP STRATEGY

Ivan McConnell, Group Chief Strategy & Partnerships Officer

REFERENCES

Only PDFs are attached

BIC(24)230 - Update on Group Strategy.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)230

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 December 2024**
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships Officer
Contact Officer / Author	Linsay Cunningham, Deputy Director of Strategy & Partnerships
Title of Report	Group Strategy – Update
Executive Summary	An overarching Strategic Framework for the Group was developed earlier this year following extensive engagement with internal and external stakeholders. This has been shared with a range of stakeholders, including NHS England who have recognised the framework and process undertaken to develop it as exemplary. Work is underway across Care Groups and corporate directorates to develop a series of subsidiary strategies and Care Group delivery plans. These are being developed in an iterative manner to capture interdependencies and ensure alignment to the overarching Strategic Framework. Engagement with Board members will continue over the coming months as each of the draft strategies are developed and shared. Developing the subsidiary strategies in this way will provide the Group with a clear articulation of its future goals, prioritised for the Group and each supported by a defined series of measures and at each level of the organisation.
Background Information and/or Supporting Document(s) (if applicable)	Supporting Document: Group Strategic Framework
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Equity is one of the four pillars on which the Strategic Framework is built and will be a critical principle in shaping the Group Strategy. Shifting from a focus on equality to one of equity will impact upon what we do and how we do it across the Group.
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Update on Development of the Group Strategy

December 2024

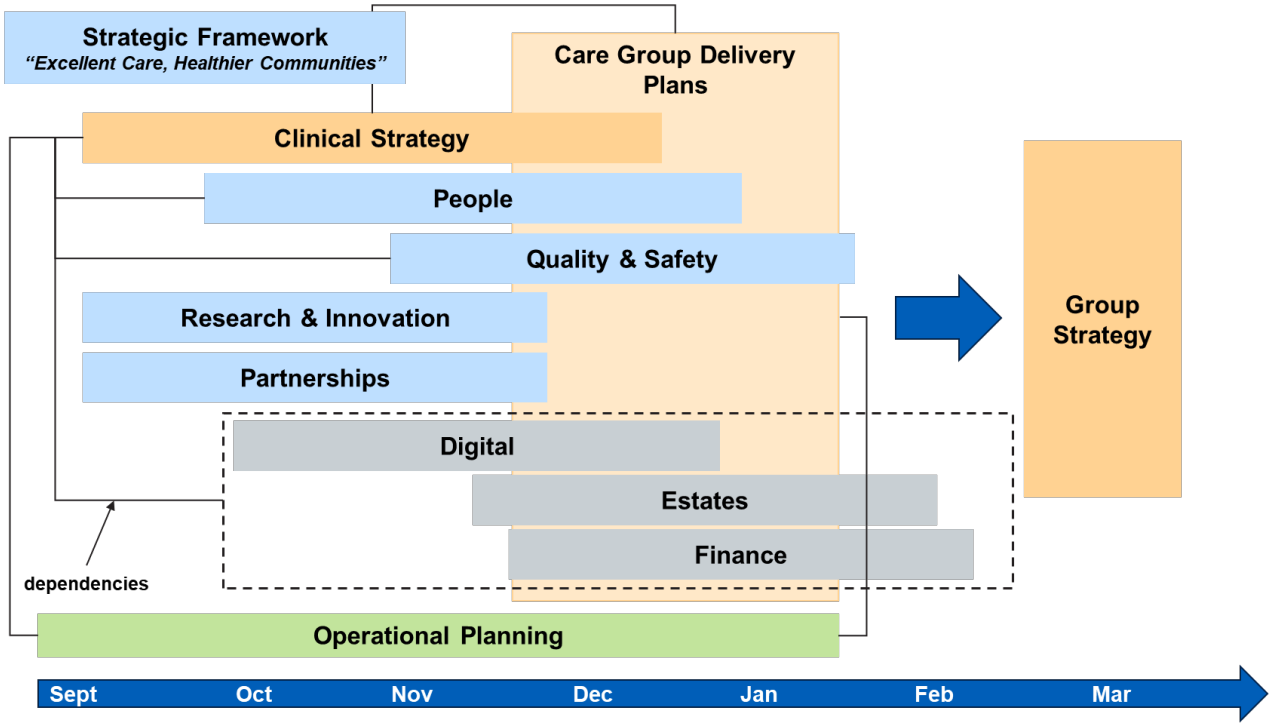
Background

From April to July 2024 extensive engagement was carried out with executive and non-executive board members and a wide range of internal and external stakeholders, culminating in the development of an overarching Strategic Framework for the Group. Over a six-week intense engagement period over 55 workshops and conversations were held and insight gathered through an online questionnaire, capturing the views of more than 1,500 people. Once Board approval was secured, this Strategic Framework was launched in July 2024 at the Top 100 Leaders' Conference and has been widely shared with stakeholders and partners (included as Annex A).

Approach to developing the Group Strategy

Now that the Strategic Framework has been agreed, a set of supporting strategies and action plans need to be developed to underpin delivery of this framework. The work undertaken to develop these subsidiary strategies, which is well underway, will support development of an overall Group Strategy.

The diagram below summarises the work being undertaken and highlights key dependencies between subsidiary strategies and the enabling workstreams of digital, estates, finance and people. The Group Strategy will be developed in the context of addressing the key organisational challenges Financial recovery, operational planning and strategic planning are also being undertaken in parallel to help alignment between short, medium and long-term plans.



Development of Subsidiary Strategies

Work is underway across Care Groups and corporate directorates to develop a series of subsidiary strategies and Care Group delivery plans.

The table below sets out Executive sponsorship and lead arrangements for each subsidiary strategy and approximate timescales for engagement and delivery of the relevant strategy document.

Strategy	Exec Sponsor	Delivery Lead	Dec	Jan	Feb	March
Clinical	Dr Kate Wood Amanda Stanford	Linsay Cunningham				
Research and Innovation	Dr Kate Wood	James Illingworth / Sathya Thozhukat				
Partnerships	Ivan McConnell	Linsay Cunningham				
People	Simon Nearney	Paul Bunyan				
Quality and Safety	Amanda Stanford					
Digital	Dr Kate Wood	Andy Haywood				
Estates and Facilities	Emma Sayner	Simon Tighe / Craig Hodgson / Alex Best				
Finance	Emma Sayner	Philippa Russell				
Care Group Delivery Plans	Dr Kate Wood Amanda Stanford	Care Group Tris *(JR/LC to support)*				
Group Strategy	Jonathan Lofthouse Ivan McConnell	Linsay Cunningham				

In most areas, engagement with key stakeholders has commenced. Work to develop finance and estates strategies will commence early in the new year, with the support of new substantive leaders for these areas.

Engagement with Care Groups is taking place throughout December and January to develop a Group Clinical Strategy linked to individual Delivery Plans (plans on a page) for each Care Group.

This work is being undertaken in an iterative manner to capture interdependencies and ensure alignment to the overarching Strategic Framework.

Developing the subsidiary strategies in this way will support with the completion of an overarching Group Strategy by Spring 2025, bringing together the priorities across all the Care Groups and corporate directorates. This will provide the Group with a clear articulation of its future goals, prioritised for the Group and each supported by a defined series of measures and at each level of the organisation.

Group Objectives

In addition, the Communications Team is working with strategy colleagues to create an accessible summary of the Group's Strategic Objectives, aligned to the Strategic Framework. This will be our communication mechanism for the strategy, setting out our five key areas of focus for the Group to all staff, ensuring that colleagues across all teams and functions are able to connect their work to the strategic objectives of the group. Engagement with Executive and Non-Executive colleagues will take place to refine this document in parallel with the development of the Group Strategy.

Ivan McConnell
Group Chief Strategy & Partnerships Officer

Dr Linsay Cunningham
Deputy Director of Strategy & Partnerships

December 2024

NHS
Humber Health
Partnership

Our Strategic Direction – A Journey to Excellence

Strategic Framework

July 2024

Who are we?

The NHS Humber Health Partnership (HHP) was formally created in April 2024. The Partnership brings together the two biggest NHS organisations in the Humber region:

- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust

United by Compassion: Driving for Excellence

We care about our people, places, communities: ***We want the best*** for our people, places, communities

Every hour of every day we welcome a new life into the world; every other minute a new patient comes through the door of one of our Emergency Departments; and each year we provide the equivalent of one outpatient appointment for every person in the Humber. We employ over 18,000 people across our group – two times the population of Immingham – and have around 600 regular volunteers.

8,700 Births

122,644
Unplanned Admissions

301,535
A&E Attendances

135,053
Day case operations

1,225,329 Outpatient Appointments

On 1st April 2024, the group implemented a new structure – the first of its kind for any hospital group across the NHS. Putting in place 14 care groups that span both banks of the Humber estuary, we have brought together the talents, skills, ideas, and commitment of our people from both organisations to drive improvement, eliminate inconsistency and deliver change.

Now is the time to set out our collective vision and ambition for the future.

This document sets the strategic direction for our new group. It reflects our commitment to our people and our communities – to providing the best possible care and making a positive and lasting impact in our communities, going beyond the direct impact of our treatments and support.

What we are proud of

Humber Health Partnership

We care about our people, places and communities – we are ***United by Compassion***
We want the best for our people, places and communities – we are ***Driving for Excellence***

We have a long and proud history of serving the Humber region and caring for its people. Our teams consistently go above and beyond to ensure those in our care get the best outcomes and feel safe and well looked after.

In everything that we do, we are led by our values. Our values will define our journey to excellence.

Our values

Compassion	We care. We want the best for our people, places and communities.
Honesty	We are honest about our shortcomings and always strive for better.
Respect	We recognise and respect everyone's unique contribution.
Teamwork	We work together to achieve the best for our patients and communities.

We have much to be proud of

At Humber Health Partnership, we are proud to make a difference in the lives of our patients and communities every day. We are proud of our creativity, dedication and sense of humour. We know our communities really well and care about doing our best for them.

Where are we now?

Our current models of care are struggling to meet existing demand and are not set up to do so in the future. Our population is less healthy than in other parts of the country and as a result people in our communities live many more years in poor health.

Humber Health Partnership

Organisational Challenges

Buildings

It would take more than £200 million to bring all our existing buildings up to standard and more than £100 million over the next 15 years to meet anticipated future demand.

Digital Infrastructure

Many of our digital systems are outdated and they do not talk to one other.

Performance

Too many people are waiting too long for diagnosis, care and treatment and staying in hospital longer than is necessary.

Financial sustainability

There is insufficient funding in the system for us to continue as we are.

Population Health Challenges

Deprivation

Much of the Humber's population lives in poverty. In Hull more than 1 in 2 live in the most deprived neighbourhoods and in North East Lincolnshire it is 4 in every 10.

Ageing

The number of over 75-year-olds in our population is increasing and will more than treble in the next 20 years. At the same time, our working age population is shrinking.

Burden of Disease

Women in the Humber will spend, on average, up to 26 years in ill-health and men up to 23 years.

Health Inequalities

People living in the more affluent areas of the Humber can expect to live for up to 13 years longer than those living in the poorest areas.

By coming together as a group, we can work on a much broader scale, we can use the assets we have differently and radically re imagine how we provide care. By working together in new ways, we can do more to support our population to live healthier, happier lives.

Excellent Care
Healthier Communities

Where are we trying to get to?

We have come together as a group because we care about our people, places and communities. We recognise that we are stronger together and can do more by sharing resources, skills and knowledge.

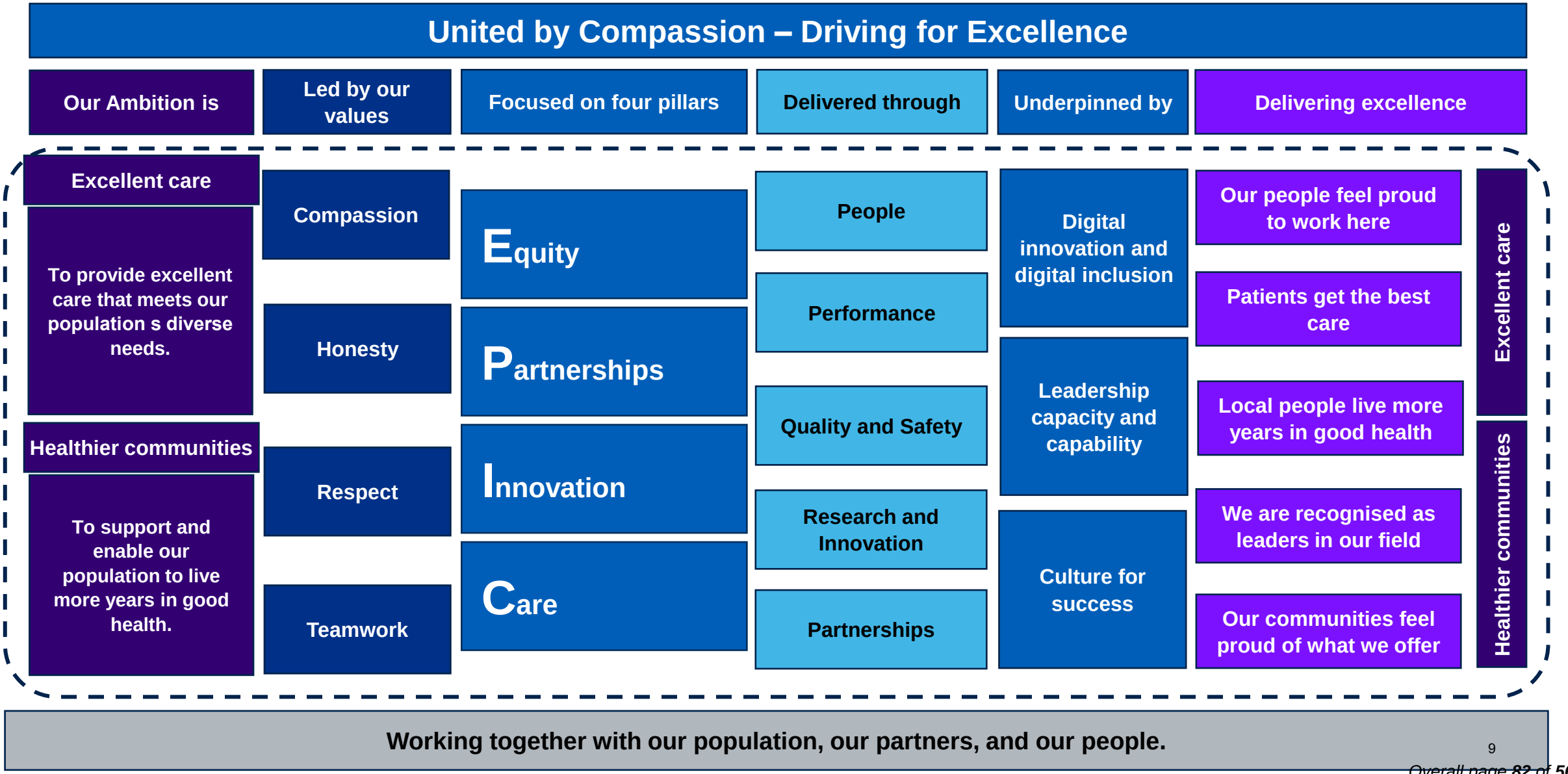
Humber Health Partnership

Our primary role is to provide high-quality healthcare services – our ambition is to provide **excellent care** that meets our population's needs. We also have a wider role to play in our communities and our local population. Our scale and our reach mean we can influence health and wellbeing far beyond the impact of our healthcare services alone. Our ambition is to build **healthier communities** by supporting and enabling our population to live more years in good health.

Our vision of **Excellent Care** and **Healthier Communities** is built on four key pillars – Equity, Partnerships, Innovation and Care. These describe the destination we are driving towards.

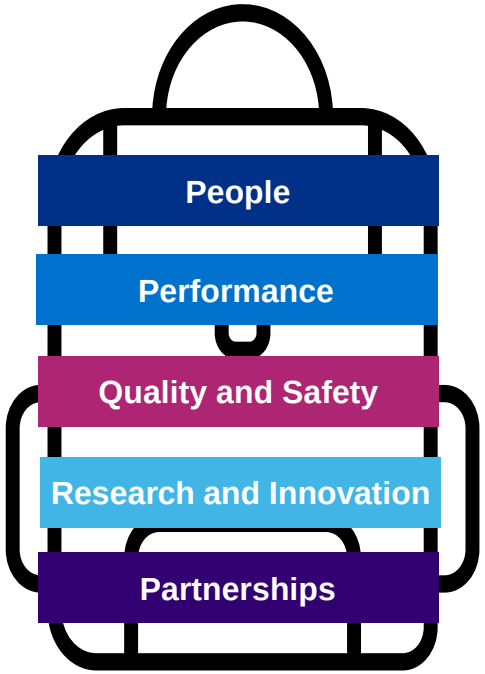
	Equity	Partnerships	Innovation	Care
Excellent Care looks like…	We deliver care that meets the needs of those living in the most deprived communities and those facing the biggest barriers (*Core20+5).	We have strong and wide-ranging academic and industry partnerships and trusted relationships across our local health and care systems.	We have a radically different model of care underpinned by effective digital, data and technology, which enables many more people to access the support they need remotely.	We provide high quality local services through our network of (District General) hospitals for all our communities and outstanding specialist services through our elective and tertiary Centre for Excellence (CHH).
	Equity is at the heart of everything we do.	**We work in partnership, not alone.**	**We are agile, we learn, and we improve.**	**First and foremost, we care.**
Healthier Communities looks like…	We improve the life chances of those living in the most deprived communities and facing the biggest barriers through supported employment, access to support for health improvement and good secondary prevention.	We have trusted relationships with our local population and together we are committed to achieving better health.	We work with partners to deliver ground-breaking research on the wider determinants of health to find new ways to improve the health and life chances of people living in rural and coastal regions.	We make every interaction we have – with a patient, carer, friend, colleague – count, seeing it as an opportunity to make a positive impact on their health and wellbeing.

Our Strategic Framework on a page



How will we get there…?
Our journey to excellence

We have a long way to go to deliver our ambitions of **Excellent Care** and **Healthier Communities**. This will be a difficult journey – we must change expectations, mindsets, culture, and long-standing ways of working. But it will be a journey worth taking – we have an opportunity, with the size, scale, and networks we have, to radically re-imagine the future of health and healthcare in the Humber.



Excellent Care
Healthier Communities

Lay the foundations

- Supporting our teams today
- Eliminating waste and duplication
- Listening to our patients and keeping them safe
- Developing research infrastructure and embedding innovation
- Playing an active role in our health and care system

Excellent Care
Healthier Communities

Transform

- Building a more flexible, adaptable and resilient workforce for tomorrow
- Radically re-imagining how and where we deliver care
- Transforming our services so they are built around the needs of those who use them
- Maximising the impact of research and innovation by aligning our expertise to the big challenges facing our population
- Expanding our influence and building new collaborative arrangements that will enable us to thrive

Excellent Care
Healthier Communities

Deliver

- **Our teams feel proud of what they do and are supported to live healthy lives.**
- **We are the best at what we do and our population gets good outcomes.**
- **Our services flex to meet different needs and local people live more years in good health.**
- **We are recognised as leaders in our field and use our influence to advocate for better health for our population.**
- **We maximise our impact for good and our population plays its part in living well.**

Developing our digital infrastructure | Building capacity and capability | Embedding the culture for success

Our People

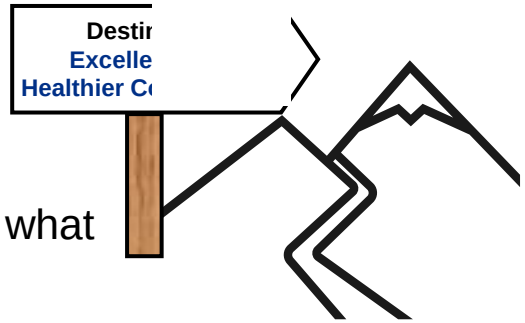
We can only deliver the scale of change that is needed if we have the right people, with the skills, knowledge and motivation to continually improve.

Delivering our strategic ambitions will require us to build the confidence and resilience of our people – instilling pride in our group and the work that we do.

We will:

- **We will look after the health and wellbeing of our people**
  - We will get the basics right for our teams, improving working environments, providing space for reflection and support to build resilience.
  - We will improve our approach to flexible working, to ensure we retain talent and enable our people to give their best at work and at home.
  - We will tackle discrimination head-on and ensure all our people are living out our values of compassion, honesty, teamwork and respect.
- **We will support our people to grow and develop to their full potential**
  - We will work to build a genuinely inclusive culture that celebrates diversity and promotes belonging so that everyone feels safe and can thrive.
  - We will make it easier for our workforce – including our volunteers – to move around between different organisations and sectors and find the role for them.
  - We will focus on talent development, supporting people to grow in their roles and work at the top of their professional licence.
- **We will build a flexible and adaptable workforce for the future**
  - We will work with our training partners to develop curricula that focus on core competencies, adaptability and innovation to help our future workforce to be creative and embrace change.
  - We will build the digital capabilities of our people to ensure they are fully equipped to deliver new ways of working for the future.
- **We will make a positive impact on our communities through our people**
  - We will re-double our efforts to inspire and support our workforce to make healthier choices for them and their families, causing a ripple effect of healthy changes across our communities.

Performance



NHS
Humber Health
Partnership

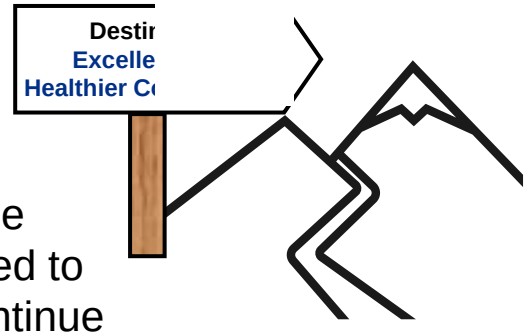
To turn the dial on our performance as a group, we need to radically change what we do and how we do it.

We will transform everything that we do and how we do it with a focus on delivering slick processes, eliminating unnecessary bureaucracy, and putting care in its rightful place.

We will:

- **We will streamline processes and remove duplication**
  - We will have a laser focus on eliminating manual processes and workarounds.
  - We will invest to save by building the digital infrastructure that allows us to remove paper-based systems.
  - We will put in place clear governance processes with as few steps as possible to enable fast and effective decision-making and implementation of change.
- **We will eliminate unwarranted variation in our service delivery**
  - We will develop delivery plans for our 14 Care Groups that align models or care and ways of working across both banks of the Humber, adopting “best in class” from across our organisations.
- **We will do things once**
  - We will look at every service and function to identify where improvements and efficiencies could be made by consolidating activities, teams and functions and doing things once across the system.
  - We will review our physical estate and rationalise wherever possible – looking at our assets across the system, not just within our organisations.
- **We will develop sustainable models of care**
  - We will reorganise our services to make the best use of people, buildings and equipment, focusing on delivering quality local services as close to home as possible and highly specialised care from defined centres of excellence.
  - We will build robust digital foundations that are secure, resilient and work seamlessly across departments, organisations and sectors.
  - We will improve the way we use data to drive decision-making in real time and plan more effectively for the future.

Quality and Safety



Humber Health Partnership

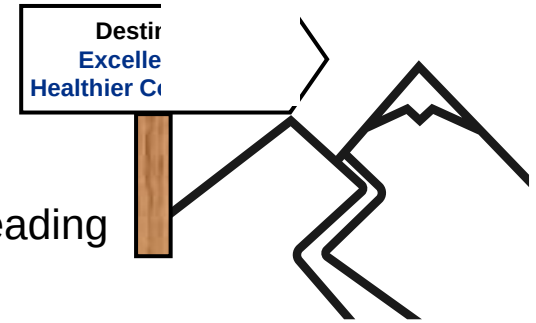
Being kept safe and well looked after is one of the top priorities for the people who use our services. As demand for our services continues to grow, we need to think very differently about how services are organised to ensure we can continue to provide safe and good quality services for our local communities.

In all that we do, we will strive to provide the kind of care we would want for ourselves and our loved ones.

We will:

- **We will keep our patients safe and reduce avoidable harm**
  - We will embed a safety-focused culture, supported by systems and processes that enable teams to deliver reliable, high-quality care.
  - We will make it easy for patients, loved ones and staff to speak up if they see something that isn't quite right and build a positive culture of learning and improvement.
- **We will deliver the best outcomes for our patients**
  - We will strive to get the best possible outcomes for every patient, recognising that what defines a good outcome will be as individual as each person we treat.
  - We will empower teams to be responsive to patient needs, giving them space to innovate and try new things and adapt what they do to suit different needs.
  - We will improve the way our teams communicate with one another, with our patients and with other organisations to ensure they are all working together as effectively as possible.
- **We will work hard to provide a positive experience for our patients and their loved ones**
  - We will really listen to our patients and their loved ones and tailor our care and support to their needs and what matters to them.
  - We will build our services around our patients and their needs, adopting a home first approach radically rethinking how and where we provide care.
  - We will see carers, family members and loved ones as an asset and encourage them to get involved in their loved one's care.
- **We will equip our patients to live healthier lives**
  - We will use every conversation to provide our patients with the tools and the knowledge they need, and the encouragement of a trusted healthcare professional, to make small but impactful changes to their health and wellbeing.

Research and Innovation



NHS
Humber Health
Partnership

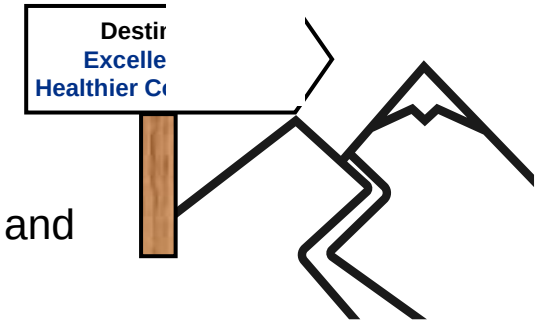
We are ambitious for our people and our population. We want to be at the leading edge of healthcare research and innovation.

Research and innovation can help us to find the new systems and ways of working we need to adapt to the changing demands of the future. We must re-focus our efforts to maximise the impact of research and innovation.

We will:

- **We will build the infrastructure we need to deliver excellent clinical research**
  - We will work with academic and industry partners to deliver the facilities, data and digital infrastructure we need to undertake quality, impactful research.
  - We will promote our nursing, midwife and allied health professionals to undertake research – giving appropriate time and resources to enable more professionals to be research-active.
  - We will build confidence and health literacy amongst our patients to enable them to make informed choices about participating in clinical trials and other research opportunities, making research more inclusive to improve our population's health.
- **We will align our research efforts to the big questions facing our population**
  - We will apply the advanced skills and knowledge of our scientific community to the big challenges facing our population and our workforce today.
  - We will work with leading research institutions who have the expertise and connections we need to find the solutions to our unique set of challenges.
  - We will leverage our industry partnerships and expertise in carbon reduction and sustainability to ensure we are leading research and helping to define the future of sustainable healthcare.
  - We will build our research capabilities and use our unique skills and assets to support wider economic regeneration in the Humber region.
- **We will equip our people to innovate and transform**
  - We will work with training providers to build research skills and capacity into curricula so that we can develop more homegrown researchers and our clinical and professional staff are engaged in relevant research that contributes to continuous improvement of our services.
  - We will foster creativity and entrepreneurship by giving greater autonomy to teams to deliver objectives within a framework.
  - We will engage and involve our communities in research and innovation, giving them a voice and influence over shaping the solutions.

Partnerships



NHS
Humber Health
Partnership

We cannot achieve success without the support of our partners, our people and our communities.

To deliver our strategic ambitions, we must solidify our existing partnerships and leverage the influence we have as a group to forge new relationships with people and organisations within and beyond the Humber.

We will:

- **We will play a vital role in local health and care partnerships**
  - We will work with partners in each of our local areas, recognising the unique challenges and opportunities in each geography, taking time to build strong relationships with each place.
  - We will build trust and credibility with our partners so that together we can take risks to deliver the type of radical change we need.
  - We will support our teams to develop closer relationships with partners at an operational level, encouraging joint ownership and collaborative problem-solving.
- **We will use our size and scale to bring national and international attention to the Humber region**
  - We will leverage the influence we have as a group to forge new relationships with wider academic and industry partners, to advocate for our region and its people and attract investment and increased attention into our area.
  - We will forge new partnerships with industry – both local and further afield – to deliver our ambitious net-zero targets and play our role in driving economic regeneration on and around the Humber estuary.
  - We will forge closer links with other like-minded organisations and influential institutions in the North, so that together we can have a stronger voice to advocate for our populations. Working together we will amplify our voice and ability to influence national policy.
- **We will define a new relationship with our communities**
  - We will take time to listen to our communities and to really understand their needs, wants and aspirations.
  - We will be clear with our population about what we need from them – and what they can do to support their own health and wellbeing.

Foundations for success

Humber Health Partnership

Delivering these actions will only be possible if we also put in place the building blocks we need – digital infrastructure, leadership capacity and capability and a culture for success.

Digital

- **We will transform our approach to digital, data and technology to enable comprehensive change**
  - We will build robust digital foundations that are secure, resilient and interoperable.
  - We will improve the way we use data to drive decision-making in real time and plan more effectively for the future.
  - We will build a virtual hospital, which will work alongside our physical sites and be fully integrated into our existing service offer.
  - We will keep digital inclusion at the heart of what we do so that those living in our most deprived communities are not excluded.

Leadership

- **We will build capacity and capability at every level, growing the leaders we need for today and tomorrow**
  - We will develop leadership capacity and capability at all levels, giving our people the tools and permission they need to lead change in their area.
  - We will nurture local talent and develop the dynamic, flexible workforce we need for the future.
  - We will build on our record of widening participation, youth volunteering and apprenticeship schemes, to grow our own future workforce – going out of our way to offer tailored opportunities that will inspire and enable local people to enter rewarding careers in health and care.

Culture

- **We will build an inclusive, just and learning culture that encourages creativity and collaboration**
  - We will work to build a genuinely inclusive culture where diversity is celebrated, and the unique skills and perspectives of each individual are recognised and rewarded.
  - We will build a culture of continuous improvement where all staff feel empowered to lead change.
  - We will embed a culture that rewards creativity, encourages appropriate risk-taking and supports people to learn from failure.
  - We will develop a culture that is outward-looking and willing to embrace new perspectives and ways of doing things.

What does it mean for me…?

Humber Health Partnership

Over the next five years, **we will challenge everything we do and how we do it**.

We will completely redesign pathways and services so that they work for the people who use them rather than fitting around the needs of those who provide them.

This means that, in the future, people will come to hospital less often and stay for less time. People living with long-term conditions will be supported and encouraged to manage their conditions at home and have a clear route for escalation when they need more help or medical input. We will work much more closely with GPs, primary care, mental health, community services and voluntary and community sector organisations so that people do not feel passed from pillar to post but instead can see everyone is working together and joining things up.

What this means for Jean

Jean is 86 years old and lives in a flat in Cleethorpes. She has several health conditions including Atrial Fibrillation and arthritis. Last year she had an operation after she fell and broke her hip.

A traditional approach

Jean has lots of different appointments with hospital doctors in different departments, for each of her conditions. These happen on different days, and sometimes she forgets to tell the doctor about recent changes in her health.

When her condition gets worse, she gets unsteady on her feet and recently she has had several falls.

Over the last few years, Jean has had multiple admissions to hospital and the last time she stayed for several weeks because she needed some extra support to get around at home.

How things could look different

Jean wears an electronic monitoring device that is connected to a control centre. When Jean's condition worsens, the device triggers an alert and automatically creates an appointment for a specialist nurse to call Jean and see how she is doing and put in place changes that could prevent a future fall.

Jean's multi-disciplinary team meets together and can share notes about her care when they need to.

When Jean does get really unwell and need hospital-level care, this can be provided through the virtual hospital in her own home.

Building the Virtual Hospital

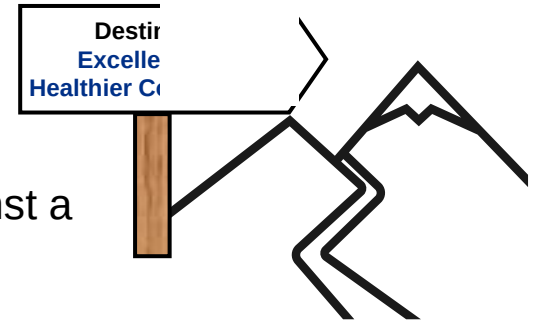
Over the next five years, we will build a virtual hospital. Our virtual hospital will work alongside our physical sites and be fully integrated into our existing service offer.

This will enable us to build on the pockets of good practice we have already – such as our COPD virtual ward or paediatric Hospital at Home – and expand our offer into homes, including care homes, across the region.

Virtual care, virtual wards and remote monitoring at scale will drive improved efficiency of services, reduce footfall on our hospital sites and support people to have a better experience of care.

We will keep digital inclusion at the heart of what we do so that those living in our most deprived communities are not excluded.

How will we know if we are successful?



Humber Health Partnership

As we continue our journey to excellence, we will measure our progress against a range of factors to see if we are on track to achieve our target outcomes.

Our people feel proud to work here

Our people feel proud to work here and they have the skills, knowledge and permission to lead change.

- Staff survey (*%age would recommend as a place to work and a place to be treated improved*)
- Recruitment and Retention (*vacancy rates reduced, turnover reduced*)

Our patients get the best care

We are the best at what we do, and we only do the things that we are best placed to do.

- Upper quartile performance in all services
- Positive report from regulators (*CQC ratings are improved*)
- People only come to hospital when they absolute need to and don't stay any longer than is necessary (*NCTRs reduced, follow-up OP rates reduced, LoS reduced, ED activity shift to UCS/UTC*)

Local people live more years in good health

We maximise our impact for good – inspiring and equipping our population to live well.

- Maximise our role in secondary prevention (*referral/success rates e.g., tobacco dependency*)
- Improve health and wellbeing of our staff (*self-reported wellness ratings?, staff sickness*)
- Improving healthy life years (*HLE improvements, esp. for women*)

We are recognised as leaders in our field

We are recognised as leaders in our field, and we use our privilege to advocate for better health for our population.

- Leader in rural and coastal health research (*research impact score/number of research studies and partnerships*)
- Leader in sustainable healthcare and NetZero (*carbon reduction achievement/income generation*)
- Providing specialist and tertiary services across a wider region (*activity levels/income generation*)

Our communities feel proud of what we offer

Those facing the biggest barriers are given the most support and it is provided in a way they can easily access.

- People have a good experience of care (*FFT, PALS/complaints*)
- People can easily access the care they need (*Support for travel, digital inclusion*)
- Population health need drives service access (*PTL by equality characteristics – reduced inequalities*)

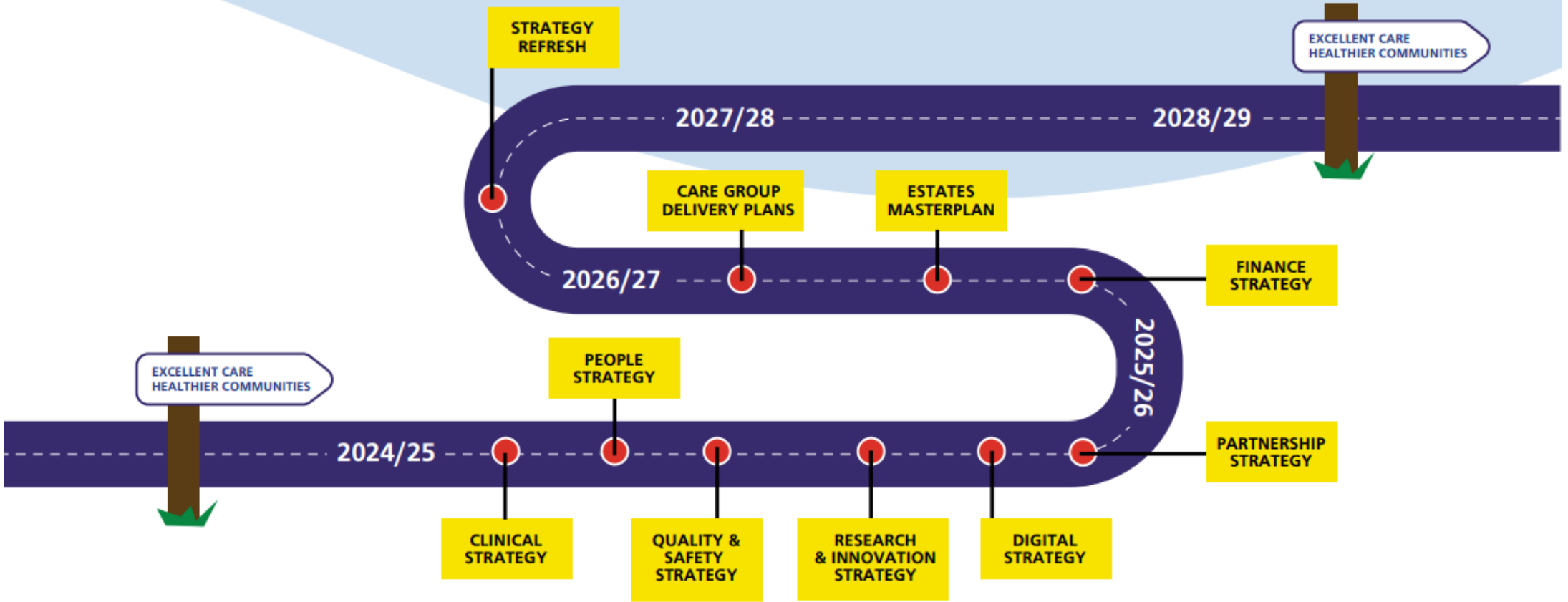
Now that we have agreed and set out our strategic direction, we will work as a group to develop a set of supporting strategies and action plans that underpin the delivery of this overarching framework.

We will focus initially on stabilisation, getting the basics right and laying solid foundations upon which we can build **excellent care and healthier communities.**

At the same time, we will start to radically transform our ways of working, questioning everything we do and how we do it. We will give teams headspace to transform their services by agreeing early on which things we will stop doing and where we will focus our efforts.

These decisions will be guided by our big strategic actions, which set the framework for our care group plans and delivery strategies across the group.

After two years, we will undertake a strategy re-fresh, reflecting on how far we have travelled and what we have yet to achieve to deliver our ambition for excellent care and healthier communities.



LAY THE FOUNDATIONS → TRANSFORM → DELIVER

3 - BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS

3.1 - QUALITY & SAFETY COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Sue Liburd & David Sulch, Non-Executive Director Committee Chairs

REFERENCES

Only PDFs are attached

BIC(24)231 - Quality & Safety Committees-in-Common Highlight Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)231

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 December 2024**
Director Lead	Sue Liburd, David Sulch – Chairs of CIC
Contact Officer / Author	Sue Liburd, David Sulch
Title of Report	Quality and Safety CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on Thursday 24 October 2024 and 28 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Paediatric EPMA system risks • Neonatal Pharmacist capacity • CQC Outstanding actions • NLAG Maternity Support Workers • National Audits/NICE Guidelines • IPC BAF • HUTH Mortality **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A

Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance below:	✓ Information ✓ Review ☐ Other – please detail

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

	Thursday 12 December 2024
	Quality and Safety Committees in Common
	24 October 2024 and 28 November 2024
	Yes

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 24 October 2024 and 28 November 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:

24 October 2024

- Board Assurance Framework
- EQIA Report
- TAVI RCP Update
- Integrated Performance Report
- CQC update report
- Maternity/neonatal Report PSIRF/Serious Incidents Reports
- Register of External Agency Visits
- Regulatory Update – Post Mortem
- Safeguarding Report
- Clinical Effectiveness Report
- Children and Young People Report

28 November 2024

- Board Assurance Framework
- EQIA Report
- CQC Update Report
- Infection Prevention and Control BAF
- Maternity/neonatal report
- Children and Young People Assurance
- Mortality, Learning from Deaths Report
- Integrated Performance Report
- Terms of Reference

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:

24 October 2024

a) HUTH/NLAG Winter Planning. A strategic bed review was required although there are financial constraints to consider.
b) HUTH TAVI update – The cultural work that has been carried out has been transformational and marked improvements had been made. The CIC decided to close the review but agreed to receive a 12 month report to ensure the improvements had been embedded. Any reportable deaths in the meantime would be reported to the CIC.
c) HUTH IPR – Duty of candour compliance was being monitored weekly and there had been improvements in performance to above 50% compliance. The CIC asked for further improvements to be demonstrated by January 2025.
d) NLAG – The maternity stop smoking incentive scheme had been commended.
e) Group Safeguarding Team – The lack of funding for a Domestic Abuse post was referred to the Workforce, Education and Culture CIC.

28 November 2024

a) Winter pressures were noted by the CIC as was the pressure on the ED Department at HUTH. The CIC to receive oversight of the ED patient safety incidents and the actions being taken to mitigate.
b) The Health and Wellbeing of Staff during winter was discussed as a priority. This would also be discussed at the Workforce, Education and Culture CIC.
c) Maternity – Work was ongoing regarding MIS 6 and Safety Action 1. South Bank Maternity support workers were still in discussions and it was hoped an agreement on pay would be reached soon. This item would be discussed at the Workforce, Education and Culture CIC in more detail. The CIC agreed reasonable assurance for both the North and South Banks.
d) Children and Young people – EPMA risks were highlighted and were not progressing in a timely manner. Another issue related to the lack of WTE Pharmacists for neonatal prescribing and this item was deferred to the Workforce, Education and Culture CIC. Limited assurance was agreed relating to medication errors and lack of Pharmacists for neonatal prescribing although the CIC understood that some of the issues were very complex.
e) Mortality - HUTH FNOF – Deep Dive – The Governance was now in place, but the long term approach based on prevention needed investment and expansion. The key issues were around flow to theatres and anesthetist capacity. The CIC were divided regarding assurance and although they understand the issues and relevant actions were in place they could not decide between limited and reasonable assurance.

4.0 Matters on which the committees have requested additional assurance:

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

24 October 2024

a) HUTH Complaints – Although the backlog was reducing, there were still issues with staff sickness and Group resources. The NLAG complaints process was commended and it was agreed that the HUTH process would be aligned.

b) HUTH/NLAG CQC outstanding actions overview. The actions were being worked through with the Care Groups and the Site Triumvirates would take responsibility for completing and embedding them. The Group Cabinet would review the progress of completing the actions. The CIC agreed limited assurance until sustained improvements were being seen.
c) HUTH CNST risks for PMRT were raised. Work was ongoing to manage the positioning of board papers and staff training.
d) The Obstetric model paper to the Board was deferred until February 2025 to allow for Cabinet review. There were issues regarding matron capacity and this was highlighted as a risk.
e) NLAG maternity support workers – It was noted that sickness within the team would impact on the ability to back fill if there was more industrial action planned. The other key issues were the Band 2 and 3 vacancies which were being placed on the risk register. The CIC gave limited assurance but noted the progress being made in other areas.
f) PSIRF – The CIC received a Never Event update. All investigations were underway and action plans in place.
g) Limited assurance was given for the Group performance relating to National Audits/NICE guidelines and NCPOD. The CIC asked for triangulation with the Care Group care plans, clarity on the key issues and evidence of what was being done to address the issues.

28 November 2024

a) HUTH Audiology system issues were discussed and a deep dive was agreed for the last quarter of 2024/25.
b) HUTH Ophthalmology – Due to a number of high risks a deep dive was agreed for the last quarter of 2024/25.
c) CQC Actions – HUTH/NLAG The CIC discussed that the grip and control was still limited but ownership of the actions was improving. The CIC agreed limited assurance, but acknowledged the work ongoing to address the issues.
d) IPC BAF was received and was now rolled out across the Group. Limited assurance was agreed as there was more work to do.
e) HUTH Mortality was improving slightly but the CIC agreed limited assurance as there was more work to do. NLAG Mortality was stable.

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

4.2 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:

The committees considered the areas of the BAFs for which it has oversight.

The CIC received the progress on the refreshed Quality and Safety BAF, including work around the gaps in controls and assurance and the actions required to address the gaps.

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to:

- Note the escalations in Section 3.1.
- Note the areas for further assurance in section 4.1.

Sue Liburd, Non-Executive Director and Chair of the Quality and Safety Committees in Common

David Sulch, Non-Executive Director and Chair of the Quality and Safety Committees in Common

29 November 2024

3.1.1 - MATERNITY SAFETY: CNST MATERNITY INCENTIVE SCHEME (MIS)

Amanda Stanford, Group Chief Nurse

REFERENCES

Only PDFs are attached

BIC(24)232 - Maternity Safety - CNST Maternity Incentive Scheme (MIS).pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)232

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12th December**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	Maternity Safety: CNST Maternity Incentive Scheme (MIS)
Executive Summary	**1.** CNST / MIS Year 6: Weekly meetings in place Progress on track- SA 8 met. Progress report attached. **2.** Additional Staffing Reports attached as part of the Safer Staffing reviews- for information
Background Information and/or Supporting Document(s) (if applicable)	**MIS Year 6 progress reports and associated appendices Staffing Reports**
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	[insert, if applicable]
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ü Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Six

HUTH and NLAG PROGRESS REPORT

December 2024

Yvonne McGrath – Group Director of Midwifery
Eloise Sims – HUTH Maternity Audit and Compliance Manager
Hayli Garrod – NLAG Maternity Audit and Compliance Manager

Working in partnership:
Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

United by Compassion:
Driving for Excellence

Background

NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) applies to all acute trusts that deliver maternity services and are members of the CNST. Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund.

The Maternity Incentive Scheme Year 6 outlines a requirement for Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds. The Trust has submitted full compliance against the 10 safety actions for the preceding three years.

What is evident throughout the scheme is the need for the Trust Board and Integrated Care System (ICB) to be cited on the safety of maternity services and therefore we have compiled this report and will continue to do so on a quarterly basis to ensure the **Quality and Safety Committees in Common** (acting on behalf of the Trust Board) is sighted on the ongoing work and the future plans.

The purpose of this report is to provide an overview of the changes from year 5 and update on the progress made on the 10 safety actions in respect of Maternity Incentive Scheme – Year Six highlighting key risks and the mitigating actions taken.

Weekly MIS Year 6 Delivery Group monitoring meetings are established to review progress and address risks identified.

Executive Summary

See below for an overview of the current compliance against the safety action requirements for HUTH and NLAG.

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

HUTH

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	0	0	3	0	3
4	1	0	17	0	18
5	1	0	5	0	6
6	0	0	6	0	6
7	0	0	6	0	6
8	0	0	20	0	20
9	0	1	8	0	9
10	0	1	7	0	8
Total	2	2	80	0	84

NLAG

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	0	0	3	0	3
4	2	0	17	0	19
5	0	0	6	0	6
6	0	0	6	0	6
7	0	0	6	0	6
8	0	0	19	0	19
9	0	0	9	0	9
10	0	0	8	0	8
Total	2	0	82	0	84

Next Steps for Sign Off:

Requirement	Date
Trust Board to be sighted/approve outstanding evidence	December 24
Trust Board evidence sign off	February 24
Local Maternity and Neonatal System / Integrated Care Board evidence review	February 24
Submission of MIS year 6 declaration	By 03 Mar 25

Safety action 1:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 30 November 2024 to the required standard?
Lead: Rebecca Julian (HUTH), Natalie Jenkin (NLAG).

Requirement		HUTH Compliance	NLAG Compliance
1.1	Have all eligible perinatal deaths from 8 December 2023 onwards been notified to MBRRACE-UK within seven working days?		
1.2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?		
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 December 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.		
1.4	Were 60% of the reports published within 6 months of death?		
1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.		
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?		

	Eligible for full CNST Assessment		Eligible for notification only		Not eligible (baby still alive)		Not eligible (post-neonatal)	
Quarter	**HUTH**	**NLAG**	**HUTH**	**NLAG**	**HUTH**	**NLAG**	**HUTH**	**NLAG**
Q3 (08 Dec – 31 Dec 23)	1	0	2	0	0	0	1	0
Q4 (01 Jan – 31 Mar 24)	4	6	1	1	0	1	0	0
Q1 (01 Apr – 30 Jun 24)	8	6	1	1	0	1	0	0
Q2 (01 Jul – 30 Sept 24)	6	5	2	4	0	1	1	0
*Q3 (01 Oct – 30 Nov 24)	7	6	1	2	0	0	0	0
Total	**26**	**23**	**7**	**8**	**0**	**3**	**2**	**0**

*Q3 cases include deaths reported up to 30th November 2024.

To date there have been a total of 69 cases (35 HUTH and 34 NLAG) that have met the reporting criteria to MBRRACE-UK. Several cases have shared care with other Trusts.

Outstanding Action Required:
October 2024 Trust Board minutes to be saved to evidence discussion of Q2 PMRT report. Q3 PMRT report to be devised in January 2024 and submitted for Trust Board review in February 2024.

Safety action 2:
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Lead: Mike Collins (HUTH), Carrie-Louise Dixon (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing 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? Final data for July 2024 will be published during October 2024.		
2.2	Did July's 2024 data 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)		

Outstanding Action Required:
Trust Board to be informed (December 2024) of both Trusts passing the July data quality and completeness checks on MSDS.

Safety action 3:
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?
Lead: Vesna Blair / Ellie Peirce (HUTH), Emma Spicer (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? **Evidence should include:** - Neonatal involvement in care planning - Admission criteria meets a minimum of at least one element of HRG XA04 - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards. - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.		
3.2	**Or** Is there an action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay			
3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.		
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.		

Outstanding Action Required:

HUTH

Transitional care pathway has been updated to include auditable standards. Awaiting final Clinical Governance sign off.

NLAG

No actions outstanding.

Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?
Lead: Uma Rajesh (HUTH), Preeti Gandhi / Lisa Pearce (NLAG)

Obstetric Workforce:

Requirement		**HUTH compliance**	**NLAG compliance**
4.1	Locum currently works in their unit on the tier 2 or 3 rota?		
4.2	OR they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP)?		
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?		
4.4	Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?		
4.5	**NOT REPORTABLE IN MIS YEAR 6** Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?		Action plan in place
4.6	**OR** has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?	N/A	
4.7	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?		
4.8	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A	N/A
4.9	Do you have evidence that the Trust position with the above has been shared with Trust Board?		
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?		
4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?		

Anaesthetic Workforce:

Requirement		HUTH compliance	NLAG compliance
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1).		

Neonatal Medical Workforce:

Requirement		HUTH compliance	NLAG compliance
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?		Action plan in place
4.14	Is this formally recorded in Trust Board minutes?		
4.15	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	N/A	
4.16	Was the above action plan shared with the LMNS?		
4.17	Was the above action plan shared with the ODN?		

Neonatal Nursing Workforce:

Requirement		HUTH compliance	NLAG compliance
4.18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Action plan in place	Action plan in place
4.19	Is this formally recorded in Trust Board minutes?		
4.20	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.		
4.21	Was the above action plan shared with the LMNS?		
4.22	Was the above action plan shared with the ODN?		

Please note where non compliance is reported above for compensatory rest and meeting BAPM neonatal standards, an action plan will be accepted for MIS year 6.

Outstanding Action Required:

HUTH:
Trust Board to be informed (December 2024) of amended/finalised figures to locum staffing audit and consultant attendance in clinical situations audit.

Safety action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Lead: Yvonne McGrath (HUTH and NLAG)

Requirement		HUTH compliance	NLAG compliance
5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.		
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.		
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. Where deficits in staffing levels have been identified must be shared with the local commissioners. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. The midwife to birth ratio The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.		
5.4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.**	Action plan in place	
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour		
5.6	A plan is in place for mitigation/escalation to cover any shortfalls in the two points above.		

Please note where non-compliance is reported, an action plan will be accepted for MIS year 6 for supernumerary labour ward co-ordinator at the start of every shift.

Outstanding Action Required:

HUTH:
Action plan for BirthRate+ deficit, plan for achievement and timescales to be shared with Trust Board (December 2024).

Safety action 6:
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?
Lead: Joanna Melia (HUTH), Sam Sockett/Hayli Garrod (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
6.1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory).		
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**		
6.3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.		
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.		
6.5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**		
6.6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?		

The LMNS has provided evidence that they are satisfied both Trusts have made all best endeavours against agreed trajectories and have met the requirements for MIS year 6.

Outstanding Action Required:
None.

Safety action 7:
Listen to women, parents and families using maternity and neonatal services and co-produce services with users.
Lead: Yvonne McGarth (HUTH), Nicola Foster / Kimberley Boyd (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.		
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as**: Safety champion meetings, Maternity business and governance, Neonatal business and governance, PMRT review meeting, Patient safety meeting, Guideline committee.		
7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: Job description for MNVP Lead, Contracts for service or grant agreements, Budget with allocated funds for IT, comms, engagement, training and administrative support, Local service user volunteer expenses policy including out of pocket expenses and childcare cost.		
7.4	If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.	N/A	N/A
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis (if available), such as a coproduced action plan.		
7.6	Has progress on the coproduced action above been shared with Safety Champions?		
7.7	Has progress on the coproduced action above been shared with the LMNS?		

Outstanding Action Required:

None.

Safety action 8:
Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?
Lead: Nichola Riggs (HUTH), Nicola Foster / Preeti Gandhi / Rachel Cavill (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
Fetal monitoring:			
8.1	90% of obstetric consultants		
8.2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)		
8.3	For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.4	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres		
Maternity emergencies and multiprofessional training:			
8.5	90% of obstetric consultants		
8.6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota		
8.7	For rotational obstetric staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives		
8.9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).		
8.10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors		
8.11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors **who contribute to the obstetric anaesthetic on-call rota.**		
8.12	For rotational anaesthetic staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		N/A
8.13	Standard removed		

Requirement		HUTH compliance	NLAG compliance
Neonatal basic life support:			
8.14	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?		
8.15	90% of neonatal Consultants or Paediatric consultants covering neonatal units		
8.16	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births		
8.17	For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.18	90% of neonatal nurses (Band 5 and above who attend any births)		
8.19	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.	N/A	N/A
8.20	90% of advanced Neonatal Nurse Practitioner (ANNP)		
8.21	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)		
8.22	In addition to the above **Neonatal basic life support (NBLS)** training, is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid **Resuscitation Council (RCUK) Neonatal Life Support (NLS)** certification or local assessment equivalent in line with BAPM basic capability guidance by year 7 of MIS and ongoing?		

HUTH:

6 new anaesthetic doctors commenced in November 2024 and have not yet undertaken their PROMPT. An action plan has been developed demonstrating the commitment to ensure all staff members complete their training within the 6-month grace period. All 6 doctors are booked to attend in January 2025.

Outstanding Action Required:

Trust Board to formally approve action plan for rotational anaesthetic doctors who have not yet completed PROMPT.

Safety action 9:
Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
Lead: Yvonne McGrath (HUTH and NLAG)

Requirement		HUTH compliance	NLAG compliance
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded (including the following)?		
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?		
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set and presented by a member of the perinatal leadership team to provide supporting context.		
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.		
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.		
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.		
9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?		
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.		
9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.		

Outstanding Action Required:

Q2 Trust Claims Scorecard to be shared with Trust Board (December 2024).
Trust Board minutes (October 2024) to be saved once available.

HUTH

Additional evidence to be gathered to further strengthen evidence already obtained for ongoing engagement sessions with staff.

Safety action 10:
Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?
Lead: Matthew Proctor (HUTH), Natalie Jenkin (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.		
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.		
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme		
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.		
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?		
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?		
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.		

Outstanding Action Required:

HUTH & NLAG:
Trust Board to be informed of recent qualifying cases for MNSI/EN, that families have been informed of the role of MNSI/EN and compliance for statutory Duty of Candour.

HUTH:
Evidence to be gathered to retrospectively demonstrate that all qualifying cases have been completed on the claims reporting wizard.

Bi- annual midwifery staffing oversight report
Hull University Teaching Hospitals

Yvonne McGrath
Group Director of Midwifery
Version One
November 2024

Executive Summary
This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, and compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also outlines the investment required to achieve compliance with Safety Action 5 of the Maternity Incentive Scheme.

1. Background

Following a March 2023 inspection, the Care Quality Commission (CQC) rated maternity services at HUTH as Inadequate, citing severe deficiencies in leadership, staff morale, staffing levels, and governance. These issues pose a direct threat to the safety and well-being of mothers and babies, necessitating immediate and decisive intervention.

HUTH is now part of the Maternity Safety Support Programme (MSSP) and received a detailed diagnostic report in June 2024. NLAG has now exited the programme, having made significant strides in improving its Maternity Services. Its establishments are broadly in line with the independent Birthrate+ staffing tools, having received proportionately higher allocations of Ockenden support funding via the ICB in the earlier years of it being available.

The report highlights the pressing need for targeted investment to stabilise and improve midwifery services predominantly at HUTH. While initial measures—such as safety huddles, the introduction of standard operating procedures, and recruitment efforts—have been implemented, these are insufficient to address the deep-rooted challenges. Leadership gaps, moral injury among staff, and unsustainable staffing levels continue to undermine the service's ability to deliver safe, high-quality care.

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Maternity Services at Hull Royal Infirmary provides inclusive care for pregnant women and their families in Hull and the East Riding of Yorkshire and we provide care to over 5000 parents and babies every year. The Maternity Service operates a traditional model with intrapartum service provision delivered at Hull Royal Infirmary (HRI). Despite the falling birth-rate both nationally and locally, the complexity of women and associated obstetric complications is rising, for example the number of safeguarding cases, the number of women with high BMI, diabetes and smoking in pregnancy. There is a midwife-led birth centre as well as specialist services for complicated pregnancies, fetal and neonatal care. Our service provides care for pregnant women and their babies throughout pregnancy, labour, and the postnatal period caring for pregnant women with pregnancy that are straightforward or highly complex.

Regular six-monthly reviews of safe staffing are undertaken as part of the trust establishment reviews, as well as monitoring of actual versus planned staffing by the Matrons in each area. There is also a daily huddle with the Local Maternity and Neonatal System (LMNS) to look at pressures across the entire LMNS footprint. There is a Monday to Friday, pan-group safety huddle to review staffing and acuity and offer mutual aid where possible. Further huddles are undertaken when needed during the day. The need to implement a speciality specific on-call rota is a priority to ensure speciality specific out-of-hours support- this is currently provided by the site team. The OPEL escalation framework is utilised to escalate concerns and development of a pan-group escalation tool is ongoing. The last report was submitted in August 2024, this additional report achieve alignment in reporting timescales with nursing Safer Staffing papers.

2. Birthrate Plus Workforce Planning

The only available workforce modelling tool for maternity services is the nationally recognised Birthrate Plus® (BR+). Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

HUTH maternity services undertook a full Birthrate Plus (BR+) assessment in 2021 and received the final report in February 2022. The final report identified the budget requirement of 187.89wte clinical midwives with an uplift on the specialist and management roles of 9.29wte resulting in a total budget requirement of 204.80wte. (Current HUTH maternity budget is set to 201.04wte).

This included a 21.6% uplift to cover annual, sickness and study leave has been included in the staffing calculations. The 2021 report identified that compared to data collated in 2018 the overall health needs of the local population have significantly increased than previously reported. This in turn has a direct correlation to the number of midwives required to deliver safe and affective care to women throughout their maternity journey. However, given the significant increased ask

for midwifery training aligned to Core Competency Framework version, an increase in uplift from 6 days to 9.4 days is required and aligns with other specialist areas across the trust such as ITU.

Data is currently being collected for a full Birthrate Plus and this may impact the recommendations on numbers of midwives required across all areas of the service.

3. Birthrate Plus Refresh November 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.

The total clinical establishment as produced from Birthrate Plus® is **197.48wte** and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services, as summarised below.

Director of Midwifery, Head of Midwifery, Matrons

Specialist Midwives with responsibility for:

- Bereavement
- Vulnerabilities
- Maternal Medicine
- Fetal wellbeing
- Screening
- Diabetes
- Infant Feeding
- Professional Midwifery Advocate
- Public Health
- Practice Development Midwife
- Recruitment and Retention
- Preterm Birth
- Perinatal Mental Health
- Saving Babies Lives Care Bundle
- Consultant Midwife
- Better Births Lead
- Practice Development
- Clinical Facilitator

Currently HUTH does not have all of the above roles. These roles are vital to ensuring the Trust meets external targets, provides high-quality, personalised care, and retains staff. In addition to these posts, consideration should also be given to recommendations from national reports such as Ockenden 2022 with regards to new roles.

Applying 12% to the Birthrate Plus clinical wte provides additional staff of 23.70wte for the above roles with it being a local decision as to which posts are required and appropriate hours allocated. Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles. Comparison of additional specialist and management wte

Current funded wte	Birthrate Plus wte	Variance wte
10.24	23.70	(13.46)

Table above shows the current funded establishment has a deficit of 13.46wte allocated for the non-clinical roles as usually required in all maternity services. A previous paper outlining the substantive funding Specialist Midwifery requirements will be resubmitted to February board.

Results

Birthrate Plus Results 2021	**Total WTE Clinical Requirement**	**Specialist Roles/Managerial**	**Recommended overall Budget**	**Current Budget**
	187.89wte	Uplift of 9.29wte	204.80wte	194.02 wte
Birthrate Plus Refresh December 2023	**Total WTE Clinical Requirement**	**Specialist Roles/Managerial**	**Recommended overall Budget**	**Budget GAP**
	197.48wte	Uplift of 13.46wte	221.17wte	27.15 wte

The Table above demonstrates the total Clinical, Specialist and Management wte comparisons.

A previous report indicated a different variance between recommended establishment and budget, with the Finance team in place the WTE has been confirmed as detailed in the table over.

The results indicate a negative variance of 27.15 from the current funded establishment with 21% uplift, however the recent funding of maternity triage (17.59 wte,16.59 wte Band 6 midwives and 1 wte Band 7 Triage Manager) reduces this gap to 10.56 WTE.

NICE (2017) recommend that a Birthrate Plus assessment is carried out every three years and that the midwifery staffing budget reflects the establishment as calculated by Birth rate plus.

Where the Trust are not compliant with a funded establishment, include the action plan and timescale for achieving this. The plan must include mitigation to cover any shortfalls and the plan must be shared with local commissioners.

Historically the Midwifery Leadership structure was comprised of two WTE Band 8As, a Lead Midwife and a Labour Ward Matron. Following the CQC inspection an additional Operational Matron role was created utilising secondments; these secondments have now ended due to staff in these secondments no longer wantingto continue in these roles (one has return to her substantive role as Labour Ward Matron (0.7 WTE) and the other has now left the Trust for another role).

A number of Band 7 Manager Roles are also secondments causing uncertainty and instability across the team. The proposed approach would ensure that all Matron and Ward Manager roles were substantively appointed to which will support stability going forward.

As per the Diagnostic Report and the previously submitted Outline Business Case urgent action is required to stabilise the midwifery leadership at Hull Royal Infirmary. Further funding is also required to reach Birthrate+ recommendations as detailed below.

Birthrate+ recommended establishment	221.17	
Funded establishment B3-B8	194.02	
Triage funding agreed (16.59 WTE B6 1 WTE B7)	17.59	
Current total	211.61	
Gap between BR+ and funded establishment	9.56	
Recommendation for B8/B7 Leadership roles in this	4.00	Community & MLU Matron (B8A) Labour Ward Manager (B7), Maple Ward Manager (B7), Community Manager (B7)
Unfunded B3s in post in community	4.92	Previously 1.66 WTE midwives removed from the community midwifery rotation budget to fund the band 2 to 3 uplift, currently 0.64 WTE funded establishment
New Band 3 post to support Diabetic team	0.64	In view of significant clinical risk- would help release midwifery time.

	9.56	
Total with new posts	221.17	

4. Current Midwifery staffing Issues and Risks

Recruitment and retention progress

Our current budget for all midwives is 194.02 WTE with 180.66 being employed as of November 2024. This includes the newly qualified midwives.

Attrition

Between May to October 2024 8 midwives left, which is slightly less than the predicted 1.5 per month. Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed. Turnover is 5.5% against aa target of 10%

Maternity Leave position

In January 2024 the maternity leave rate was at 8.1% of our whole midwifery workforce. This is now gradually coming down, only 3.05% of midwives are on maternity leave in October 2024.

Sickness absence rates May to October 2024:

Sickness levels show a significant rise from the early part of 2024. The most common reason is mental health concerns,

Month	May	June	July	August	September	October
% of all midwives	4.9%	5.2%	5.4%	5.7%	5.2%	5.2%

Reasons for short term sickness

Mental health/Stress due to skill mix and pressures of workload

Culture and lack of support
Physical

Themes/issues causing stress:

Lack of respect amongst colleagues with the Unit not being seen as a whole but seven separate areas	Badgernet and the limited ongoing support/teaching whilst the system is embedded
No connection between senior leaders and staff on "shop floor". Matrons and HoM/DoM are often invisible, unreachable and unreliable	Blame culture
Staff not feeling well-led and sensing chaos amongst the senior team which leads to unrest and instability	Minimal praise, reward and warmth but regular criticism and demands from top down
Amount of e-learning to do on top of work, often in own time to meet targets	Presenteeism of colleagues with poor behaviours not managed effectively
Moral injury as staff not able to deliver the care they aspire to due to staffing shortages and lack of training. Compassion fatigue	Appeals for six requests on e-roster and weekly paid overtime ignored by Trust
No succession planning or investment in staff to develop and grow	No immediate response to support staff following a traumatic event if at all
PMA team consisting of some staff who are unapproachable, managers and/or unable to maintain confidences	"Superiority attitudes" from labour ward making it difficult to communicate – particularly in relation to admissions of patients

The impact of sickness absence, maternity leave and the backfill from other areas for the triage service is affecting the quality of delivery in the following ways:

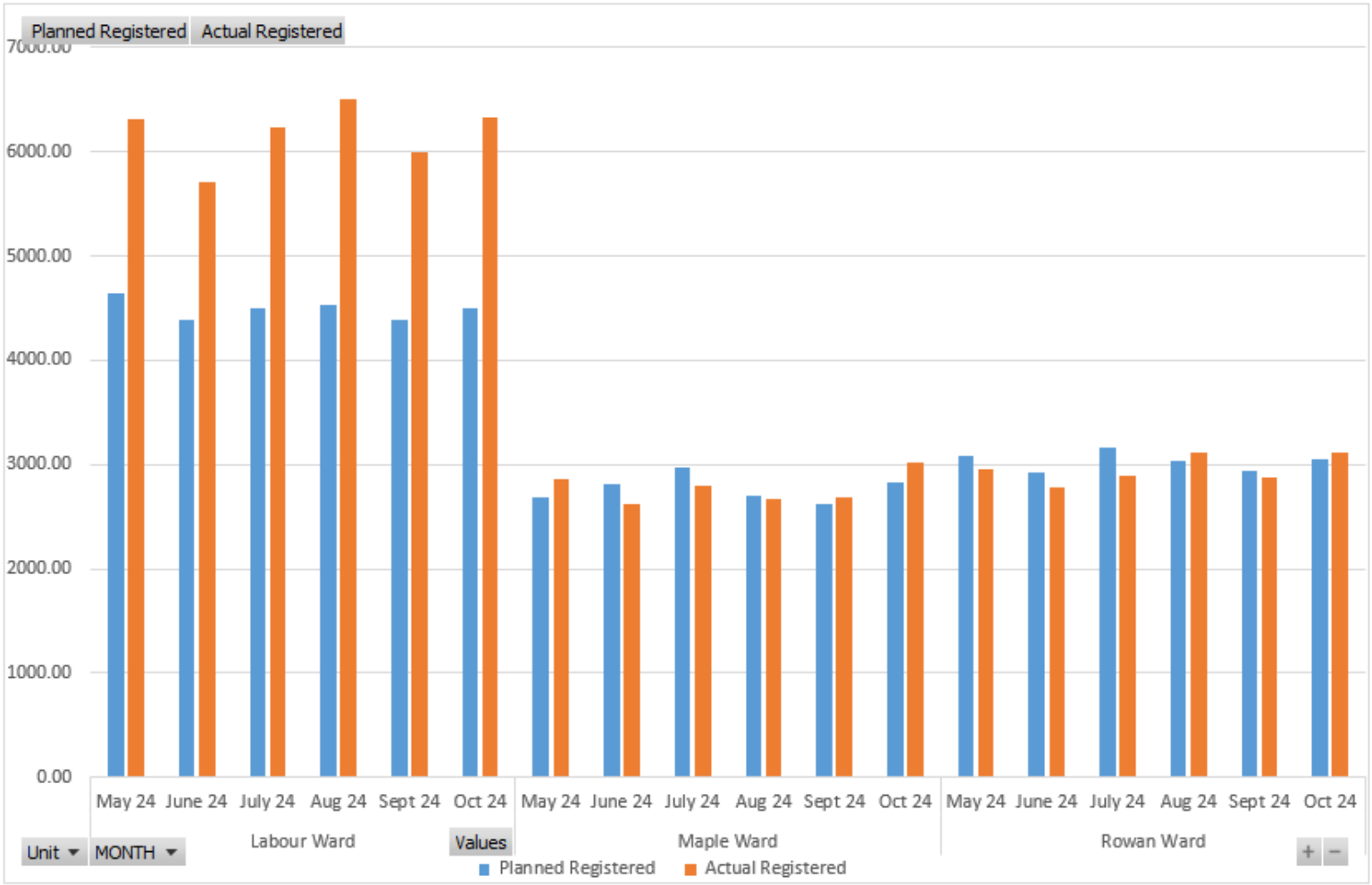
Labour ward coordinator is not supernumerary for the whole shift
Ability to provide a robust home birth service
Cancellation of planned activity in community mainly booking appointments, potential to impact on targets for AN screening,
Delay to induction of labour

Actions taken to address attrition

Recruitment and retention (R+R lead) attends mandatory training to increase communication, offer support and opportunity to deliver a presentation around compassionate interventions and emotional intelligence to a wider audience instead of on a one-to-one basis
Senior midwives to work with the Organisational Development team to push for "Culture Champions" and "Wellbeing Champions" across the group and discuss further the option of a "staff council"
Recruitment and retention lead/Education leads/PMA to support the matrons with restorative support sessions with OD team
Support the ward managers with restorative support sessions with OD
Increase the amount of formal staff listening forums from one to two per month

Transforming and improve the induction and preceptorship packages for new starters to our Trust so that they feel they are receiving a “personalised care plan” on arrival and to see them through their first year at HUTH
Link in with Royal College of Midwives reps, chaplains and wellbeing team to ask them to increase visibility in our unit to support staff
HUTH Maternity Staff Communication closed Facebook group established to share information regarding new starters, achievement and upcoming events
R+R Lead working closely with counterpart at NLaG to align services.

5. Planned Versus Actual Midwifery Staffing Levels (Inpatient Areas)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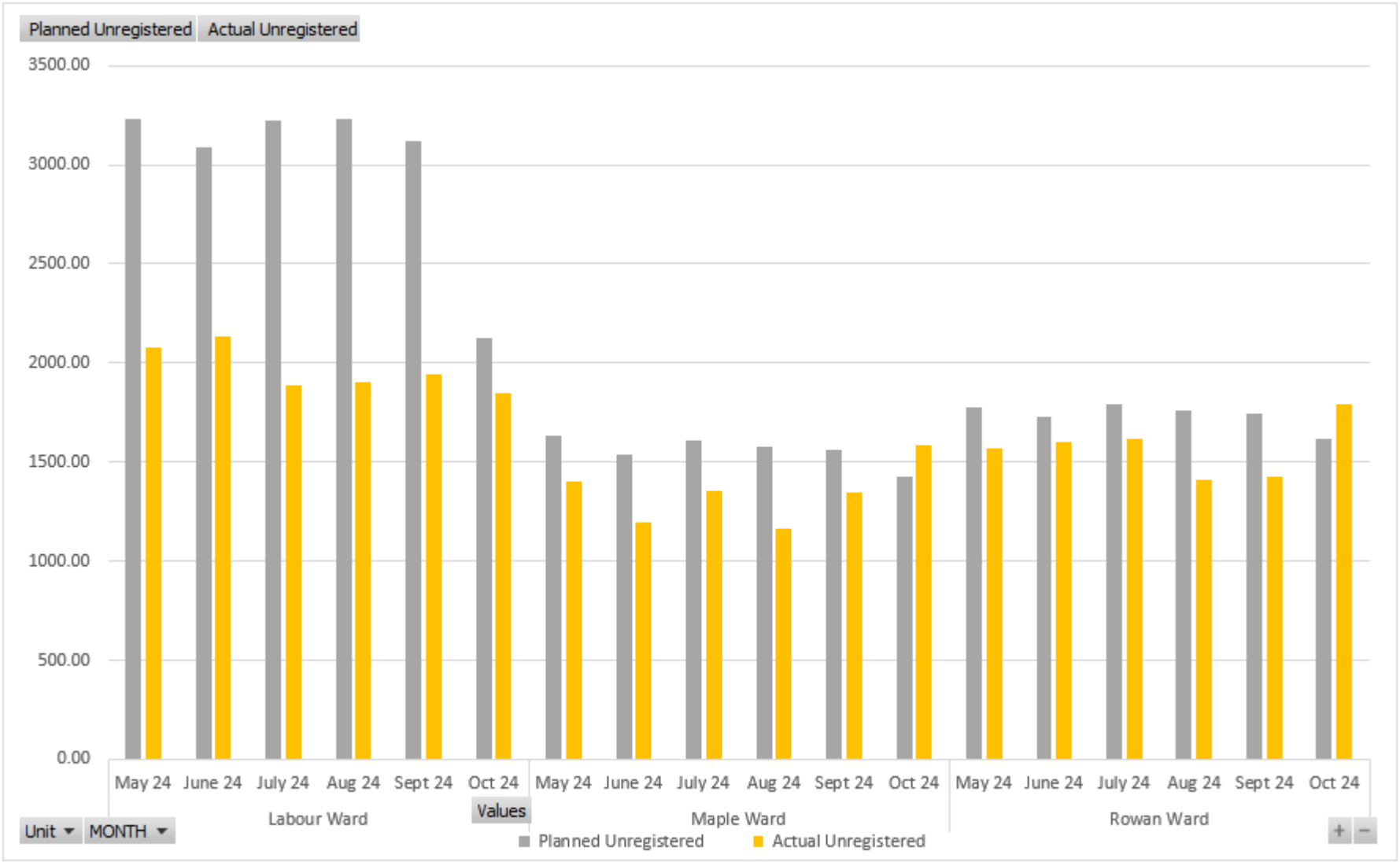
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Sept 24
Oct 24
Labour Ward
Maple Ward
Rowan Ward
Values
Unit
MONTH
Planned Unregistered
Actual Unregistered

Fill rates are monitored daily, and staff redeployed based on the acuity. All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

7. Specialist Midwives

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for Hull University Teaching Hospital NHS calculated to be 7.9% (9.69wte management roles plus 5.24wte specialist MWs non clinical).

8. Birth Rate Plus Live Acuity Tool

The Birth Rate plus Live Acuity Tool it is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

Request midwifery staff undertaking specialist roles to work clinically.
Elective workload prioritised to maximise available staffing.
Managers at Band 7 level and above work clinically
Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
Activate the on-call midwives from the community to support labour ward.
Liaise closely with maternity services at opposite sites to manage and move capacity as required

Double Pay incentive is offered for midwifery shortfalls to support the maintenance of safety

There is an overall impact on deliver of CNST Year 6 safety actions 5– all workforce related, and despite the reductions in thresholds for compliance, this is still a significant risk.

Supernumerary Labour Ward Co-ordinator
Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

	Number of days per month	Number of shifts per month	Compliance
May	31	62	94%
June	30	60	89%
July	31	62	92%
August	31	62	94%
September	30	60	94%
October	31	62	99%

There has been 26 incidents from May 2024 to October 2024 that the labour ward coordinator has not been supernumerary On review of these incidents, it was a period of high activity on the labour ward, short term sickness and the inability to fill vacant shifts. An action plan is in place as per MIS Year 6 requirements.

9. One to One in Established Labour
Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

	Number of days per month	Number of shifts per month	Compliance
May	31	62	100%
June	30	60	99
July	31	62	100%
August	31	62	100%
September	30	60	100%
October	31	62	100%

There has been1 recorded incidents in these 6 months where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events:

	1st May 2024 – 31st October 2024						
Delivery Suite	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**Total**
Delayed or cancelled time critical activity	5	20	1	28	48	39	141
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	4	0	2	4	2	12
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes meds)	0	0	0	0	0	0	0
Delay in providing pain relief	2	0	1	0	1	0	4
Delay between presentation and triage	0	0	4	0	0	0	4
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0
Delay between admission for induction and beginning of process	0	5	5	32	26	33	101

Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	1	0	0	0	0	1
Labour Ward Coordinator not supernumerary – providing 1:1 care for a woman	0	0	0	0	1	0	1
Coordinator unable to maintain supernumerary status – NOT providing 1:1 care	4	7	5	4	4	1	25
TOTAL	11	37	16	66	84	75	289

10. Recommendations

To order to achieve compliance with the Maternity Incentive Scheme requirements and stabilise the Leadership structure it is recommended that the ask to substantively fund the posts outlined in the table is supported and agreed at December board. If this is not agreed compliance with MIS Year will not be achieved.

Complete the Action Plan to achieve compliance with the 1:1 care in labour and supernumerary status of the Labour Ward Co-Ordinator,

Continue to monitor staffing, sickness and attrition rates, complete staffing reports and Birthrate+ reviews as per MIS guidance.

Develop ongoing recruitment strategy and work in partnership with Recruitment colleagues and universities to ensure an appropriate pipeline for midwifery staff is in place.

Fund additional training (£3600) to support improved use of the Birthrate+ Acuity Tool across all in-patient areas.

Bi- annual midwifery staffing oversight report
Northern Lincolnshire and Goole NHS Foundation Trust

Yvonne McGrath
Group Director of Midwifery
November 2024

Executive Summary
This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, and compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents.

1. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Maternity Services at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provides inclusive care for pregnant women and their families in North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and surrounding areas. There are three hospital sites – Diana Princess of Wales (Grimsby) Scunthorpe General Hospital and Goole District Hospital and provide care to over 3500 parents and babies every year, operating a traditional model with intrapartum service provision. Despite the falling birth-rate both nationally and locally, the complexity of women and associated obstetric complications is rising, for example the number of safeguarding cases, the number of women with high BMI, diabetes and smoking in pregnancy. There is a midwife-led birth centre as well as specialist services for complicated pregnancies, fetal and neonatal care. Our service provides care for pregnant women and their babies throughout pregnancy, labour, and the postnatal period caring for pregnant women with pregnancy that are straightforward or highly complex.

Regular reviews of safe staffing are undertaken as part of the trust establishment reviews, as well as monitoring of actual versus planned staffing by the Matrons in each area. There is also a daily huddle with the Local Maternity and Neonatal System (LMNS) to look at pressures across the entire LMNS footprint. There is a Monday to Friday, pan-group safety huddle to review staffing and acuity and offer mutual aid where possible. Further huddles are undertaken when needed during the day. The need to implement a speciality specific on-call rota is a priority to ensure speciality specific out-of-hours support- this is currently provided by the site team. The OPEL escalation framework is utilised to escalate concerns and development of a pan-group escalation tool is ongoing.

2. Birthrate Plus Workforce Planning

The only available workforce modelling tool for maternity services is the nationally recognised Birthrate Plus® (BR+). Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

NLaG maternity services undertook a full Birthrate Plus (BR+) assessment in 2021 and received the final report in July 2022. The final report identified the budget requirement of 167.02wte clinical midwives with an uplift on the specialist and management roles of from 15.80 to 18.37 (2.57wte), resulting in a total budget requirement of 185.39wte. Current NLaG maternity budget is set to 187.94wte. This demonstrated a positive variance of 2.55wte across both services if providing care in a 'mainly traditional model'.

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

Data is currently being collected for a full Birthrate Plus and this may impact the recommendations on numbers of midwives required across all areas of the service.

3. Results

Birthrate Plus Results 2021	Total WTE Current Funded	Recommended 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	15.80	18.37	-2.57
Total clinical, specialist and management wte	**187.94**	**185.39**	**2.55**

The results indicate a positive variance of 2.55wte from the current funded establishment. This is primarily in the clinical roles Specialist posts so an increase in postnatal support staff will release midwifery hours to address the shortfall.

NICE (2017) recommend that a Birthrate Plus assessment is carried out every three years and that the midwifery staffing budget reflects the establishment as calculated by Birth rate plus.

4. Specialist Midwives

Birth Rate Plus recommends that 9-11% of the total establishment are not included in the clinical numbers, this includes management positions and specialist midwives. The current percentage for Northern Lincolnshire and Goole NHS Foundation Trust is calculated to be 11% and equates to 18.37wte which is a small deficit to the current establishment of 15.80wte. Currently NLaG does not have all of the specialist midwife roles as per national recommendations such as Ockenden 2022 and Saving Babies' Lives version three, 2023 (as per the table below).

Role	Currently in post
Director of Midwifery, Head of Midwifery, Matrons	P
Specialist Midwives with responsibility for:	
Bereavement	P
Vulnerabilities	
Maternal Medicine	
Fetal wellbeing	P
Screening	P
Diabetes	P
Infant Feeding	P
PMA	
Public Health	P
PDM	P
Digital Midwife	P
Recruitment and Retention	P
Preterm Birth	
Perinatal Mental Health	P
Saving Babies Lives Care Bundle	P
Consultant Midwife	P
Risk and Governance	P
Better Births Lead	
Practice Development	
Clinical Facilitator	P

5. Current Midwifery staffing Issues and Risks

Recruitment and retention progress

Our current budget for all midwives is 187.94 WTE. The vacancy rate is currently 10.2 WTE.

Attrition

5.1% turnover rate against a target of 10%. Most leavers have been associated with retirement, however 1.4 WTE have left within the first year post-qualification.

Pastoral support and Retention midwife role of supporting midwives (specifically early career and International Midwives) impacting positively on the service.

- v Emotional support, following work related and personal situations impacting their mental wellbeing.
- v Sign posting to other agencies for specialist support, such as counselling and mental health support through our internal services.
- v Wellbeing support to staff off on long-term sick to enable them to return to work and remain at work.
- v Listening to colleagues without the need of offering resolution (as this may not always be possible)

Maternity Leave position

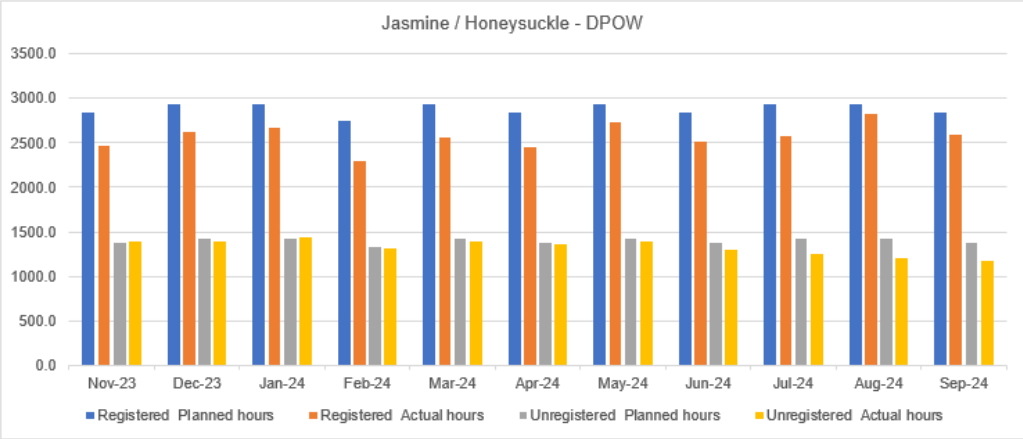
In October 2024 the maternity leave rate was at 2.36% of our whole midwifery workforce.

Sickness absence rates May 2024 to Oct 2024:

Sickness levels for Nursing and Midwifery Registered staff (short-term and long-term). The most common reason Is mental health concerns.

Month	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
% of all midwives	5.14%	6.30%	7.2%	7.0%	6.7%	7.2%

6. Planned Versus Actual Midwifery Staffing Levels (Inpatient Areas)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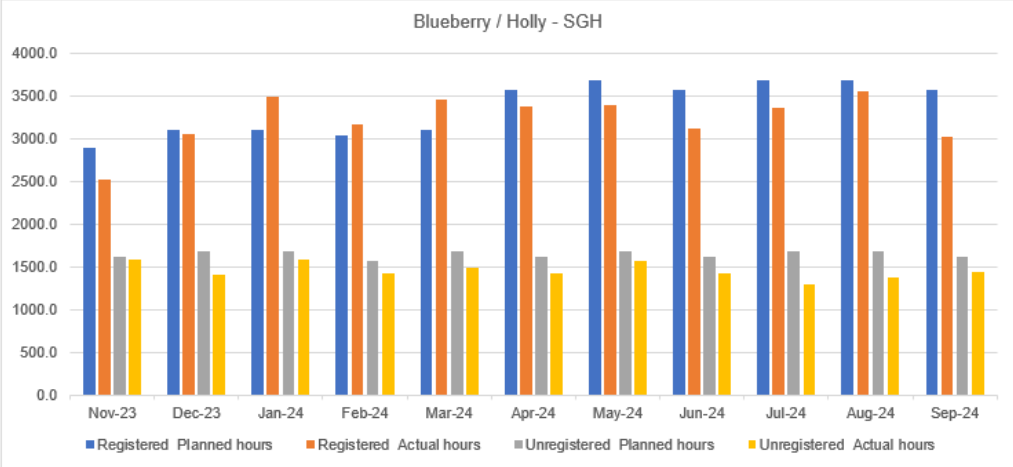
Blueberry / Holly - SGH
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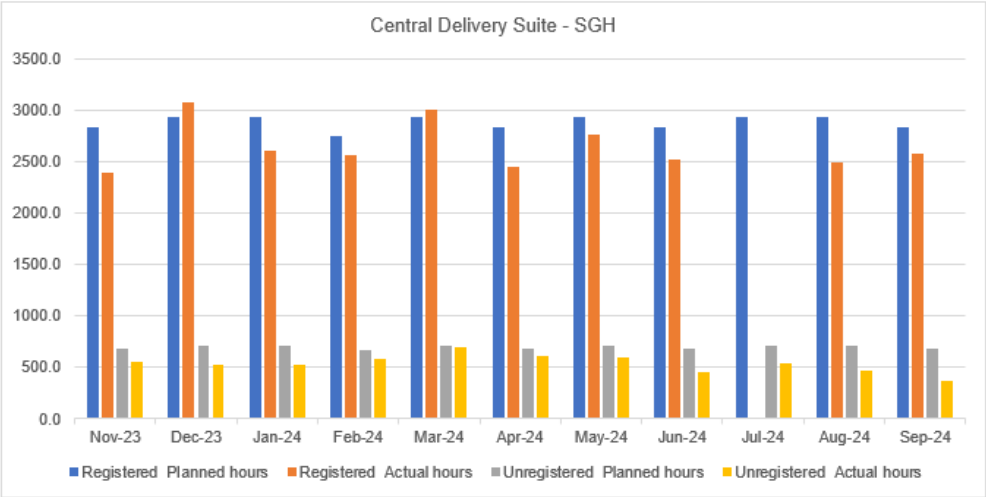
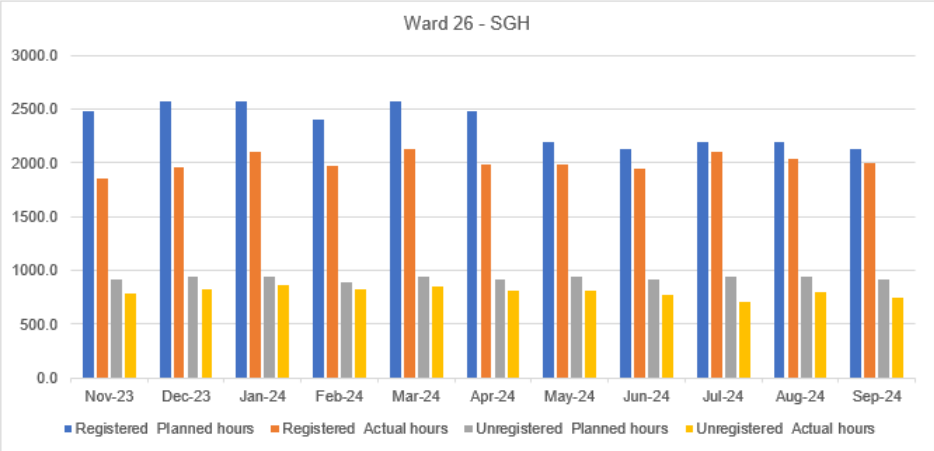
Unregistered Planned hours
Unregistered Actual hours


Central Delivery Suite - SGH
3500.0
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Ward 26 - SGH
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours

Fill rates are monitored daily, and staff redeployed based on the acuity. All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

7. Birth Rate Plus Acuity Tool

The Birth Rate plus Acuity Tool it is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

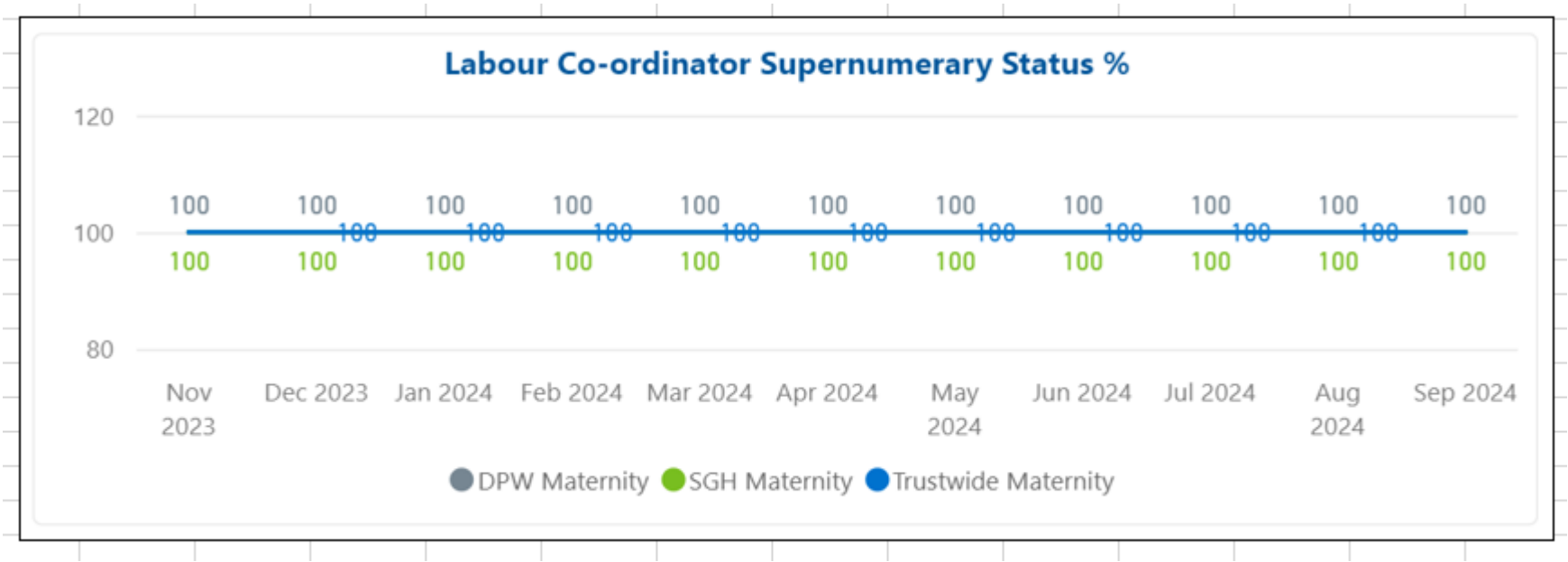
When staffing is less than optimum, the following measures are taken in line with the escalation policy:

Request midwifery staff undertaking specialist roles to work clinically.
Elective workload prioritised to maximise available staffing.
Managers at Band 7 level and above work clinically
Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
Activate the on-call midwives from the community to support labour ward.
Request additional support from the on-call midwifery manager.
Liaise closely with maternity services at opposite sites to manage and move capacity as required
Double Pay incentive is offered for midwifery shortfalls to support the maintenance of safety

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

The following chart outlines the compliance by month:



There have been 0 recorded incidents in the last 12 months where the labour ward co-ordinator is not supernumerary.

8. One to One in Established Labour

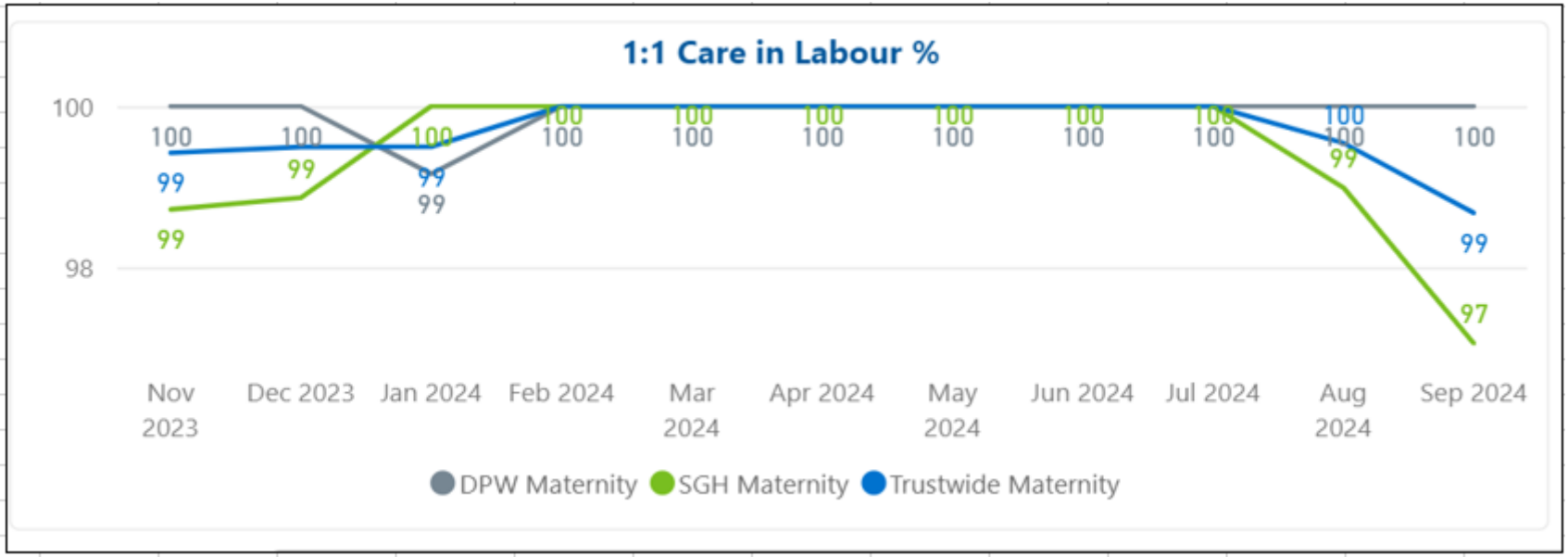
Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

	Number of days per month	Number of shifts per month	Compliance
November 23	30	60	100%
December 23	31	62	100%
January 24	30	60	100%
February 24	31	62	100%
March 24	31	62	100%
April 24	29	58	100%
May 24	31	62	100%
June 24	30	60	100%
July 24	31	62	100%
August 24	31	62	100%
September 24	30	60	100%
October 24	31	62	100%
November 24	30	60	100%

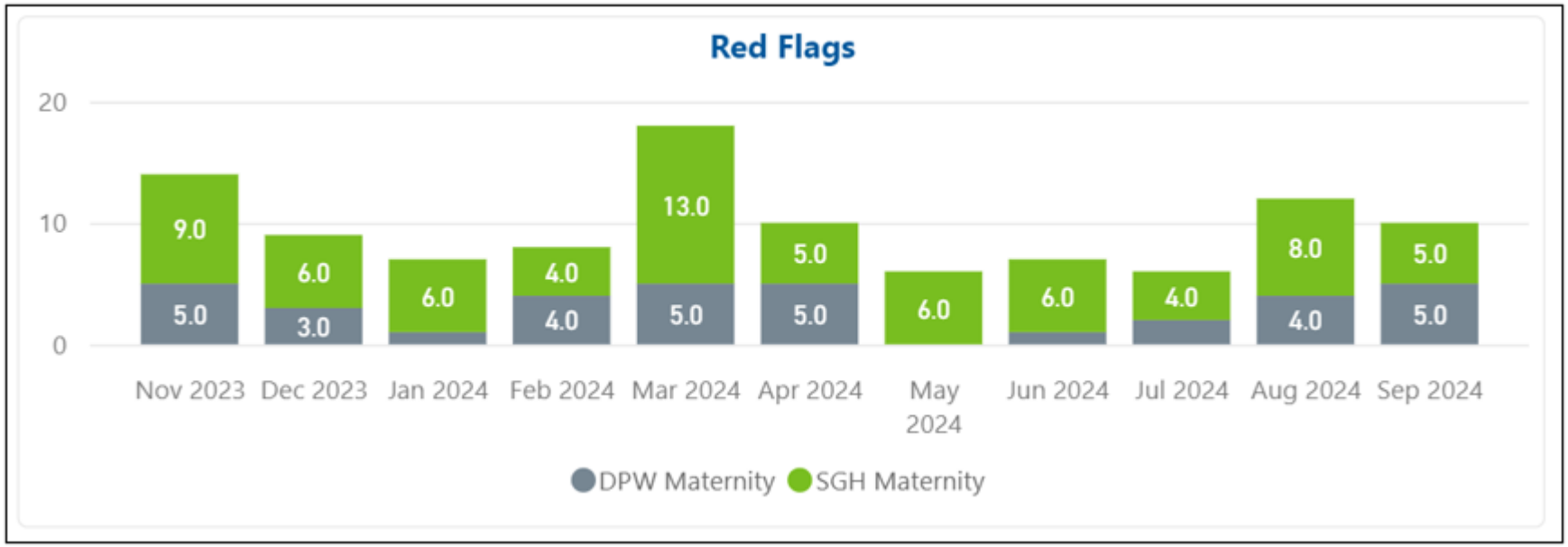
There have been 0 recorded incidents in these 12 months where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour. However, it should be noted that 1:1 care in labour figures may be reported less than 100% due to inputting errors onto CMIS This is exampled in the chart below as per Power BI reporting. A prospective audit is undertaken and reported by the Maternity Matrons on the Maternity Audit Dashboard. Figures of compliance demonstrate a rate of 100% over the last 12 months.



Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following table provides a breakdown of the red flag events during November 2023 and November 2024


Red Flags
20
10
0
9.0
5.0
6.0
3.0
6.0
4.0
4.0
13.0
5.0
5.0
5.0
6.0
6.0
4.0
8.0
4.0
5.0
5.0
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
Jun 2024
Jul 2024
Aug 2024
Sep 2024
DPW Maternity
SGH Maternity

Trustwide Maternity Dashboard

Indicator	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024
Midwife to Birth Ratio	21.8 ↗		19.6							
Red Flags	9.0 ↘	7.0 ↘	8.0 ↗	18.0 ↗	10.0 ↘	6.0 ↘	7.0 ↗	6.0 ↘	12.0 ↗	10.0 ↘
(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)	1.0 ↘	1.0	1.0	3.0 ↗	2.0 ↘	1.0 ↘	0.0 ↘	0.0	1.0 ↗	4.0 ↗
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	2.0	1.0 ↘	3.0 ↗	2.0 ↘	2.0	3.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘
(c) Missed medication during an admission to hospital	1.0 ↗	0.0 ↘	0.0	2.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	1.0 ↗
(d) Delay of more than 30 minutes in providing pain relief	1.0	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	0.0	0.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	6.0 ↗	4.0 ↘	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
(g) Delay of 2 hours or more between admission for induction and beginning of process	1.0 ↗	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	0.0	0.0	1.0 ↗	1.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘
(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	1.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	3.0 ↘	5.0 ↗	2.0 ↘	7.0 ↗	1.0 ↘	2.0 ↗	1.0 ↘	0.0 ↘	7.0 ↗	3.0 ↘
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
Actual v Planned Staffing %	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
1:1 Care in Labour %	99.5 ↗	99.5 ↗	100.0 ↗	100.0	100.0	100.0	100.0	100.0	99.5 ↘	98.7 ↘
Vacancies	28.4 ↘	22.8 ↘	22.5 ↘	21.1 ↘	26.1 ↗	25.6 ↘	26.1 ↗	2.8 ↘	28.5 ↗	29.7 ↗
Vacancies - Registered	22.4 ↘	16.9 ↘	16.9 ↗	17.8 ↗	16.5 ↘	15.2 ↘	17.0 ↗	2.1 ↘	19.8 ↗	16.1 ↘
Vacancies - Unregistered	5.9 ↘	5.9 ↘	5.5 ↘	3.3 ↘	9.6 ↗	10.4 ↗	9.1 ↘	0.7 ↘	8.8 ↗	6.8 ↘
Serious Incidents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Complaints	0.0 ↘	2.0 ↗	2.0	2.0	2.0	1.0 ↘	1.0	1.0	3.0 ↗	1.0 ↘
PALS	3.0	6.0 ↗	2.0 ↘	8.0 ↗	4.0 ↘	5.0 ↗	4.0 ↘	7.0 ↗	1.0 ↘	5.0 ↗
Sickness Absence (Division) %	5.7 ↗	5.7 ↘	4.8 ↘	4.6 ↘	5.0 ↗	5.0 ↗	5.1 ↗	5.3 ↗	5.2 ↘	5.2

9. Recommendations

Review the revised BR+ requirements- data collection currently ongoing- against the new report once available via reporting to Quality Committee-in-Common and Trust Board-in-Common to ensure that compliance with MIS Year 6 requirements to demonstrate there is agreed plan to fund to BR+ recommendation including an agreed timescale.

Although MIS Year 6 compliance is achieved Family Service quad request that the funding for additional posts at NLAG is supported to ensure compliance with all national standards and quality improvement initiatives.

To align with HUTH and purchase the Birthrate Plus Acuity App and associated training (£20160). This will enable of a bespoke platform that would enable access to the acuity status across the Group.

NHS
Humber Health
Partnership

FAMILY SERVICES CARE GROUP

NHS Resolution

Maternity (and Perinatal) Incentive Scheme

Year Six

Safety Action 4:
Obstetric Medical Workforce

Engagement of Short and Long Term Locum Medical Staff

September 2024

Yvonne McGrath – Group Director of Midwifery

Hayli Garrod – Maternity Audit and Compliance Manager

Working in partnership:
Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

United by Compassion:
Driving for Excellence

Contents

Introduction

NHS resolution is operating year six of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The scheme applies to all Acute NHS Trusts that deliver maternity care and incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all 10 of the safety actions will recover the element of their contribution to the CNST MIS fund.

To comply with safety action 4 of the MIS, in particular standard a: obstetric medical workforce, the Trust must provide assurance that guidance on the engagement of short and long term locums, developed by the Royal College of Obstetricians and Gynaecologists (RCOG) has been implemented by 01 February 2024. The guidance states that recent high-profile cases in maternity care have highlighted the need for adequate support and supervision of locums who enter the workplace. These individuals face the challenge of providing excellent clinical care but without the knowledge of the organisation or familiarity with the staff with whom they will work. Therefore, the RCOG strongly recommends that healthcare organisations engaging locum doctors refer to the RCOG guidance to support these individuals and ensure they comply with recommended processes such as pre-employment checks and appropriate induction.

A ‘locum’ refers to a doctor who is either placed by a locum agency or a locum bank in a healthcare provider organisation or directly engages with healthcare organisations for short-term work (placements of two weeks or less). An NHS certificate of eligibility for locums in O&G was introduced as a pre-requisite for employment of short-term locums for middle grade rotas from February 2023. Locum doctors who have obtained CCT/CESR/CESRCP and are on the GMC specialist register can be employed in a middle grade locum post without a certificate of eligibility if they have current NHS experience (within the past six months) and they have not been out of clinical practice for more than two months such that a more supported return to work package would be necessary (verified via CV). They must provide, as a minimum, references from previous jobs and structured feedback from their last two employers. O&G trainees will require a certificate when they undertake short term locum placements in the following locations: Outside of their deanery/HEE Local Office or in a trust (within their deanery/HEE Local Office) where they have not previously worked as a ST3-7.

A short-term locum is one where the placement is for a duration of two weeks or less. A long-term locum is one where the placement is for longer than two weeks duration.

The RCOG guidance details the requirement for healthcare providers to follow and provide a monitoring tool/checklist to be adopted into use. Where shortfalls are identified, the Trust must demonstrate that processes have been put in place and an action plan has been developed to address any deviations. This must then be shared with the Trust Board, Trust Board Safety Level Champions and the Local Maternity and Neonatal Services (LMNS).

To gain an insight of current processes in Obstetrics and Gynaecology across the Care Group and assess compliance against the standards detailed in MIS, a retrospective audit was undertaken, reviewing locum activity/engagement over a six month period (01 February 2024 - 31 July 2024) focusing on tier 2 or 3 (middle grade) rotas. A breakdown of compliance is detailed from page 5 onwards.

Project Team/Discipline Leads (with responsibility for change if required)	
Miss Gandhi	Chief of Family Services Care Group
Yvonne McGrath	Group Director of Midwifery – Family Services Care Group
Mr Abdullah / Mr Qureshi	Divisional Clinical Leads, NLAG
Uma Rajesh	Divisional Clinical Lead, HuTH
Caroline Corbett	Strategic HR Business Partner, Family Services Care Group
Emma Smith	Senior Improvement and Delivery Manager - Family Services Care Group
Hayli Garrod	Maternity Audit and Compliance Manager, NLAG
Mary Johnson	Medical Rostering Service Lead, NLAG
Nicola Fletcher / Jessica Sutton	Rota Co-ordinators, NLAG

References / Basis for Standards

1. NHS Resolution, Maternity (and perinatal) Incentive Scheme – Year Six, Version, 2024
2. Royal College of Obstetricians & Gynaecologists, Guidance on the engagement of short-term locums in maternity care, August 2022
3. Royal College of Obstetricians & Gynaecologists, Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales.

Objectives

1. To assess compliance against national guidance
2. Assess policies and procedures in place
3. Identify areas for improvement.

Method

NLAG
For the purposes of satisfying MIS requirements, all Obstetric and Gynaecology rotas were reviewed to identify shifts covered by locum medical staff (internal and external) for the period of 01 February 2024 to 31 July 2024 by the Rota Co-ordinators.

To provide additional assurance a list of locum doctors who have worked in the Trust either as an agency or Care1Bank doctor between the above dates was provided by the master vendor (Holt Doctors) as medical locum shifts at NLaG are booked through Holt Doctors. Reassurance was also provided from the vendor stating that prior to booking any doctor for a locum shift, checks are undertaken externally for certificate of eligibility.

HuTH
Information identified and obtained from the Medical Staffing and Assistant Business Manager for the time period of 01 February 2024 to 31 July 2024.

Summary of Key Findings: Short Term Locums

Standard 1 Description:
NHS Trusts/organisations should ensure that the following criteria are met for employing **short-term** (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota *or* b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) *or* c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

NLaG Breakdown of compliance

During the audit period a total of 260 tier 2 or 3 rota shifts in Obstetrics and Gynaecology were covered by 37 locum doctors on a short term basis (<2 weeks). The table below details the split between internal and external locum cover.

Short term locum staffing numbers (≤2 weeks)				
	Internal		**External**	
Site	**No. of locum doctors booked**	**No. of shifts covered**	**No. of locum doctors booked**	**No. of shifts covered**
SGH	12	106	7	20
DPOW	12	107	6	27
TOTAL	**24**	**213**	**13**	**47**

The tables below demonstrate the criterion met in relating to standard 1 and the overall compliance for internal and external locum doctors.

Standard Compliance			
INERNAL Locum Staffing			
Site	**Currently work in their unit on the tier 2 or 3 rota**	**Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)**	**Hold a certificate of eligibility (CEL) to undertake short term locums**
SGH (n=12)	12	-	N/A
DPOW (n=12)	10	2	N/A
Achievement: 100% compliance			

Standard Compliance			
EXTERNAL Locum Staffing			
Site	**Currently work in their unit on the tier 2 or 3 rota**	**Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)**	**Hold a certificate of eligibility (CEL) to undertake short term locums**
SGH (n=7)	N/A	1	6
DPOW (n=6)	N/A	3	3
Achievement: 100% compliance			

HuTH Breakdown of compliance

During the audit period 0 locums were used to cover tier 2 or 3 rota shifts in Obstetrics and Gynaecology were covered by 3 locum doctors on a short term basis (<2 weeks). The table below details the split between internal and external locum cover.

Short term locum staffing (≤2 weeks)				
	Internal – Remarkable Bank		**External**	
Site	**No. of locum doctors booked**	**No. of shifts covered**	**No. of locum doctors booked**	**No. of shifts covered**
HuTH – Tier 2	0	0	3	5
HuTH – Tier 3	0	0	0	0

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	**Currently work in their unit on the tier 2 or 3 rota**	**Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)**	**Hold a certificate of eligibility (CEL) to undertake short term locums**
HuTH (n=4)	N/A	3	N/A
Achievement: 100% compliance			

Standard Compliance			
INERNAL - Short term locum staffing (<2 weeks)			
Site	**Currently work in their unit on the tier 2 or 3 rota**	**Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)**	**Hold a certificate of eligibility (CEL) to undertake short term locums**
HuTH (n=0)	N/A	N/A	N/A
Achievement: Not Applicable			

Summary of Key Findings: Long Term Locums

Standard 2 Description:
Trusts/organisations should implement the RCOG guidance on engagement of **long-term** locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.
Minimum evidence: Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (Appendix B) to audit their compliance and have a plan to address any shortfalls in compliance.

NLaG Breakdown of compliance

During the audit timeframe the Trust employed 0 long term locums to cover middle grade rotas in Maternity or Gynaecology. Therefore, it was not possible to determine compliance against the standard.

For the purposes of the MIS submission, compliance against this standard will be declared.

Long term locum staffing (>2 weeks)				
	Internal		**External**	
Site	**No. of locum doctors booked**	**No. of shifts covered**	**No. of locum doctors booked**	**No. of shifts covered**
SGH	0	0	0	0
DPOW	0	0	0	0

NLAG Current Process – Employment of Locums

Locum staff who are put forward to fill vacant shifts have their CVs forwarded by the supplying agency/regional bank. This is then sent onto the Clinical Leads by the Rota Co-Ordinator. Locum Medical staff can only be employed if their compliance is up to date. Due to changes in the framework legislation made in February 2023 no locum doctor can be booked unless fully compliant. Medical locum shifts at NLaG are booked through the master Vendor Holt who has a team responsible for checking and updating compliance. The LMS (Locum Management System) sends notifications for compliance close to expiring.

Locum doctors working at NLaG are given an Induction. This is arranged with the Rota Co-ordinators and Clinical Leads within the division. The locum doctor is then required to sign the document to evidence that this has taken place. When receiving the booking the Rota Co-Ordinator is sent a photograph so that ID badges, door access and system access can be arranged. Any bookings made outside of normal working hours are processed by the Site Matron and an induction will be given relating to the area that they will be working in.

The RCOG compliance and effectiveness tool was introduced for use during MIS year 5 which has allowed a retrospective audit trail and greater oversight for the clinical leads. A Standard Operating Procedure was also developed during MIS year 5 and the Trust continues to work in accordance with this.

HuTH Breakdown of compliance

Long term locum staffing (>2 weeks)				
	Internal		External	
Site	No. of locum doctors booked	No. of shifts covered	No. of locum doctors booked	No. of shifts covered
HuTH - Tier 2	0	0	0	0
HuTH - Tier 3	0	0	3	375

Standard Compliance			
EXTERNAL - Long term locum staffing (>2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
HuTH (n=3)	N/A	N/A	3
Achievement: 100% compliance			

In addition to the information below, there were also 395 shifts covered by internal Obs & gynae consultants as WLI.

HuTH Current Process – Employment of Locums

In order to ensure compliance, the following should be followed:

Also see CP616 Management of Induction of New Employees Policy Essential measures:

1. Pre-Appointment Check list – Appendix A This will be undertaken by Medical Staffing and the Health Group Business Team.

2. Induction Programme – Appendix B This is tailored to suit the requirements of the position. It will be sent electronically to the new employee approximately two weeks before their start date.

3. Completion of Position – Appendix D Essential information for Business Team to aid with on boarding: Prior to start date, send an email to the new consultant / locum containing the following: 1. Welcome to the Trust 2. Obstetrics and Gynaecology Induction Booklet 3. Link to the HUTH Internet, inviting them to explore the website at their leisure.

4. Provide information in regard to accommodation on site if applicable.

Hull University Teaching Hospitals NHS Trust

APPENDIX A – Pre Employment Checks Appropriate pre-employment checks to be completed via HUTHT Medical Staffing, Clinical Director and/or Clinical Lead for Health Group.

Requirement	Received	Validated
Curriculum Vitae (review to be undertaken by Clinical Director / Clinical Lead or delegated Authority)		Reviewed By:
GMC Registration		
Licence to Practise		
NHS Certificate of Eligibility (include feedback from previous employers)		
Confirmation that locum doctors who have obtained CCT/CESR/CESRCP and are on the GMC specialist register have current NHS experience (via CV)		
2 x References (as a minimum)	Structured feedback from their last two employers	
Pre Employment Checks - Language - Health Clearance - Other (if required)		
Does the applicant have GMC conditions or undertakings on their registration?	If Yes: please describe	YES / NO
Identify what skills, expertise and competencies required for the Position?	Please list:	

Business Team to:

Share Job Plans / Rota prior to arrival	Initial 6 weeks	
On Boarding Process		

APPENDIX B – Induction Programme Checklist

(this is not exhaustive and may include other items required specific to the role)

Requirement – WEEK 1	When	Completed
Departmental Induction – Meet & Greet - Senior Member of the Team - Senior Members of the Midwifery Team - Business Team - Secretary (if appropriate)	On Arrival	
Visit ALL Areas including - Theatres - Wards - Clinics (Ground Floor)	On Arrival	
Cascade information regarding the Appointment to: - Consultants - Non-Resident On Call Teams - Health Group QUAD	Within 1 week	Secretary
Identify a NAMED Consultant to support	On Arrival	NAME:
Procedure for reporting sickness absence, annual leave, study leave etc		
Issue Smart Card	Within 1 week	
Familiarise with ALL HUTHT Policies / Guidance and practices	Within 1 week	
Fire / Health and Safety Briefing - Shown washroom / changing facilities - Evacuation assembly points - Cafeteria -		

Organise Shadowing Rota Provided prior to attendance if possible	First Week of appointment	
Uniform - Standards - Order uniform / scrubs if required		
KEY Items - ID Cards - Security Pass / FOB - Access codes		
Access to IT Systems - Lorenzo - BadgerNet - NHS Email - HEY247		
Attendance at Corporate Induction 1st Monday of every month / Tuesday if this is a Bank Holiday Under exceptional circumstances this can be deferred but must attend within 3 months of employment	DATE:	
Complete ALL Mandatory Training See **Statutory and Mandatory Training Policy**	Within 1 week or prior to attendance at the Corporate Induction	
Provision of IT/Telephone Equipment (if required)		
Incident Reporting - Escalation process - DATIX -		

Requirement – WEEK 2	**When**	**Completed**
Allocate own clinics to new consultant / locum, but with reduced numbers		
Complete ALL Additional Required Training (Where available)	Within 3 Months of arrival	
Travel Arrangements - Car parking arrangements - Order permit (if required)		
Requirement – WEEK 3	**When**	**Completed**
Allocate normal activity for new consultant / locum for them to start to undertake	Within 3 Months of arrival	

Essential measures on completion of post:

Feedback on performance to both the locum doctor and to the employing agency.
Completing the required end of placement/exit report and peer/colleague feedback for the doctor.

Notifying the doctor and locum agency (where relevant) if any significant information of note arises in relation to the doctor's practice during their placement (and/or the doctor's responsible officer if the agency is not the doctor's designated body)
Agreeing with the locum agency or NHS England local team (where relevant) whether any necessary investigation is carried out in the organisation, or whether referral to the GMC is appropriate, including quality elements within the service level agreement (if applicable) with the locum agency to facilitate the above.

Consultant Attendance per RCOG recommendation

Snapshot Audit

June 2024

U Rajesh

Consultant on site hours	Must attend during resident hours
Monday to Friday 8am to 7pm (excluding bank holidays) **Monday to Thursday (currently 1:7 weeks) 20:30-08:00 hours** **Saturday & Sunday and bank Holidays daytime 8am -11am** **Friday to Sunday nights 20:30-08:00 hours** **During above times, an Obstetric Consultant must be present in theatre (unless the consultant is dealing with another emergency case in either obstetrics or gynaecology** **In this situation this information should be documented in the medical records**	• ALL Trial of Instrumental deliveries • All full Dilatation CS's • Any medically Complex situation • Preterm CS's < 28weeks • All Twin pregnancies • Any Vaginal Breech birth Must attend during resident hours Unless attending an emergency or doctor competent in managing • Any patient in obstetrics OR gynaecology with an Estimated Blood Loss>1.5litres and ongoing bleeding • Trial of instrumental birth • Vaginal twin birth • Caesarean birth at full dilatation • Caesarean birth for women with a BMI >40 • Caesarean birth for transverse lie

HUTH Current ratified SOP as per RCOG Recommendations

Consultant Must attend

- **Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary**
- **Caesarean birth for major placenta praevia / abnormally invasive placenta**
- **Caesarean birth for women with a BMI >50**

- Caesarean birth <28/40
- Premature twins (<30/40)
- 4th degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal collapse e.g septic shock, massive abruption Post -Partum Haemorrhage >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated

- Gynaecology Laparotomy

HUTH Current ratified SOP as per RCOG Recommendations

Snapshot Audit

- Compliance to attached HUTH SOP per RCOG reviewed
- 1st June to 14th June 2024 24 /7
- 100% Completion on all the shifts
- Prospective audit
- Completion by LW coordinators
- 8am-9pm shift and 9pm to 8am shift audited
- HUTH has resident consultant Obstetrician and Gynaecologist Mon-Fri 24/7 and 8am to 11am sat Sunday ,Sat ,Sun nights 8.30pm to 8am extending Resident hours to 149hours

HUTH Current ratified SOP as per RCOG Recommendations

Results and themes

- Main reasons for Consultant attendance request during all the shifts during Audit period:
  - Preterm CS
  - Full Dilation CS
  - PPH at CS
  - Trial in theatre
  - Second theatre (3 instances in audit period)
  - Ovarian Cystectomy at CS
  - Twins
  - No Recorded issues with non attendance or non compliance
  - ***Feedback given to all Consultants and Coordinators for good practice***

  Any issues with attendance as per RCOG guidance based SOP will continue to be escalated to CD maternity via Labour ward Matron or coordinators and reviewed proactively

To reach Birthrate+ recommended budget

Background

Maternity Incentive Scheme Year 6- Safety Action 5

Where Trusts are not compliant with a funded establishment based on BirthRate+ or equ
calculations, Trust Board minutes must show the agreed plan, including timescale for ach
appropriate uplift in funded establishment. The plan must include mitigation to cover any
shortfalls.

Summary

Birthrate+ is the recommended tool for establishing maternity staffing requirements. A tal
review was undertaken in 2021 and a full review is currently ongoing. A further 17.59wte
were agreed in October reducing the gap between BR+ and budges. This action plan de
actions taken to meet the requirements of Maternity Incentive Scheme Year 6.

Any important links/references

MIS-Year-6-guidance.pdf (resolution.nhs.uk)

Version Control

Version Code
V1.0 To reach Birthrate+ recommended budget

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bletop
midwives
tails the

Date updated	Highlight Changes
25th November 2024	Document updated

Green - Completed (Audits - Minimum target reached)
Amber - On Track for completion
Red - Not on track, deadline passed (Audits - Not achieved)
Blue - Completed and evidenced (Audits - Stretch target achieved)

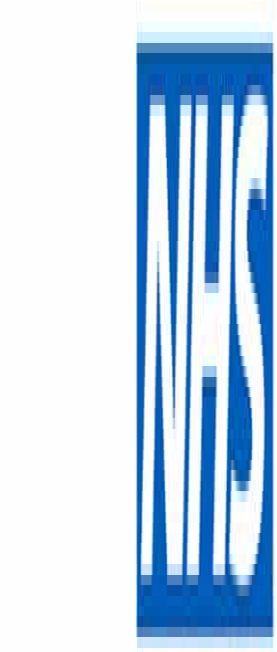
No.	Recommendation	Actions / Key Milestones
1	As per MIS Year 6 requirements funded establishment for midwifery must match Birthrate+ recommendation	1. Review budgets and establishments with finance to confirm actual budget. 2. Finance paper to be completed to request financial support to reach BR+ requirements
2	Bi-annual staffing paper to be shared with board including mitigation of any shortfalls.	1. Bi-annual reports shared at board, additional report shared at cabinet in Novemeber and will be shared at December board to align timing with Safer Staffing papers. This paper clearly lays out the remaining deficit to reach BR+ and requests that this funding is support. Previously the reported funded establishment was not accurate, the new Finance team is in place for the Care Group and the review described has now occured 2. Mitigation of shortfalls clearly described in staffing paper
3	Share a plan to address deficits with local commissioners	1. LMNS well-sighted on staffing deficits and challenges, however this action plan will also be shared as per MIS guidance.

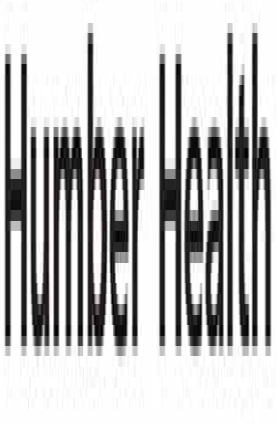
To reach Birthrate+ recommended budget

Director of Midwifery
Version 1.0
Update 25th Novemeber 2024

Expected Impact	Strategic Lead	Forecast Completion Date	RAG Status
Enable recruitment to BR+ recommendations. Improved patient safety, staff and service User Experience	DoM	01/10/2024	
Funding to BR+ recommendations o be agreed enabling recruitment, improved patient safety, staff and service user experience.	DoM	01/12/2024	
Ensure LMNS are sighted and enabled to support where possible	DoM	30/11/2024	

Actual Completion Date	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
	1. Paper outlining staffing requirements went to Cabinet in July and QSC in August with agreement for reworked paper to go to October Board. 2. Gap previously identified in BR+ tabletop review identified the establishment incorrectly at 205.01with 221.17wte required (a gap of 16.16wte) 3. Funding for 17.59 WTE to staff Maternity triage agreed at private board in October closing the gap between BR+ and funded establishment. However a budget review of B3-B8 midwifery establishment confirmed that the establishment is 194.02 not 205.01 WTE. Mitigations in place as outline in staffing reports and November QSC responsibility to support funding BR+ requirements delegated to Cabinet as the CEO was in attendance. Further staffing sent to November cabinet and response awaited.	
	1. QSC and Board minutes	
	1. Email reply confirming receipt of action plan	


NHS


Humber Health

CNST MIS Year Six - Action plan.

Safety Action 8.

This action plan is regarding the Maternity Emergencies and Multiprofessional training (PROMPT) and the requirement for obstetric anaesthetic doctors, including anaesthetist in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.

For rotational anaesthetic staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. This action plan is to confirm a commitment and action plan to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.

There were 6 Anaethetists that commenced at the trust in November 2024 and therefore will be required to complete this by May 2025.

Hull University Teaching Hospitals.

Requirement	Lead	Action to be taken	Timescale	Evidence	Current position
Ensure all Anaesthetists after 01/07/24 are booked onto PROMPT	Nichola Riggs	Confirmed staff list as requested from Anaesthetic Admin team 18/10, who commence in November. Emails sent to staff members to see if they have evidence of previous PROMPT training. If not, requested to book on. ES chased 20/11/24 to request remaining 3 staff members to book onto PROMPT.	30/11/2024	Email evidence of staff communication Hey247 record	**Complete 28/11/2024** All 6 anaesthetists have confirmed dates of PROMPT training for January, and this is recorded on Hey247. This is 2-3 months in from their start-date.
Training Lead to monitor attendance	Nichola Riggs	Nichola Riggs to monitor attendance and escalate any DNA to Anaesthetic Lead. Noted due to getting booked onto training in January, there are multiple training dates following that the staff could then be booked onto which will be within 6 months and achieve compliance.	01/02/2025		**Ongoing 28/11/2024**

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 2

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at Trust level (Board or directorate) quality meeting.

Humber Health Partnership

Claims Scorecard April 2014 –June 2024 (90 claims)

Top injuries by volume:	**Top injuries by value:**
Fatality (16) Unnecessary pain (15) Additional / unnecessary operation(s) (13) Stillborn (11) Bladder damage (5)	Cerebral Palsy (4) Brain damage (7) Stillborn (13) Fatality (9) Cardiac Arrest (1)
Top causes by volume:	**Top causes by value:**
Failure / delay in diagnosis (11) Failure / delay in treatment/operation (11) Inadequate nursing care (6) Failure to recognise complication (6) Failure to act on abnormal test results (6)	Failure to monitor 1st stage of labour (3) Failure / delay in treatment (2) Failure / delay in diagnosis (1)

Incidents Q2 24/25

Top 5 incident by volume:

Term NNU admissions **(48)**
Post partum haemorrhage (PPH) >1500mls **(39)**
Shoulder Dystocia **(16)**
3rd and 4th degree tears **(9)**
Still Birth **(3)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **256**

Complaints Q2 24/25

There have been 10 complaints received:

Attitude
Communication
Treatment / plans of care
Delays

All 10 complaints are still open.

Learning Q2 24/25

Thermoregulation of the newborn as ATAIN theme
Reduced fetal movements training to be mandatory yearly on Hey24/7
Reminder to all staff to use Amnisure when SROM is suspected to aid confirmation
Escalation of underreporting on DATIX – Acuity/red flags/delay in IOL
Timely escalation of CTG concerns and miss classification of CTG
Never event – Swab left insitu following EMLSCS

Themes Q2 24/25

Hypothermic neonates on the wards (labour ward and postnatal ward)
Incorrect interpretation of CTG's
Escalation of a deteriorating baby on CTG's.
Reduced fetal movements advice/false assurance
Delay in IOL and ARM >24hrs

Action Plan Q 24/25

Not started | In progress | Complete

Develop guideline for Extreme Preterm SROM antibiotic therapy/repeating steroids pathway	July 2024	
Explore the introduction of fetal monitoring champions on the wards and in community to support staff	Oct 2024	
Thematic review of CTG interpretation / deteriorating baby to be undertaken with the LMNS.	Sept 2024	
Introduction of teaching session on neonatal study day for the prevention of neonatal hypothermia.	Sept 2024	

Northern Lincolnshire and Goole - Maternity Incentive Scheme (SA9)

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at Trust level (Board or directorate) quality meeting.

NHS Humber Health Partnership

Claims Scorecard April 2014 –June 2024 (55 claims)

Top injuries by volume:	**Top injuries by value:**
Fatality (16) Unnecessary pain (15) Additional / unnecessary operation(s) (13) Stillborn (11) Bladder damage (5)	Brain damage (3) Cerebral palsy (2) Wrongful birth (1) Bladder damage (3) Fatality (9)
Top causes by volume:	**Top causes by value:**
Failure / delay in treatment (15) Failure / delay in diagnosis (8) Inadequate nursing care (3) Operator error (3) Intra-operative problems (3)	Failure / delay in treatment (2) Intra-operative problems (1) Other (1) Fail in antenatal screening (1)

Incidents Q2 24/25

Top 5 incident by volume:

Staffing levels - (Mat) **(47)**
Task saturation / workload volume (acuity) **(25)**
Communication failure between different teams **(20)**
Unexpected admission to NICU **(19)**
Delayed treatment or procedure **(18)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **522**

Complaints Q2 24/25

There have been 4 complaints received:

Communication / treatment (2)
Staff attitude (2)

2 complaints are still open and 2 have resolved

Learning Q2 24/25

For each Bakri balloon, vaginal pack or aquacel wick retained, a coloured wristband is to be placed for each in order to know how many items have been retained.

Antenatal CTGs should not be discontinued before the 60 minute computerised analysis has been produced.

Senior obstetrician should review CTGs which don't meet the Dawes Redman criteria

Placentas should be sent as a whole for cytogenetic.

Themes Q2 24/25

Communication/attitude between women / birthing people and staff.

Action Plan Q2 24/25 Not started | In progress | Complete

Introduce the use of coloured wristbands to identify any retained items	October 2024	
Fetal Monitoring Learning Lessons to be sent to all staff with regards to not discontinuing a CTG if the Dawes Redman criteria is not met	September 2024	
Escalation on huddles and manager's meetings that placentas should be sent whole when cytogenetics are required	August 2024	

3.1.2 - MATERNITY & NEONATAL SAFETY CHAMPIONS OVERVIEW ASSURANCE / ESCALATION REPORTS - NLAG & HUTH

Stuart Hall & Sue Liburd, NED Maternity & Neonatal Safety Champions

REFERENCES

Only PDFs are attached

BIC(24)233 - Maternity & Neonatal Safety Champions Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front sheet

Agenda Item No: BIC(24)233

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 December 2024
Director Lead	N/A
Contact Officer/Author	Sue Liburd, Non-Executive Director Stuart Hall, Non-Executive Director
Title of the Report	**Maternity & Neonatal Safety Champions 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. 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. The report sets out matters of risk to escalate which include the instability in some senior leadership roles, but note the positive progress made which has included the appointment of a Group Director of Midwifery who commenced in post in June 2024.
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 the following are in place: • 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); and • Effective team working.
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 ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other – please detail below:

Maternity & Neonatal Safety Champion's Report
For October and November 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 October and November 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

- 8 October: Maternity Safety Support Programme sharing event
- 11 October: HUTH Safety Champion Walkaround
- 17 October: Maternity and Neonatal Assurance Group
- 25 November: QUAD Meeting

NLAG

- 15 October: HNY LMNS Delivery Board
- 7 November: NLAG Safety Champion Walkaround (DPoW)
- 25 November: QUAD Meeting
- 28 November: Presented Shining Light Award at Scunthorpe

Stuart Hall is in his last month as Maternity and Neonatal Safety Champion and will handover to David Sulch in January.

Positive News and Feedback

- Safety Action 8 requirements successfully achieved across the Group. The Group is on-track to declare full compliance with the Maternity Incentive Scheme across both Trusts.
- New Head of Midwifery now in post at HUTH
- Training opportunities for staff in 2025 to increase knowledge of Birth Trauma and Trauma-informed care.
- New Governance Structure now in place.
- The Safety Champions were pleased to note the MAMA Award for the Hull Midwifery Bereavement Team

Areas for Escalation

- Delays in induction of labour at HUTH.
- Further industrial action at DPOW, although all risks were managed, agreement to end the dispute is not yet in place.
- Requirement for funding to stabilise the Matron and Manager structure at HUTH.
- Increasing levels of caesarean section and the risk of this continue to increase and the associated impact on outcomes and service delivery.
- Levels of medication errors across Neonates.
- For neonates, children and young people the need to ensure the “Voice of the Child” is heard both internally and externally.
- Recruitment required to move to a 24 hour triage service
- Concerns around staff sickness levels and maintaining safe staffing
- Band 2/3 vacancy at HUTH as the issues with Band 2/3 are worked through.

Activities planned next month:
The following activities are planned during the month: **Group:** Timeout day in January 2025 to set objectives and further develop the Safety Champion role in 2025. **HUTH** • 5th December HNY LMNS Delivery Board • 11th December Safety Champion Walkaround • 19th December: Maternity & Neonatal Assurance Committee meeting **NLAG** • 5th December HNY LMNS Delivery Board • 19th December: Maternity & Neonatal Assurance Committee meeting 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)
30th September 2024

Sue Liburd
Non-Executive Director Maternity &
Neonatal Safety Champion (NLAG)

Stuart Hall
Non-Executive Director Maternity &
Neonatal Safety Champion (HUTH)

Sue Liburd
Non-Executive Director Maternity &
Neonatal Safety Champion (NLAG)

3.1.3 - MATERNITY & NEONATAL SAFETY ASSURANCE REPORTS - NLAG & HUTH

Amanda Stanford, Group Chief Nurse

REFERENCES

Only PDFs are attached

BIC(24)234 - Maternity & Neonatal Assurance Report.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)234

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 December 2024**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	Maternity & Neonatal Assurance Reports – NLAG & HUTH
Executive Summary	**1.** Key risks related to induction of labour delays at HUTH and provision of a 24 hour triage. Plan to recruit to vacancy ongoing. **2.** Key risks at NLAG related to increasing vacancy rate and MSW industrial action **3.** Deep dive into Pre-term birth and 'Born Before Arrival' births. Pre-term birth review demonstrates the influence of deprivation. Born Before Arrival deep dive indicates ongoing work required on effective triage.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	[insert, if applicable]
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ü Assurance ☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

November 2024

Contents

Item 1: Executive Summary & Highlight Report

This Maternity & Neonatal Safety Assurance Report for November outlines the progress and challenges in improving safety across Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust. Key initiatives include the Maternity and Neonatal Safety Improvement Plan and the CNST Maternity Incentive Scheme Year 6, with both trusts focusing on workforce planning, service user feedback, and training compliance. While progress is being made, areas needing improvement include data quality and specific training compliance. The report also highlights critical incidents.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

Plans are developing to devise an overarching Maternity and Neonatal Safety Improvement Plan that will encompass actions and improvements driven by both local and national drivers. Work continues on the MATSIP and plans are in place to meet with key members of staff to capture and stratify all actions. A draft plan is attached. The first Maternity and Neonatal Improvement Group meeting takes place in December and the MATSIP oversight will occur in this meeting with regular reporting within this assurance report.

2.2 CNST MIS Year 6: 10 Steps to Safety

Hull University Teaching Hospitals NHS Trust

The Trust has utilised the NHS Resolution Audit tool during the year to track compliance with the standards.

Green - Completed
Amber - On Track for completion
Red - Not on track
Blue - Completed and evidenced

Safety action	Red	Amber	Green	Blue	
1 National Perinatal Mortality Review Tool					Qtr1 and Qtr 2 reports have been presented to Board, with data also covering the period from Dec 23 period. Q1 and Q2 reports have included action plans in line with NHSR audit tool provided to support Year 6 compliance.
2 Maternity Services Data Set (MSDS)					The finalised MSDS Scorecard for July submission was published during October. All CQIMs passed the quality check.
3 Transitional Care Services					Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). Initial actions and QI leads identified. Meeting with LMNS to provide update 19/11/2024. Draft Transitional Care Updated Guideline for ratification at Neonatal Governance on 29/11/2024
4 Clinical Workforce Planning					Consultant attendance audit to be shared at December board and action plans to be shared with ODN by w/e 22/11/2024
5 Midwifery Workforce Planning					Issues identified with daily co-ordinator supernumerary status. Work on Action Plans in progress. Funded establishment does not match BR+ recommendations- however progress towards this made was funding for triage agreed and a further paper will be presented to Cabinet to resolve the outstanding gap. On track to demonstrate sufficient progress.
6 SBLCB V3					The LMNS have indicated that they agree that 'all reasonable endeavours' have been taken to achieve the agreed trajectories to declare compliance with MIS Year 6

7 Service User Feedback / Co-produced Services					The Trust's evidence of progress against the 2023 CQC survey is due to be updated to Maternity and Neonatal Assurance Group (MNAG) in November 2024 and be presented to Trust Board in December 2024.
8 Training					Compliance <90% for certain staff groups. However, trajectory indicates targets will be met by 30th November 2024.
9 Floor to Board					Awaiting further evidence of Safety Champions meeting with perinatal leadership team (due December 2024). Trust board minutes required to demonstrate fill completion
10 MNSI / Early Notification Scheme					The Trust has finalised written duty of candour for one remaining case.
Total		**5**	**4**	**1**	

Northern Lincolnshire and Goole NHS Trust

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					Trust Board papers include overview of PMRT but full detailed report not uploaded. Discussion to be held with NHSR to determine if acceptable.
2 Maternity Services Data Set (MSDS)					The finalised MSDS Scorecard for July submission was published during October. All CQIMs passed the quality check.
3 Transitional Care Services					Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). Initial actions and QI leads identified. Meeting to share update with LMNS on 19/11/2024
4 Clinical Workforce Planning					Unable to demonstrate progress made against action plans submitted in year 5 for compensatory rest (not measured in MIS Year 6) and BAPM neonatal workforce requirements due to financial restrictions. Evidence of progress is required to allow the Trust to declare compliance. Action plans to be shared with ODN by w/e 22/11/2024. Compensatory rest SOP for final ratification due to a minor amendement.
5 Midwifery Workforce Planning					N/A
6 SBLCB V3					The Trust have been advised that through best endeavours enough evidence has been submitted to declare compliance. Quality improvement measures required for non-compliant interventions.
7 Service User Feedback / Co-produced Services					The Trust's evidence of progress against the 2023 CQC survey is due to be updated to Maternity and Neonatal Assurance Group (MNAG) in November 2024 and be presented to Trust Board in December 2024.
8 Training Plan					Compliance <90% for certain staff groups. However, trajectory indicates targets will be met by 30th November 2024. These have been reviewed on a line by line basis with Chief of Service and at the MIS Year 6 Delivery Group to ensure there are plans in place for indiivduals to attend.
9 Floor to Board					Awaiting further evidence of Safety Champions meeting with perinatal leadership team (due December 2024). Trust board minutes required to demonstrate fill completion
10 MNSI / Early Notification Scheme					N/A

Total	**0**	**4**	**2**	**4**	

2.3 Perinatal Quality Surveillance Model

Hull University Teaching Hospitals NHS Trust

CQC Maternity Ratings	**Safe**	**Effective**	**Caring**	**Responsive**	**Well Led**	**Overall**
	Inadequate	Requires improvement	Good	Requires Improvement	Inadequate	Inadequate

Maternity Support Programme	Yes

Data measure	**September 2024**
Findings of review of all perinatal deaths using the real time data monitoring tool	9 cases reviewed in Qtr 2. Graded C or D - 3 (33%) Themes: RFM, Gestational Diabetes MDT management, Hypertension management, Service user engagement
Number of cases referred to MNSI/ENS	MNSI referrals - 2 IP SB (latent phase ?labour/Delay in IOL for 5 days).
Family's informed of referral to MNSI/ENSR	Yes
Findings of review of all cases eligible for referral to MNSI	Staff interview stage.
Number of incidents graded as moderate or above and what action is being taken	AAR 1 closed (35+2 cooled baby) 1 outstanding (multiple failed trial without catheter) PSII 2 ongoing (Meconium aspiration requiring ECMO and Never Event - both led by patient safety team) Learning themes: FSE use in pre-term labour (guidance updated and shared). Thematic reviews Q2 of PPH (local ward based skills and drills and PROMPT education input), perineal trauma (80% warm compress. 0 4th degree tears) Shoulder Dystocia (x1 clavicle fracture x1 ?erbs palsy. 46% associated with pool use and 10 declared <2mins - PROMPT educational agenda)

Compliance with duty of candour (within 10 working days)	Yes		
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report		
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	Reviewed daily and plans put in place to mitigate risk e.g.double pay incentive, use of mutual aid across the group		
Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	20550.75	16686.25	81.20%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	8158.25	5639.67	69.13%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	16530.67	10947.25	66.22%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	870.00	611.00	70.23%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	Reviewed daily and plans put in place to mitigate risk e.g. use of locums and offer of enhance rates where required.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Maternity teams feeling burnt-out- delays in induction of labour and lack of a 24 hour triage.		
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No		
Coroner Reg 28 made directly to the Trust	0		
Progress in achievement of CNST 10	Please refer to body of report		

Northern Lincolnshire and Goole NHS Foundation Trust

CQC Maternity Ratings	Safe	Effective	Caring	Responsive	Well Led	Overall
DPOW	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Goole	Requires Improvement	Good	Good	Good	Good	Good
SGH	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Maternity Support Programme	No

Data measure	September 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	9 perinatal deaths occurred in Q2 (Jul – Sept 24), 4 were for notification only, 5 are being/will be reviewed through the PMRT processes. All 9 have been notified to MBRRACE (2 notifications submitted late but MBRRACE confirmation reviewed that this will not affect compliance. Key themes identified from Q2 cases PMRT or continued from previous quarterly reviews are as follows: Paediatrician not called soon enough for delivery despite end of life care pathway plan in place. Mother not referred for uterine artery doppler or serial scans despite previous hypertension. Kleihauer bloods not tested All Postnatal bloods and investigations not being taken.
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	N/A

Findings of review of all cases eligible for referral to MNSI	N/A		
Compliance with duty of candour *(within 10 working days)*	N/A		
Number of incidents graded as moderate or above / action taken	2 cases (1 moderate / 1 fatal)		
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report		
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively. Reviewed daily and plans put in place to mitigate risk e.g. DPI, use of mutual aid across the group.			
Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	11,367.0	10,191.0	89.7%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	4,605.0	3,727.1	80.9%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	5,520.0	4,668.2	84.6%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	2,760.0	2,221.3	80.5%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	100% compliant – no gaps identified.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Overall positive feedback about the rollout of Badgernet. Maternity teams feeling burnt out.		
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No		
Coroner Reg 28 made directly to the Trust	0		
Progress in achievement of CNST 10	Please refer to body of report		

2.5 Maternity and Neonatal Dashboards

Development of a Maternity and Neonatal Dashboard has commenced and will comprise of the following indicators.

- Activity Indicators
- Maternal Morbidity Indicators
- Neonatal Mortality & Morbidity Indicators
- Workforce Indicators
- Postnatal Indicators
- Risk Management Indicators

These indicators will be underpinned with SPC charts where relevant to support recognition of themes, trends and risk and enable appropriate management and quality improvement. The dashboard for Hull Royal Infirmary showing progress is attached, further work is required. This process will be replicated for NLAG.

Item 3:

In month developments and updates

3.1 Maternity and Neonatal updates

Positive News

Skills and drills in the clinical areas across the Group including a perimortem caesarean section in A&E.

The photo illustrates the patient arriving via ambulance at the beginning of the skills and drill in A&E

First Maternity & Neonatal Intelligence Co-Ordination meeting occurred on the 6th of November- this forum will support development and governance of service user feedback and co-production going forward.

The new Family Services Governance structure commenced on the 1st of November with Family Service Care Group Clinical Governance.

Areas of Concern- Hull Royal Infirmary

Induction of labour- delays in commencing and progressing inductions of labour. Frequent mutual aid across the Group and LMNS, however not all women are prepared to transfer even when capacity allows. Deep dive requested by site triumvirate and work has commenced on this and will be shared in the December assurance report.

Triage provision- funding now in place significant recruitment to support a 24 hour triage and fill the current vacancy rate will be required.

Areas of Concern- Northern Lincolnshire and Goole

Maternity Support Worker industrial action pressures (11th-25th of November), causing significant the risk, is however being mitigated with daily review of staffing, mutual aid and additional midwifery staffing
Midwifery vacancy rates across NLAG.

Safety Champion Walkabouts in October & November

11th October 2024 at Hull Royal Infirmary
7th November 2024 at Diana, Princess of Wales Hospital

Hull University Teaching Hospitals NHS Trust

Item 4: Maternity Training Compliance

HUTH and NLAG 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 (at HUTH).

Safety action (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 90% must be achieved by 30th of November 2024.

Hull University Teaching Hospitals NHS Trust

The Trust must achieve 90% attendance for staff groups listed in the core competency framework for the following training modules by 31 November 2024:

1. Fetal monitoring training
2. multi-professional maternity emergencies training
3. Neonatal Life Support Training

Attendance rates are monitored within the division monthly and there is ongoing monitoring.

Fetal Monitoring – 13 November 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).	
Staff Group	**HuTH Compliance**
Obs consultants & SAS grade doctors	100%
Other medical staff on obs rota *(commenced before 01 July 24)*	93%
Other medical staff on obs rota *(commenced after 01 July 24)*	100%
Midwives	93%

Staff who are out of compliance or due to come out of compliance prior to the 30th November are booked to attend on the 27th November 2024. Due to the numbers on the obstetrics rota, there are 7 doctors due to attend on 27th.

PROMPT – 13 November 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.	
Staff Group	**HuTH Compliance**
Obs consultants & SAS grade doctors	100%
Other medical staff on obs rota *(commenced before 01 July 24)*	95%
Other medical staff on obs rota *(commenced after 01 July 24)*	100%
Midwives	93%
Midwifery Support Workers	100%
Anaesthetic consultants	100%
Anaesthetic staff on Obs rota *(commenced before 01 July 24)*	88%
Anaesthetic staff on Obs rota *(commenced after 01 July 24)*	0%

New anaesthetic doctors commenced in November 2024 and will be booked onto training.

Neonatal Resuscitation – 13 November 2024	
Staff Group	**HuTH Compliance**
Neonatal/paediatric consultants / SAS grade doctors	90%
Neonatal/paediatric junior doctors *(commenced before 01 July 24)*	100%
Neonatal/paediatric junior doctors *(commenced after 01 July 24)*	Counted in above
Neonatal nursing staff / senior nurses	97%
Advanced neonatal nurse practitioners	75%
Midwives	92%

In respect of the Advanced neonatal nurse practitioner, there is 1 due to complete training on 19 November 2024 to secure 100% compliance.

Northern Lincolnshire and Goole NHS Foundation Trust

There has been a notable decline in compliance during September 2024 due to the new intake of rotational doctors. A recovery plan is in place with additional training sessions for fetal monitoring and PROMPT held throughout September and October.

Fetal Monitoring – 13 November 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	88%	86%	87%
Other medical staff on obs rota *(commenced before 01 July 24)*	83%	100%	93%

Other medical staff on obs rota *(commenced after 01 July 24)*	85%	86%	85%
Midwives	94%	93%	93%

Remaining obstetrics consultants and doctors are scheduled to attend training on 22 November 2024 which will ensure compliance.

PROMPT – 13 November 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	88%	86%	87%
Other medical staff on obs rota *(commenced **before** 01 July 24)*	100%	100%	100%
Other medical staff on obs rota *(commenced **after** 01 July 24)*	77%	71%	75%
Midwives	96%	94%	96%
Midwifery Support Workers	100%	93%	98%
Anaesthetic consultants	83%	100%	92%
Anaesthetic staff on Obs *rota (commenced **before** 01 July 24)*	100%	83%	92%
Anaesthetic staff on Obs rota *(commenced **after** 01 July 24)*	N/A	N/A	N/A

For rotational obstetric staff, there are 6 staff due to attend on 20 November 2024 and 3/4 anaesthetic consultants which will deliver compliance.

Neonatal Resuscitation – 13 November 2024			
Staff Group	**DPOW**	**SGH**	**Trustwide**

Neonatal/paediatric consultants / SAS grade doctors	57%	86%	71%
Neonatal/paediatric junior doctors *(commenced before 01 July 24)*	88%	100%	93%
Neonatal/paediatric junior doctors *(commenced after 01 July 24)*	100%	100%	100%
Neonatal nursing staff / senior nurses	96%	100%	96%
Advanced neonatal nurse practitioners	100%	-	100%
Midwives	95%	94%	95%

For rotational staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. An action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date.

Item 5: Learning lessons Hull University Teaching Hospitals NHS Trust

5.1 Maternity & Newborn Safety Investigation (MNSI) cases (ongoing)

MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
037146	No	Yes	Yes	Draft report stage – sent for comment
038040	No	Yes	Yes	MNSI have made contact with Family. Interview stage
038053	No	Yes	Yes	MNSI have made contact with Family. Bereavement contact continues. Interview stage
038632	No	Yes	Yes	MNSI referral consent gained and made. Interview stage
038708	Yes – sent via legal	Yes	Yes	ENS referral made. PSII 2024/9004 (above) MNSI in contact with the family.

5.2 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
W320222, W320191 – Uterine rupture 34+5	Obs	Moderate	Awaiting WPSS. MIRM recommendation Moderate harm (MDT review at perinatal forum for shared learning of J/Inverted T incision) Good care noted and reaction to changing situation. Neonatal attendance at WPSS – baby well. Verbal DoC provided and written DoC in progress.
W320428 – BBA 35+4 (Cord snapped and haemorrhage. APGAR 4 @ 14mins)	Obs	Moderate	Awaiting WPSS. Recommended Service to Service review at DBTH as patient not known to HUTH. Booked at DBTH and all care via DBTH. Discharged within 24hrs prior to birth ?labour. BBA ta home. Maternity services receive phone call from YAS to state enroute with baby (poor condition). Teams (Obs and Neonatal) waiting at entrance to W&CH. Required multiple blood transfusions. Actively cooled. MRI (05/11/2024 – awaiting review). Verbal DoC provided. After speaking with neonatal services (as not MNSI/PMRT criteria) to arrange round table with DBTH; YAS and HUTH to review incident.
PSII 2024/9004 – Unbooked Romanian lady, not know to the area attended in labour via A&E. Active second stage 2hrs prior to AVD.	Obs	Moderate	MNSI referral made. Family provided consent. Extensive social concerns noted following delivery. MIRM performed. Actively cooled. HIE not detected. ENS referral made. DoC provided.
PSII 2024/9004 - G2P1 37/40 Type 2 diabetic lady prev LSCS attended triage evening with ?SROM, No FH heard, Scan by Registrar and consultant no FH seen on scan went home overnight, re-	Obs	Fatal	Escalation of diabetic MDT following MIRM. To follow PMRT. DoC provided. MNSI referral.

attended 09:00 on 05/10/2024 IUD confirmed by departmental USS. delivery of 4.6kg stillborn by LSCS			

Northern Lincolnshire and Goole NHS Foundation Trust

5.3 Maternity & Newborn Safety Investigation cases

MNSI number	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
None open				

5.4 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
329189 – Antepartum stillbirth	Obstetric	No harm	Rapid review undertaken with no learning points

Item 6: Listening to our staff

Listening events continue planned across the Group for the Autumn
Ongoing work on Maternity Safety Champion Culture Improvement Plan
Score survey feedback events for staff have now been completed and sessions with the Quad continue to develop an action plan
Ongoing work to develop action plan from staff survey findings.
Tea trolley mornings led by Recruitment, Retention and Pastoral Lead Midwife, Helen Smith and supported by Freedom to Speak Up Guardian, Fran Moverley and Matt Smith from Organisation Development at Hull Royal Infirmary to discuss culture led by on discussing the 'bad apple' tea trolley.

"This tea trolley represents the majority of our staff. Brilliant, shiny, healthy apples, of all different shapes, colours and sizes, but essentially all the same. Amongst them are a couple of bad apples. People are not bad apples, they just display bad apple behaviour, like those shown in the poster below. People usually act out because they're feeling vulnerable, frustrated, lonely, under pressure or anxious and we must try to understand the feelings behind their behaviour."

The Incivility Reporting tool has been relaunched to enable staff to report incivility in situations that they do not feel able to challenge behaviours.

Item 7: Saving Babies' Lives Care Bundle (v3)

Northern Lincolnshire and Goole NHS Foundation Trust

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four	Assessment five
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25
Assurance review date	25 October 2023	18 December 2023	20 March 2024	10 June 2024	19 September 2024
Element 1: Smoking in pregnancy	10%	70%	70%	70%	90%
Element 2: Fetal growth restriction	55%	70%	90%	90%	85%
Element 3: Reduced fetal movements	50%	100%	100%	100%	100%

Element 4: Fetal monitoring in labour	40%	80%	80%	80%	100%
Element 5: Preterm birth	48%	70%	81%	67%	74%
Element 6: Diabetes	17%	67%	67%	83%	83%
TOTAL	**41%**	**71%**	**81%**	**77%**	**83%**

Following peer validation of evidence submitted for quarter 1 2024/25 by the LMNS, a grading of "significant assurance" was assigned with an overall compliance of 83% for all 6 elements.

The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024.

However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. The table below provides the projected targets set by the LMNS. The LMNS have confirmed agreement that compliance with MIS Year 6 has been achieved although ongoing work is required to reach full implementation by March 2026.

	Mar-24	Interventions fully implemented	Quarterly review points		Mar-25	Progress required	Interventions fully implemented	Mar-26
Element 1	70%	7/10			90%	2	9/10	100%
Element 2	90%	18/20			95%	1	19/20	100%
Element 3	100%	2/2			100%		2/2	100%
Element 4	80%	4/5	June '24	Sept '24	100%	1	5/5	100%
Element 5	81%	22/27			92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Hull University Teaching Hospitals NHS Trust

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four	Assessment five

Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25
Assurance review date	13 October 2023	18 December 2023	19 March 2024	10 June 2024	18 September 2024
Element 1: Smoking in pregnancy	30%	40%	50%	60%	70%
Element 2: Fetal growth restriction	45%	50%	90%	95%	95%
Element 3: Reduced fetal movements	0%	50%	50%	50%	50%
Element 4: Fetal monitoring in labour	0%	20%	20%	20%	40%
Element 5: Preterm birth	41%	48%	67%	70%	67%
Element 6: Diabetes	17%	17%	83%	83%	83%
TOTAL	**34%**	**43%**	**69%**	**73%**	**74%**

Following peer validation of evidence submitted for Q1 2024/25 by the LMNS, with an overall compliance of 74% for all 6 elements. Following re-submission of 2 additional audits, this increased to 76%.

The table below provides the projected targets set by the LMNS.

	Mar-24	Interventions fully implemented	Quarterly review points					Mar-26
Element 1	70%	7/10						100%
Element 2	90%	18/20						100%
Element 3	100%	2/2						100%
Element 4	80%	4/5	June '24	Sept '24				100%
Element 5	81%	22/27						100%
Element 6	67%	4/6						100%
Total	81%	57/70						100%

Evidence of progress against the agreed improvement trajectory was discussed and areas of sustained improvement where high levels of reliability have been achieved were identified. The targets for elements 1, 2 and 6 are on track for March 2025. Quality improvement activity continues for the elements that have not yet reached the target. The LMNS have confirmed agreement that compliance with MIS Year 6 has been achieved although ongoing work is required to reach full implementation by March 2026.

Commented [RC1]: Feels like we need a comment here on 3 (fetal movements) and 4 (fetal monitroing - as we are way off March 25 targets?

Item 8: Avoiding Term Admissions to NICU

Northern Lincolnshire and Goole NHS Foundation Trust

% of term babies that required admission to the NNU (October 2024)				
Site	Number of Births	Number of Births (≥37 weeks gestation)	Number of Term Baby Admissions to NNU	**%**
DPOW	162	147	9	6.1%
SGH	117	105	4	3.8%

Hull University Teaching Hospitals NHS Trust

% of term babies that required admission to the NNU (October 2024)				
Site	Number of Births	Number of Births (≥37 weeks gestation)	Number of Term Baby Admissions to NNU	**%**
HUTH	374	346	14	4.07

Item 9: Service User Feedback

9.1 Hull Royal Infirmary Friends and Family Test – September 2024

For September 2024 a total of 87 responses were received as part of the Friends and Family Test for Maternity Services. 86.2% of the feedback was positive.

Maternity Services	
Ward/area	**Number of responses**
Midwifery Led Unit	11
Maple ward	5
Rowan Ward	47
Labour and Delivery Suite	9
Community Midwifery Team	2
Rainbow/bereavement Suite	13

Maternity Services		
Response option	**Number**	**Percentage**
Very good	70	80.4%
Good	5	5.7%
Neither good nor poor	2	2.2%
Poor	4	4.6%
Very poor	6	6.9%
Don't know	0	0%

In addition, the service receives significant volumes of thank you cards, and historically feedback has been collated via a facebook page – work is underway to consolidate these.

9.2 Northern Lincolnshire and Goole NHS Foundation Trust Friends and Family Test – September 2024

Neonatal Care

For September 122024 a total of 12 responses were received as part of the Friends and Family Test for NICU across the Trust. 92% of the feedback was positive, 1 response (8%) was in the 'don't know' category.

NICU - Trustwide		
Response option	**Responses**	**Percentage**
Very good	11	92%
Good	0	0%
Neither good nor poor	0	0%
Poor	0	0%
Very poor	0	0%
Don't know	1	8%

Some of the comments received are detailed below:

NICU DPOW:

"Amazing caring staff. Truly went out of their way to help and care for me and my baby. We appreciate you so much".

"Nurses, docs, everyone has been so supportive, caring and kind. We have always been kept informed with all choices and made inclusive. Can't thank everyone enough".

"Passionate and caring staff, complete care and supply. We really liked the idea of the diary. They made the extra effort to make the stay as pleasant as possible for the patient. We felt we were in good hands".

NICU SGH:

"All staff have been fantastic and supportive in a hard time".

"Excellent care and information sharing throughout our stay".

"NICU staff and services were amazing, friendly and helpful. They could not do more for us. Shout out to Hannah and Lynn who were genuinely amazing. Made what was a stressful time so much easier. Lots of love from all of us".

Maternity Care

For September 2024 a total of 70 responses were received as part of the Friends and Family Test for Maternity Services across the Trust. 94.6% of the feedback was positive.

Maternity - Trustwide		
Response option	**Responses**	**Percentage**
Very good	66	94%
Good	2	3%
Neither good nor poor	0	0%
Poor	0	0%
Very poor	0	0%
Don't know	2	3%

Some of the comments received are detailed below:

Maternity DPOW:

"Great care given after the birth of my little girl. Felt very reassured by the midwives that visited me, listened to all my concerns".

"I've never felt so cared for in such a vulnerable situation, everyone involved in our care has gone above and beyond to make sure we were all taken care of not just physically but emotionally too. I literally couldn't ask for more and will always be so grateful".
"Good, friendly and approachable staff. Made a worrisome experience into a positive one. Great punctuality and listened to all our concerns. Carley went above and beyond to help support us from delivery to discharge and made us feel like a priority".

Maternity Goole:

None received.

Maternity SGH:

“All staff have been amazing, so caring and understanding. Very supportive. Everyone is so friendly and make you feel welcome. I have been looked after amazingly. I cannot thank the staff enough for the support they’ve given both mentally and physically”.

“The midwives, consultants and everyone else have been helpful, kind and caring”.

“Staff are amazing, kind, compassionate and professional. Have felt safe and cared for, thank you”.

Item 10: Maternity Survey CQC Action Plan

Northern Lincolnshire and Goole NHS Foundation Trust

The action plan has been co-produced between maternity services and Maternity and Neonatal Voices Partnership (MNVP) Lead.

The action plan includes 7 actions - 3 complete and 4 in progress.

1. Work is ongoing in collaboration with MNVP lead regarding partners staying overnight at SGH (issues around old estates and facilities)
2. A leaflet regarding guidance for partners staying overnight has been produced and is awaiting governance ratification
3. Issues in relation to GP care were identified and have been escalated to the Local Maternity and Neonatal System (LMNS).

The action plan is monitored by Safety Champions and LMNS Board.

Hull University Teaching Hospitals NHS Trust

The action plan has been co-produced between maternity services and Maternity and Neonatal Voices Partnership (MNVP) Lead.

The action plan includes 28 actions - 25 complete and 3 in progress.

1. All remaining actions related to involving partners staying and the longer term aspiration to reintroduce dads staying overnight.

The action plan is monitored by Safety Champions and LMNS Board.

For further details please refer to appendix A and B.

Item 11: Triangulation of Claims Scorecard Q2 2024/24

11.1 Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole - Maternity Incentive Scheme (SA9)

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at Trust level (Board or directorate) quality meeting.

NHS Humber Health Partnership

Claims Scorecard April 2014 –June 2024 (55 claims)

Top injuries by volume:	Top injuries by value:
Fatality (16) Unnecessary pain (15) Additional / unnecessary operation(s) (13) Stillborn (11) Bladder damage (5)	Brain damage (3) Cerebral palsy (2) Wrongful birth (1) Bladder damage (3) Fatality (9)
Top causes by volume:	**Top causes by value:**
Failure / delay in treatment (15) Failure / delay in diagnosis (8) Inadequate nursing care (3) Operator error (3) Intra-operative problems (3)	Failure / delay in treatment (2) Intra-operative problems (1) Other (1) Fail in antenatal screening (1)

Incidents Q2 24/25

Top 5 incident by volume:

- Staffing levels - (Mat) **(47)**
- Task saturation / workload volume (acuity) **(25)**
- Communication failure between different teams **(20)**
- Unexpected admission to NICU **(19)**
- Delayed treatment or procedure **(18)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **522**

Complaints Q2 24/25

There have been 4 complaints received:

- Communication / treatment (2)
- Staff attitude (2)

2 complaints are still open and 2 have resolved

Learning Q2 24/25

For each Bakri balloon, vaginal pack or aquacel wick retained, a coloured wristband is to be placed for each in order to know how many items have been retained.
Antenatal CTGs should not be discontinued before the 60 minute computerised analysis has been produced.
Senior obstetrician should review CTGs which don't meet the Dawes Redman criteria
Placentas should be sent as a whole for cytogenetic.

Themes Q2 24/25

- Communication/attitude between women / birthing people and staff.

Action Plan Q2 24/25 Not started | In progress | Complete

Introduce the use of coloured wristbands to identify any retained items	October 2024	
Fetal Monitoring Learning Lessons to be sent to all staff with regards to not discontinuing a CTG if the Dawes Redman criteria is not met	September 2024	
Escalation on huddles and manager's meetings that placentas should be sent whole when cytogenetics are required	August 2024	

11.2 Hull University Teaching Hospitals NHS Trust

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 2

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at Trust level (Board or directorate) quality meeting.

NHS Humber Health Partnership

Claims Scorecard April 2014 –June 2024 (90 claims)

Top injuries by volume:	Top injuries by value:
Fatality (16) Unnecessary pain (15) Additional / unnecessary operation(s) (13) Stillborn (11) Bladder damage (5)	Cerebral Palsy (4) Brain damage (7) Stillborn (13) Fatality (9) Cardiac Arrest (1)
Top causes by volume:	**Top causes by value:**
Failure / delay in diagnosis (11) Failure / delay in treatment/operation (11) Inadequate nursing care (6) Failure to recognise complication (6) Failure to act on abnormal test results (6)	Failure to monitor 1st stage of labour (3) Failure / delay in treatment (2) Failure / delay in diagnosis (1)

Incidents Q2 24/25

Top 5 incident by volume:

- Term NNU admissions **(48)**
- Post partum haemorrhage (PPH) >1500mls **(39)**
- Shoulder Dystocia **(16)**
- 3rd and 4th degree tears **(9)**
- Still Birth **(3)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: 256

Complaints Q2 24/25

There have been 10 complaints received:

- Attitude
- Communication
- Treatment / plans of care
- Delays

All 10 complaints are still open.

Learning Q2 24/25

- Thermoregulation of the newborn as ATAIN theme
- Reduced fetal movements training to be mandatory yearly on Hey24/7
- Reminder to all staff to use Amnisure when SROM is suspected to aid confirmation
- Escalation of underreporting on DATIX – Acuity/red flags/delay in IOL
- Timely escalation of CTG concerns and miss classification of CTG
- Never event – Swab left insitu following EMLSCS

Themes Q2 24/25

- Hypothermic neonates on the wards (labour ward and postnatal ward)
- Incorrect interpretation of CTG's
- Escalation of a deteriorating baby on CTG's.
- Reduced fetal movements advice/false assurance
- Delay in IOL and ARM >24hrs

Action Plan Q 24/25 Not started | In progress | Complete

Develop guideline for Extreme Preterm SROM antibiotic therapy/repeating steroids pathway	July 2024	
Explore the introduction of fetal monitoring champions on the wards and in community to support staff	Oct 2024	
Thematic review of CTG interpretation / deteriorating baby to be undertaken with the LMNS.	Sept 2024	
Introduction of teaching session on neonatal study day for the prevention of neonatal hypothermia.	Sept 2024	

Item 12 : Quality Improvement Projects

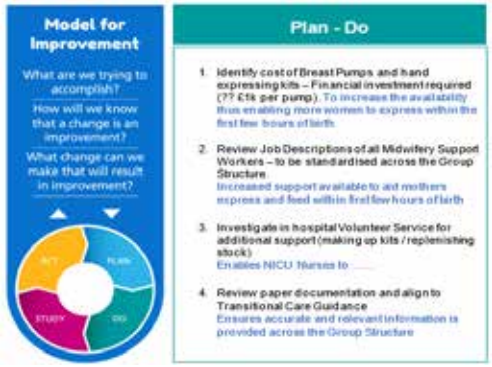
Early Breastmilk Feeding Project

Following a review of themes and trends from ATAIN reports it was identified that early breastfeeding could reduce the number of babies having to be treated under transitional care services.

Project aims:

To increase the number of babies who receive breastmilk within the first 2 hours of life by 30% within the first 3 months of the project go live.
To standardise the quality and consistency of conversations around breastfeeding within community and antenatal setting (including medics)
To prevent admission on the Transitional Care Unit / Neonatal unit
To reduce the length of stay of babies on Transitional Care and the Neonatal unit.

A stakeholder event took place in August 2024 with the LMNS and MNVP leads where the initial actions were agreed. Progression of actions has been delayed allowing the Heads of Midwifery to lead the project and gather momentum.



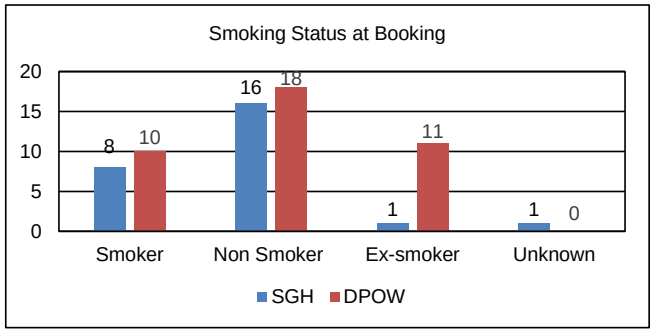
Item 13: Pre-term birth deep dive

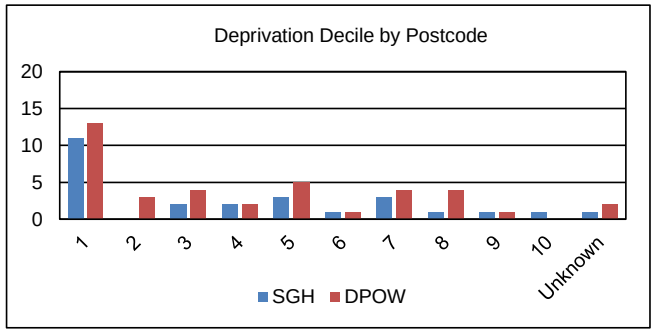
Northern Lincolnshire and Goole NHS Foundation Trust

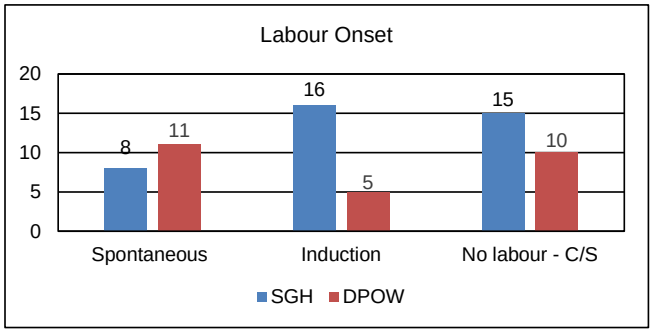
Background
As part of the reporting for Saving Babies' Lives 2024/25 it was identified that the Trust that the pre-term birth rate and has continuously breached the target of compliance set by the LMNS. To identify any contributing factors, missed opportunities and identify the indications for pre-term induction the request was made for a deep dive to be undertaken for quarter 1 2024/25.

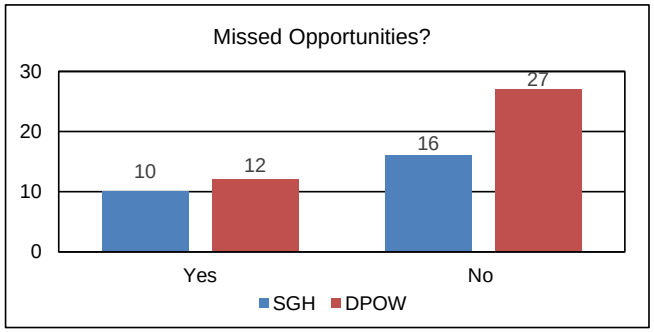
Method
The cohort of birthing people/women was provided by Information Services and included all pre-term deliveries during April, May and June 2024. Data was sourced from the maternity case notes by the Patient Safety Midwives at both DPOW and SGH. During the time period 82 birthing people were identified for review (34 birthing at SGH/Goole and 48 at DPOW). At the time of analysis 16 were excluded as the case notes could not be located and in 1 case the gestation at delivery was 39 weeks (SGH). Final analysis is based on a total of 65 cases (26 at SGH and 39 at DPOW).

Summary of Findings









*2 inductions were undertaken due to antenatal stillbirth (1 DPOW / 1 SGH).

Summary

Smoking Status- SGH	DPOW
Never smoked: 13 cases. Non-smoker: 6 cases. Smoker: 7 cases. Stopped before booking: 1 case. Unknown smoking status: 1 case	Never smoked: 17 cases. Ex-smoker: 6 cases. Smoker: 9 cases. Stopped smoking post-conception: 3 cases. Stopped prior to conception: 4 cases. Not documented: 1 case.

Deprivation Decile	DPOW
Decile 1 (most deprived): 9 cases. Decile 2-5: 8 cases. Decile 6-10: 8 cases. Unmatched data: 1 case.	Most deprived (Decile 1): 13 cases. Decile 2-5: 13 cases. Decile 6-10: 11 cases. Unmatched: 2 cases.
Common Risk Factors- SGH	DPOW
Gestational diabetes (GDM): Found in 5 cases. Preterm premature rupture of membranes (PPROM): 5 cases. Twin pregnancies: 5 cases. Pre-eclampsia: 4 cases. Fetal growth restriction (FGR): 4 cases.	Gestational Diabetes (GDM): Present in 7 cases. Preterm premature rupture of membranes (PPROM): Found in 8 cases. Multiple pregnancies (twins): 6 cases. Pre-eclampsia or hypertension: 8 cases. Placenta-related complications: 6 cases, including placenta previa and low PappA Recurrent reduced fetal movements (RFM): 5 cases.
Missed Opportunities- SGH	DPOW
Missed antibiotics or delayed administration: 5 cases. Missed steroids: 4 cases. Declined or incomplete surveillance: 1 case.	Missed or incomplete urinalysis: Documented in 12 cases. Missed or delayed antibiotics: Found in 3 cases. DNA (Did Not Attend) follow-up delays: Reported in 5 cases. Steroid omission or delays: 1 case. Suboptimal care due to lack of documentation: 3 cases.
Avoidable- SGH	DPOW

The majority of cases (22 out of 26) were deemed non-avoidable due to either patient-specific complexities or unavoidable clinical decisions. Only 4 cases had documented avoidable factors	The majority of cases (31 out of 39) were deemed non-avoidable due to clinical complexities. Potential for a different outcome was noted in 8 cases, primarily due to: Missed or delayed urinalysis. Failure to chase DNA appointments. Delayed management of PPROM or suspected infections
Indications for Early Delivery- SGH	DPOW
Preterm premature rupture of membranes (PPROM): Most common reason, contributing to 6 cases. Maternal sepsis, pre-eclampsia, or hypertension: Documented in 6 cases. Fetal growth restriction (FGR): 5 cases.	PPROM: 8 cases. Placenta-related complications (previa, abruption): 6 cases. Hypertension, pre-eclampsia, or cholestasis: 8 cases. Reduced fetal movements (RFM): 5 cases.

*5 cases were transferred from other Trusts

Summary of themes

1. Missed Steroid Opportunities: Steroids were often not administered due to rapid labour progression or missed interventions, particularly for cases presenting late in advanced labour.
2. Smoking and Deprivation Correlation: Smokers often belonged to the most deprived decile (1), highlighting potential socio-economic influences on pregnancy outcomes.
3. Missed Urinalysis: Missed or delayed urinalysis was a recurring issue, representing a missed opportunity for early detection of complications.
4. Chronic Conditions: Cases with recurrent preterm birth, GDM, or multiple pregnancies had frequent complications, emphasizing the need for enhanced monitoring.

Conclusion

The review highlights potential opportunities in preventing pre-term birth and ensuring the appropriate pre-term optimisation was undertaken at both DPOW and SGH.

To accompany this review, deliveries that occur before 34 weeks gestation are scrutinised where measures relating to perinatal optimisation pathway (in accordance with the Periprem passport) have not been recorded on the neonatal Badgernet system or are failing Element 5 of Saving Babies Lives' interventions. The reviews are undertaken by the Patient Safety Midwives and Neonatal Ward Managers on a quarterly basis and reported as part of the Saving Babies Lives' submission to the LMNS.

A further detailed review will take place in collaboration with the LMNS to review all women who delivered in quarter 2 of 2024/25 below 34 weeks gestation. This work is being undertaken across all Trusts within the LMNS to determine where further support is required to embed the required interventions is required and will complement the ongoing work to fully implement the Saving Babies Lives' Care Bundle. It is anticipated the report will be available early in 2025.
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Item 13: 'Born Before Arrival' Deep Dive

Hull University Teaching Hospital

'Born before arrival' at Hull University Teaching Hospitals

Nationally, there has been a noted rise in 'freebirths', a number of drivers have been suggested for this increase (Greenfield et al, 2021), A freebirth refers to a situation where a woman intentionally plans to birth at home without healthcare professionals in attendance- this is legal and should not routinely generate safeguarding concerns Whilst there is clear evidence that (Hutton et al, 2016; Reitsma et al 2020) planned homebirth in a well-resourced healthcare system is a safe option, the outcomes for women and babies born in a 'freebirth situation' are unclear. Freebirths, fall into two categories, women who do not share their intention to freebirth and those who will freebirth if a homebirth service is not available on the day they birth. In both situations, the birth will be recorded as a 'Born Before Arrival' (BBA).

Locally, women who wish to have homebirths express their concerns around the instability of the homebirth, which can be unavailable due to staff support the acute areas for unit escalation or the service not being available due to short-term staff sickness.

A high number of BBA's were noted on the dashboard and 'deep dive' was undertaken to review these cases and identify any themes and action required.

Women planning a homebirth contact the Labour Ward at Hull Royal Infirmary and are triaged over the phone. If a homebirth service is not available an alternative of care in the Midwifery Led-unit or Labour Ward will be offered.

The 'Deep Dive' revealed issues with data quality as significantly higher number of BBA's were identified compared to the numbers reported on the BI report (17)- Forty-four BBA's were identified. Four freebirths were identified and one further birth attended by a private midwife.

Most women who experienced a BBA did so at home due to precipitate labour. 39 women had contacted the unit prior to the birth, the majority were multiparous women. One women delivered on route and one in the hospital entrance and one in the. There were three concealed pregnancies, one known pre-term intrauterine death who spontaneous laboured at home prior to planned admission and one late miscarriage.

The 'deep dive' demonstrates a need to consider inviting women to attend the unit or ensuring timely attendance of the Community Midwives for women who have to birth at home. Ensuring a robust history about previous births is documented clearly and appropriate plans for birth are made for women who are at increased chance of a precipitate birth. In addition, antenatal education around signs and symptoms of labour to pregnant people and their families would be advantageous so that clarity on when to contact the hospital.

Recruitment into core community posts has stabilised the homebirth service with two Community Midwives (required for a homebirth) now on-call most of the time. Increased stability may support a reduction in the number of women who feel that freebirth is there only about. In addition exploring feedback from women via Maternity & Neonatal Voices Partnership will enable understanding of any barrier's women experience when calling in labour.

Currently the CMW on call system is used for homebirth and also for escalation into the unit at times of acuity. Exploring and looking at different options for escalation into the unit would help to stabilise the homebirth service further. A review of Community Midwifery services is currently underway. The actions identified in this review and part of the Community review will form part of the Maternity and Neonatal Single Improvement Plan as it is developed.

Summary Table

	Total	Breakdown
BBA's	44	Total number of BBA's
Precipitate labour	39	Had called unit and not attended in time for birth
Freebirths	5	x 2 were booked for homebirth and did not contact the hospital x 2 patient choice x 1 private midwife

References

Greenfield, M. et al (2021 *Between a Rock and a Hard Place: Considering "Freebirth" During COVID-19.* https://doi.org/10.3389/fqwh.2021.603744

Hutton, Eileen K. et al. (2019) *Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses* eClinicalMedicine, Volume 14, 59 - 70

Reitsma, Angela et al. (2020) *Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses* eClinicalMedicine, Volume 21, 100319

Appendix A: HUTH Co-produced CQC Survey Action Plan

Maternity Survey Action Plan 2023

Version 1.0

NHS Humber Health Partnership

No.	Recommendation	Actions / Key Milestones	Strategic Lead	Forecast Completion Date	Progress	RAG Status
The Start of your Care in Pregnancy						
1	**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?** Choice of place of birth is discussed on an individual basis with the community midwife at the booking appointment and then reviewed at opportunistic times during the antenatal period. Choice around place of birth can be changed by the woman at any point in her pregnancy. Decision around choice of home birth is undertaken with reference to Low risk midwifery guidelines and antenatal risk assessment, and women are advised of their risk factors. There is information on the Trust and LMS website to support women in their choices.	Review Booking Letter and make changes	AH/SS	Aug-24	13.11.24 - Badgernet changes made, to explore pan group booking information. To D/W SW changes across the LMNS to align all information	
		Ensure the LMNS choice video is on the HUTH site	LC	Jul-24	13.11.24 - videos are played within all areas of acuity (ADU,Triage and AMC)	
		Review LMNS website to ensure it is easily accessible	SW	Jul-24	13.11.24 - access is possible and possible review due to pan group.	
		Explore the potential of inviting women before booking to carousel event to explore choice and place of birth	GH/AH	Sep-24	13.11.24 - families of all gestations are invited and attend the carousel event	
		Look at carousel event across the Group	SW/LC	Sep-24	13.11.24 - fully implemented within HUTH	
		Longer term plan review booking information informing women they are booking for the LMNS/ new branding and information across LMNS	SW	Dec-24	13.11.24 - Badgernet changes made, to explore pan group booking information. To D/W SW changes across the LMNS to align all information	

Antenatal Check Ups						
2	**B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?** During every midwifery/medical contact with the woman and her family it is considered safe and good practice to question women in relation to their current and past medical history. This can be misinterpreted by the woman as the professional not been aware of her medical history. The group is currently implementing BadgerNet digital system to support personalised care planning	Implementation of BadgerNet	Digital Midwife/Midwifery Managers	Mar-24	13.11.24 - fully implemented within HUTH	
		Implementation of personalised care plan within BadgerNet	Digital Midwife/Midwifery Managers	Mar-24	13.11.24 - fully implemented within HUTH	
		Feedback taken to the carousel event regarding the BadgerNet notes/and the App	JH	Jul-24	13.11.24 - regular feedback is taken from the MNVP and fed into the LMNS digital steering group	
		Understand why the 20-week scan is not on the BadgerNet notes	LC	Aug-24	13.11.24 - continuing to use 2 systems and all scans are uploaded onto lorenzo. Scans are acknowledged within Badger and if escalation is required are documented within Badger	
		Check if BadgerNet has the ability to translate leaflets into different languages and how many	Digital Midwife	Jul-24	13.11.24 - Badger translates into the familes chosen language	
		Share learning across the Group for the implementation of BadgerNet at NLAG	Digital Midwife	Oct-24	13.11.24 - digital midwife supported implementation of Badgernet within NLAG (pangroup)	
		Ensure reachdeck is publicized to families with additional needs for example language, literacy etc.	LC	Jul-24	13.11.24 - as above	
2.1	**B14 - Thinking about your antenatal care, were you involved in decisions about your care?**	Revisit personalised care plan that was developed across the LMNS	SW/LC	Oct-24	13.11.24 - personalised care plans are included within Badgernet	
		Share video with midwives and women on personalised care planning	SW/LC	Oct-24	13.11.24 - videos are played within all areas of acuity (ADU,Triage and ANC)	
		Relaunch personalised care plan	SW/LC	Oct-24	13.11.24 - personalised care plans are included within Badgernet	
Labour and Birth						
3	**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?** "Comments about being sent home or 'turned away' as not far along enough, and feeling bad about going back and wasting midwives time".	Implementation of maternity telephone triage	JC/LC/WM	Nov-23	13.11.24 - fully implemented within HUTH	
		Explore 24/7 telephone triage	JC/WM/RM	Oct-24	13.11.24 - central telephone system fully implemented to allow 24/7 telephone triage	
		Visit to Southampton 16th July 2024 who have a group telephone triage model	LC/SW	Aug-24	13.11.24 - action completed by Sallie and Lorraine	
		Longer term aspirations for a group telephone triage	RM/YM/LC	Dec-24	13.11.24 - central telephone system fully implemented to allow 24/7 telephone triage in HUTH and exploring options of pan group telephone triage	

Care in Hospital After Birth						
4	**D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?** Detailed Feedback from families "out of hours dads are not allowed on the ward to settle our loved ones in and to see what bed they are in which is inequitable". "My partner had a difficult birth and I was not able to stay to help with our baby"	Discuss feedback with PN manager and involve ward staff	CN	Sep-24	13.11.24 - please refer to 15 steps spreadsheet	
		Involve partners in birth revisited service if required and ensure they have support too	SWJC	Oct-24	13.11.24 - birth afterthoughts clinics implemented and triaged by the LMNS	
		Link dad representative to ward manager to work on collaborative post-natal QI projects	RS	Jul-24	Simon keen to have lots of input on the wards via MNVP. Dad board put up. Vending machines and hot drinks machine now on the ward	
		Test some quick improvements of supporting partners to be able to settle their partners in to the ward overnight	TD	Jul-24	13.11.24 - continuing to explore the 'golden hour' on Rowan ward to support partners with that transition onto the ward	
		Implement personalised planning for families with specific care needs with ward manager	CN	Oct-24	13.11.24 - personalised care plans are included within Badgernet	
		Interim measure look at segregating the ward area for partners who stay over	TD	Oct-24	13.11.24 - continuing to explore the 'golden hour' on Rowan ward to support partners with that transition onto the ward	
		Explore the feasibility of a partners facility on Rowan ward	CN	Dec-24	13.11.24 - cold drinks and food and hot drinks vending machine now on Rowan ward. Unable to have partner/family kitchen due to limited space on the ward	
		Longer term aspiration plan to reintroduce dads staying overnight/ will need surveys and collaboration	TD	Dec-24	13.11.24 - MNVP dad group to aid collection of survey. Continuing to explore the 'golden hour' on Rowan ward to support partners with that transition onto the ward	

Appendix B: NLAG Co-produced CQC Survey Action Plan

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Maternity Survey Action Plan 2023

Version 2.0

NHS Humber Health Partnership

No.	Recommendation	Actions / Key Milestones	Strategic Lead	Forecast Completion Date	Progress	RAG Status
1	**D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?** Found partner was able to stay with them as long as they wanted (in hospital after birth) Trust 35% Picker average 57%	Revisit partners staying overnight at SGH (scope possibility of partitions)	Claire Brothwell (Maternity Matron SGH) Vicki Booth (Maternity Matron DPOW)	Aug-24	29/10/24 Claire Brothwell to arrange to meet with Kimberley Boyd (Lead for North & North East Lincolnshire Maternity & Neonatal Voices Partnership) to progress partners staying overnight at SGH. Partners are welcomed to stay overnight at SGH however the old estates available are not suitable currently. Re DPOW - partners have facility to stay overnight to support.	
		Review guidance re communication for partners	Shaliny Marjara (Acting Ward Manager - Ward 26 - SGH)	Aug-24	29/10/24 Leaflet in progress and will be ratified as per governance process.	
2	**F19. At the postnatal check-up (around 6-8 weeks after the birth), did the GP spend enough time talking to you about your own physical health?** Felt GP talked enough about physical health during postnatal check-up Trust 58% Picker average 70%	Add to agenda at Northern Lincolnshire Women and Children's Board	Nicola Foster (Head of Midwifery)	Aug-24	30/10/24 Discussed at LMNS Choice and Personalised Care working group (Nicola Foster) Northern Lincolnshire Women and Children's Board has been disbanded therefore unable to action as planned. Sallie Ward (LMNS midwife) has taken action to support communication to GP's (work ongoing within LMNS re communication with GP's)	
3	**F20. At the postnatal check-up (around 6-8 weeks after the birth), did the GP spend enough time talking to you about your own mental health?** Felt GP talked enough about mental health during postnatal check-up Trust 60% Picker average 72%	Add to agenda at Northern Lincolnshire Women and Children's Board	Nicola Foster (Head of Midwifery)	Aug-24	30/10/24 Discussed at LMNS Choice and Personalised Care working group (Nicola Foster) Northern Lincolnshire Women and Children's Board has been disbanded therefore unable to action as planned. Sallie Ward (LMNS midwife) has taken action to support communication to GP's (work ongoing within LMNS re communication with GP's)	

4	**B3. Were you offered a choice about where to have your baby?** Offered a choice of where to have baby Trust 65% Picker average 76%	Highlight to community midwifery teams re antenatal discussions including choice of where to have baby.	Michelle Smith (SGH community midwifery manager) Christine Page-Patrick (DPOW community midwifery manager)	Aug-24	9/10/24 Discussed at team leaders meeting. Community midwifery managers to cascade to community midwifery teams.	
5	**C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?** Partner / companion involved (during labour and birth) Trust 88% Picker average 94%	Discussion at Team Leader's Meeting	Nicola Foster (Head of Midwifery) Vicki Booth (Maternity Matron DPOW) Claire Brothwell (Maternity Matron SGH)	Aug-24	9/10/24 Discussed at team leaders meeting. Matrons to cascade to midwifery teams.	
		Antenatal education and communication to include and highlight involvement	Nicola Foster (Head of Midwifery) Michelle Smith (SGH community midwifery manager) Christine Page-Patrick (DPOW community midwifery manager)	Aug-24	9/10/24 Discussed at team leaders meeting. Community midwifery managers to cascade to community midwifery teams.	

3.2 - PERFORMANCE, ESTATES & FINANCE COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Gill Ponder and Helen Wright, Non-Executive Director Committee Chairs

REFERENCES

Only PDFs are attached

BIC(24)235 - Performance, Estates & Finance Committees-in-Common Highlight Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)235

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 December 2024
Director Lead	Gill Ponder, Helen Wright, Chairs of Performance, Estates and Finance CIC
Contact Officer / Author	Gill Ponder, Helen Wright, Chairs of Performance, Estates and Finance CIC
Title of Report	Performance, Estates and Finance Committees in Common Escalation Report
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting(s) held on 30 October 2024 and 27 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	12 December 2024
Report from:	Performance, Estates and Finance Committees in Common
Report from meeting(s) held on:	30 October 2024 and 27 November 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance Estates and Finance Committees-in-Common at their meeting(s) held on 30 October 2024 and 27 November 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:

- *Board Assurance Frameworks including Risk Register Report*
- *CQC Actions Report – Group*
- *Business Planning Timetable and Progress Update*
- *Group Finance Report Months 6/7*
- *Costing and Benchmarking*
- *Review of Effectiveness*
- *Procurement Improvement Plan*
- *Group Integrated Performance Report (including Cancer Deep Dive)*
- *Winter Plan*
- *Estates and Facilities – General Update and Fire Action Plan*
- *Contract approval – Sleep Therapy Services, Equipment and Consumables*

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) Limited assurance was given regarding the ability to deliver the Financial Plan given the current best case anticipated gap to plan of circa £13.4m . The CIP targets significantly increase in H2 and there remains a risk of £8m in relation to assumed income that has not been confirmed. The year to date performance reflects a shortfall

against plan of £1.5m, largely due to a pay award funding gap, but HUTH received £1.4m of non-recurrent ERF income in Month 7 and £2m of non-recurrent balance sheet flexibility was also released. It is critical that the Care Groups manage within their budgets.

There is a risk to the cash position if the CIP is not delivered, which is of particular concern for HUTH. The plan is more challenging in this half year and the current forecast is that the plan will deliver £11.8m less than the £84.6m target, although this is an improvement on the Month 6 position of a £14.2m shortfall.

The ICB are aware of the current gap to plan and the steer is that this will be declared to NHS England at month 9 once all gap closing activities have been explored. The work being undertaken by PA Consulting highlights significant opportunities to improve performance, however the execution of the plan will take time and limited benefits will be realised this year. An updated forecast and recommendation on the most likely financial outturn after all attempts have been made to close the gap will be brought to the December meeting. Despite limited assurance that the plan will be delivered, the Committees received reasonable assurance that the plan is well understood and that there is significant collective focus on minimizing the deficit.

b) Urgent Care – Performance had deteriorated at HUTH on the 3 key enablers of time to first clinical assessment, time in department and improved frailty assessment times, due to an anomalous increase of 7% in patients presenting at ED in October.. This had resulted in ED congestion and longer ambulance handover times. NLAG had been less affected, but had also seen a slight deterioration in performance in October, although there had been an overall sustained improvement at NLAG of 10% compared to last year. The difference across the Group was mainly due to the grip and control achieved with more resources allocated to managing ED risks and performance at NLAG. The shortage of this resource at HUTH resulted in poor bed management and key risk areas included Boarding, ambulance handovers and SDEC. Best practice would be shared. Improvement activities continued to focus on improving flow through the hospitals and a MADE event was planned with system partners to improve discharge rates of patients that no longer needed to be in an acute hospital. Limited assurance was agreed by the CICs for HUTH, due to unsustained performance improvements, increased demand resulting in shortage of assessment space and the impact of the local GP collective action, but the CICs were reasonably assured by improvements in performance at NLAG.

c) Elective Care - The Group had not achieved the plan to eliminate 65 week waits by the end of September with HUTH reporting 15 patients and NLAG reporting 11. By the end of October, this number had reduced to 19 across the Group. The main causes of the continued long waits for those 19 patients were workforce shortages for plastic surgery and some patients being given insufficient notice of admission dates which they had then declined. The Group were on track to achieve the new target of having no more than 8 patients waiting more than 65 weeks by the end of December. There remain concerns about the level of demand which had not reduced in line with operational plans, growing waiting lists due to a 7% increase in referrals which presented a risk to sustaining the 65 week wait position and non-delivery of RTT. A range of improvement plans were in place, including seeing patients by 40 weeks, improving theatre utilisation rates and work with PA Consulting to improve outpatient transformation initiatives. Whilst the Group was amongst the best in the country for delivery of 65 week wait reductions, which the CICs commended, non-delivery of the RTT performance standard, demand continuing to exceed planned reductions and concerns about the overall waiting list growth resulted in limited assurance being agreed by the CiCs.

Diagnostics – Whilst the number of people waiting over 6 weeks for diagnostic tests increased over the summer leave period, mutual aid focused on those modalities where the Group benchmarked worst such as DEXA scanning had resulted in a 20% reduction in the number of patients on the waiting list and a 50% reduction in those waiting over 6 weeks for their tests. This performance had moved the Group into the top 50% in the country. Additional activity was planned to improve performance further and additional capacity from the CDC's will also improve waiting times when that becomes available. Reasonable assurance was agreed due to the significant improvements being seen, although the CICs were also alerted to the discovery of a potential data quality issue at HUTH which was under investigation. A report on that would be brought back to the Committees once investigations had been completed.

Cancer – The CiC carried out a deep dive into Cancer performance and concluded that there was Limited Assurance for the reasons outlined below, including increased referral rates without a corresponding increase in activity levels, leading to an increased backlog. The Group remains in Tier 1 support for Cancer. Non-recurrent funding allocations had not led to sustained improvements in performance. The 62-day performance against target had been affected by results deteriorating in large services that had historically met the required standards. Risks included workforce recruitment and retention and early recognition of benign pathology to enable patients to be removed from the Cancer pathway if Cancer had been ruled out. Improvement plans were in place, including sweating diagnostic assets at weekends and focusing on improving the enablers to achieving the 62-day performance standard.. There were signs of significant improvements in these enablers, with HUTH achieving 76.7% and NLAG achieving 73.3% against the faster diagnosis standard of 75% and early indications that both Trusts would achieve around 80% when October's results are published. Improvements had also been made in decision to treat by day 38. The CiCs recognised the hard work that had led to these improvements, which had not yet been sustained or resulted in an improvement in the 62-day performance.

d) Winter Plan – The Winter Plan first presented to the CiC in October required further work on the bed bridge to ensure that at least the same number of beds available last Winter would be available this year and to identify essential additional spending, based on risk assessments.

   The updated Winter Plan was not received at the November 2024 meeting but a verbal update was given and the plan approved by Cabinet was circulated after the meeting. An increase in demand of 6% had been assumed in the Winter Plan and flow improvement activity was underway, including a 2-week MADE event due to start on 25 November 2024, support from PA Consulting, expansion of virtual wards and investments in Community capacity, paediatrics, pharmacy in-reach and additional site management resources on the North Bank. The focus was on patient safety, care and experience and the QI team were working with teams to improve board and ward rounds to identify discharges early. The CIC noted that the financial planning element had been supported by the PA Consulting review. Staff health and wellbeing were noted as critical to delivery. The CiCs were reasonably assured by the plans which would be presented for approval at the Boards-in-Common on 12 December 2024.

e) Contract Approvals - The CIC approved the Sleep Therapy Service equipment and consumables contract.

f) The CIC received updates on the business and financial planning processes for 2025/26, which would cover a 2-year period and would be based on assumptions until the central planning guidance was received. The plans were well thought out and communications were ongoing with regular updates on progress. They will come to the Committees in February for review, prior to submission for approval at the April Boards in Common.

g) Following a verbal update in November, a more detailed PA Consulting update will be received at the December 2024 meeting, highlighting the benefits of the work carried out and the actions in place to close the unidentified CIP gap.

The review includes theatres, outpatients, diagnostics and flow. Workplans are in place to underpin the proposals and no major risks had been flagged. The lack of PMO capability was highlighted and needs to be addressed in order to deliver the significant benefits that have been identified.

h) Estates and Facilities – The CiCs noted actions in place to mitigate risks and progress made on the lift upgrade programme at HRI and the positive impact of the PSDS work at Scunthorpe Hospital addressing a number of longstanding backlog maintenance risks on that site. The lack of decant facilities at both Trusts had been added to the Risk Register, because it restricted access for deep cleans and routine maintenance, especially over the Winter period. The new Public Sector Decarbonisation Schemes had opened and bids have been submitted based on carbon saving opportunities as bids were no longer approved on a first come, first served basis. Bid values would be confirmed within the next reporting period. It must be noted that there is now an expectation that the Trust will match any funding received.
The CICs received the comprehensive Group fire action plan and noted that the NLAG Fire Authorised Engineer had also been appointed to cover HUTH.
The CICs agreed that they had received reasonable assurance on Estates and Facilities items.

i) The CIC received a Procurement update which highlighted the savings programme and how it was progressing well, despite the 15% vacancy rate and 221 expired contracts which the team lacked capacity to work on. All of the issues had comprehensive plans and actions in place. The CIC wondered if we should be investing more to make additional savings from Procurement and Contract Management activities. Reasonable assurance was agreed.

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

5.1 The new revised BAF strategic risks were presented to the CIC. The scores for finance (25) and performance (20) were approved by the CIC.

The Committees liked the new format of the BAF, but would like to see the journey to get to a tolerable score for each strategic risk.

The high-level risk report was presented alongside the BAF. The Committees requested that this was tailored to each CiC, that mitigations for each risk were clearly included and that the impact of mitigations was clear by having a pre and post mitigation score for each high-level risk.

Both the BAF and the high-level risk register were to be presented together on a quarterly basis in the future. The CIC workplan would be updated accordingly.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the items for escalation in section 3.1
- Note the items where the CIC have requested additional assurance in section 4.1

Gill Ponder, Non-Executive Director and CIC Chair, NLAG

Helen Wright, Non-Executive Director and CIC Chair, HUTH

27/11/2024

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)236

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 December 2024**
Director Lead	**Tony Curry, Chair of CIC**
Contact Officer / Author	**Tony Curry, Chair of CIC**
Title of Report	Workforce, Education and Culture CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on Thursday 24 October 2024 and 28 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Consultant Job Planning **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

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

	Thursday 12 December 2024
	Workforce, Education and Culture Committees in Common
	24 October 2024 and 28 November 2024
	Yes

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 24 October 2024 and 28 November 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:

24 October 2024

a) Group Board Assurance Framework
b) Group CQC Actions Update
c) Group Freedom to Speak Up Reports
d) Group Integrated Performance Report
e) Group Job Planning Report
f) Medical Education Annual Report
g) HUTH Guardian of Safe Working Annual Report
h) Wellbeing Progress Report
i) Bank Temporary Staffing and Spend
j) Employee Relations Report
k) Medical Workforce Strategy
l) E-Rostering Progress Report

28 November 2024

a) Group Board Assurance Framework
b) Registered Nursing and Midwifery Staffing (HUTH/NLAG)
c) Apprenticeship Levy Annual Report
d) Undergraduate Medical Education Annual Report (HUTH/NLAG)
e) Guardian of Safe Working Hours Quarterly Report (HUTH/NLAG)
f) Retention of Staff (NLAG) Deep Dive
g) WRES and WDES Action Plans
h) Group Leadership Programme
i) Appeal Panel – NED decision

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:

24 October 2024

a) HR update – Negotiations were ongoing regarding the NLAG maternity support workers, a further increased offer had been made but had been rejected. Further strike action was being considered.
b) Group CQC Actions – There were no changes to the previous reported position. The CIC agreed that there was no assurance regarding the mandatory training compliance that was outstanding and requested a plan to be presented to the next meeting. Work with line-managers was ongoing to encourage protected time and to avoid DNAs (did not attends).
c) The Freedom to Speak Up Guardians at HUTH/NLAG had been recognised by the National Team for their Group Partnership working. Significant assurance was given due to the confidence in the FTSU guardians.
d) The CIC were impressed by the work ongoing regarding staff wellbeing and took significant assurance from the report presented.
e) Funding for the Domestic Abuse role for staff had ceased and this was now a risk to the organisation. The issue would be raised at Group Cabinet and the outcome presented to the CIC.

28 November 2024

a) Band 2/3 Job Description issue was discussed. This is a national issue but there was no national steer on how to resolve. Discussions were ongoing.
b) Healthcare Support Workers – Back pay discussions were ongoing with the Unions.
c) Flu vaccination rates for both organisations were around the national average at 30%, but this was low in comparison to previous years.
d) NLAG Nurse agency spend across the Group had reduced dramatically. Vacancies and retention were also improving.
e) Retention deep dive – There was an improving position and exit interviews were in place. Higher turnover was still being reported for estates, healthcare assistants and admin.

4.0 Matters on which the committees have requested additional assurance:

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

a) The Group Agency position was in a positive position with c£6.6m being saved in the first half of the financial year compared to spend in the same period for last year, mainly due to the reduction in registered nurse agency spend. There were still issues regarding consultant vacancy position but there were mitigations in place to address this. The Committee noted the good work, but there was still work to be done.
b) The CIC discussed the Medical Education funding and raised a concern that it could not be part of the Cost Improvement Programme. The Chief People Officer was managing this and was meeting with the Group CEO and Group CFO.
c) The consultant job planning process was being aligned across the Group. The Job Planning Policy was currently being reviewed by both Local Negotiation Committees. The CIC agreed limited assurance due to there being more work to do.
d) There had been significant progress regarding e-Rostering across the Group. The CIC agreed reasonable assurance for this item.

28 November 2024

a) Additional assurance was requested regarding violence and aggression towards staff and a report to be brought back examining the issues around where the incidents were taking place and if there were any ethnical issues attached.
b) Apprenticeship Levy changes – a comprehensive report was received detailing the current apprenticeship work and the changes to the Levy. The CIC agreed significant assurance for the work being carried out.
c) Medical Education annual reports – HUTH had seen an increase in incivility reports and there were national issues impacting the Group regarding Physician Assistants. Reasonable assurance was agreed but further information was required.
d) WDES and WRES action plans were presented.
e) The CIC approved the proposal to remove NEDs from Appeal Panels.

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

4.2 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:

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

The CIC received the progress on the refreshed Workforce BAF, including work around the gaps in controls and assurance and the actions required to address the gaps.

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to:

- Note the escalations in Section 3.1.
- Note the areas for further assurance in section 4.1.

Tony Curry, Chair of the Committees in Common

28 November 2024

3.3.1 - FREEDOM TO SPEAK UP GUARDIAN (FTSUG) REPORT - QUARTER TWO

Liz Houchin & Fran Moverley, FTSUGs

REFERENCES

Only PDFs are attached

BIC(24)237 - Freedom To Speak Up Guardian (FTSUG) Report - Quarter Two.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)237

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	12th December 2024
Director Lead	Simon Nearney, Chief People Officer
Contact Officer/Author	NLAG – Liz Houchin, Freedom to Speak Up Guardian HUTH – Fran Moverley, Freedom to Speak Up Guardian
Title of the Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 2)**
Executive Summary	Each report provides the Q2 2024-25 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 24th October 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 ☐ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 2 Report July to September 2024

Liz Houchin
14th October 2024

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 2 2024/2025

1. Executive Summary

1.1 This paper provides an update regarding the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Freedom to Speak Up Guardian (FTSUG) activity during quarter 2 (Q2) of the 2024/2025 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Group Priorities

2.1 This paper satisfies the Group Strategic Objectives of ‘Our People – we will look after the health and wellbeing of our people’ and ‘Quality & Safety – we will keep our patients safe and reduce avoidable harm’.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at NLAG in place that allow staff to raise concerns, including, but not limited to:

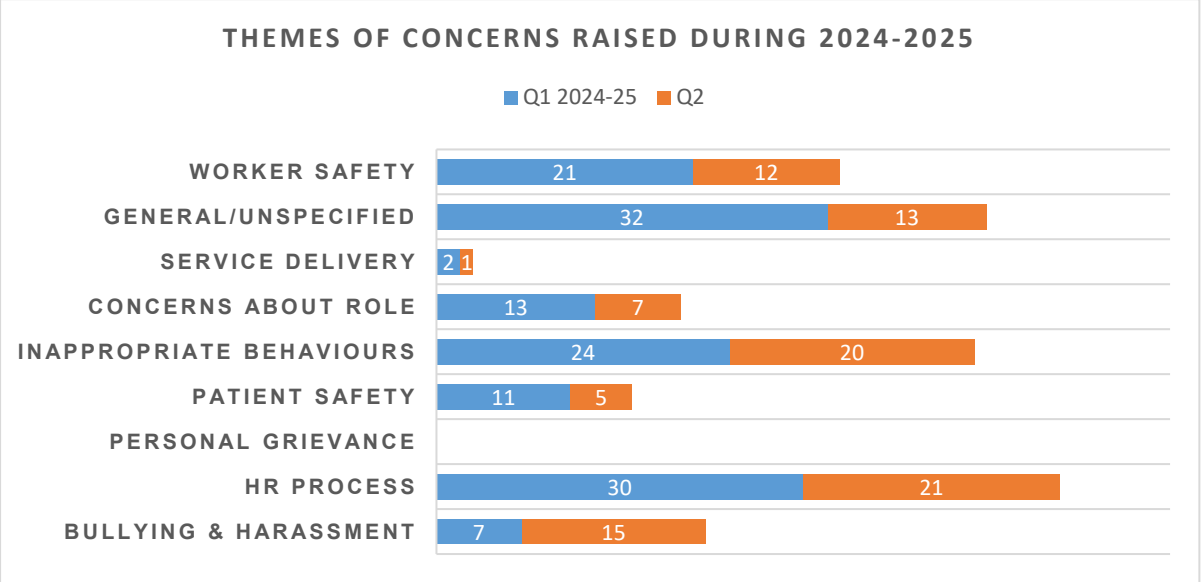
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (DCP126)
- Grievance Policy (DCP084)

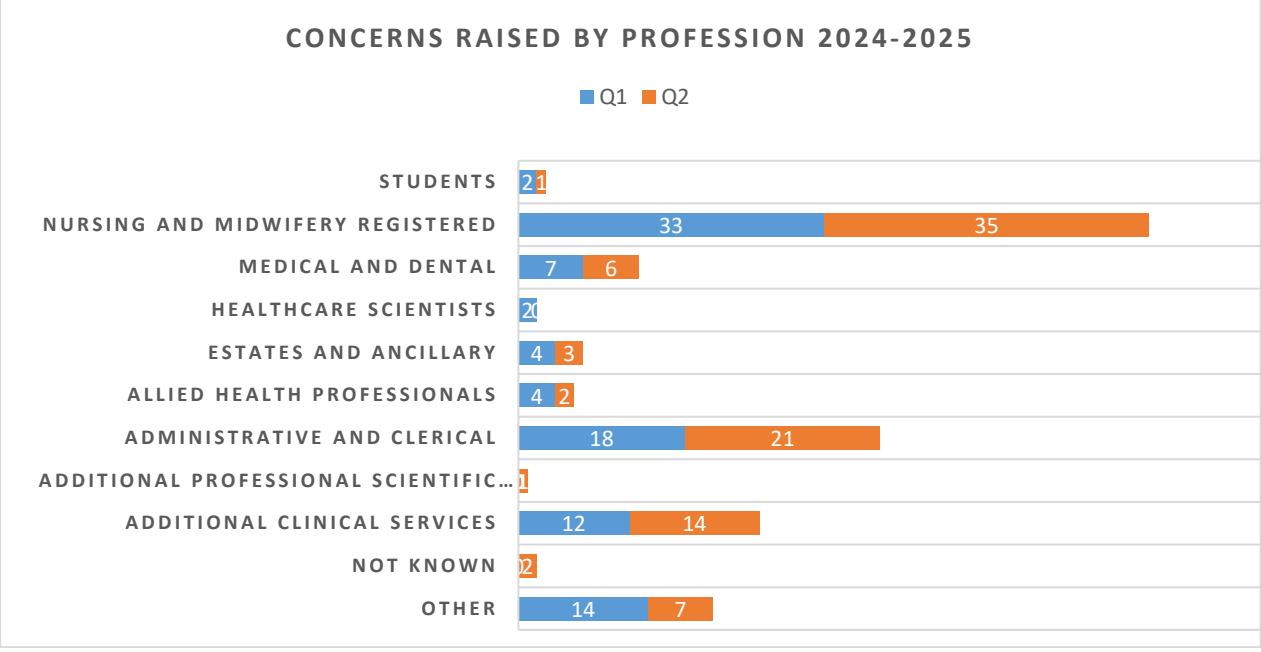
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st July 2024 to 30th September 2024 (Q2) – data, comments and assessment

4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 The following graphs show the themes and the professions who contacted the FTSUG during Q2.





4.3 In Q2 2024-25, 92 concerns were received. 30% of these were closed on the same day after giving advice or signposting.

- 8 concerns were raised anonymously in Q2, all through the Staff App.
- In Q2 5 concerns involved an element of patient safety. This puts the Trust in the third quartile nationally, the peer figure being 11% (figures accessed from Model Hospital data October 2024).
- In Q2 15 concerns involved an element of bullying and harassment which puts the Trust in the high quartile nationally, the peer median figure being 3 (figures accessed from Model Hospital data October 2024).
- In Q2 20 concerns involved an element of inappropriate behaviours which puts the Trust in the high quartile nationally, the peer median figure being 26 (figures accessed from Model Hospital data October 2024).

4.2 The Q2 figure of 92 is significantly higher than Q2 in 2023-24 which was 76. The main themes raised were around behaviours, HR process and bullying & harassment.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed. Quarterly Meetings have been set up with the Managing Directors, Medical Directors and Directors of Nursing for both Teams North and South for their oversight and awareness.

4.6 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

Quarter 2023-24	Feedback received	Would you speak up again? Yes
Q2	13	13

Data analysis of the completed evaluation forms indicate colleagues aged between 25-70 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British, Black or Black British and White backgrounds accessed the FTSUG in Q2.

Within the feedback received, the following are extracts of qualitative feedback received:

I was a mess, I was suicidal and had no one to speak to but you listened to me and now I am in a much better place, so thank you.

Liz was extremely supportive, kind and compassionate and was very helpful with the process of raising concerns. A big thank you.

I write these few words with tears in my eyes and immense gratitude in my heart for arranging today's meeting. After almost a year of continuous harassment finally someone found time to listen to my predicament.

4.7 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 FTSU Guardian received a concern from a colleague who felt they were being bullied by a colleague. The FTSUG met the colleague to discuss options and to ensure that the colleague was aware of the wellbeing resource available to them, as the situation was impacting on their health. The colleague decided that they would like the FTSUG to contact the management team and raise this with them. Meetings were held and a resolution was reached, colleague who raised this was happy with the outcome and thanked FTSUG for listening, arranging the meeting and 'being there'.

4.8 Champions Update

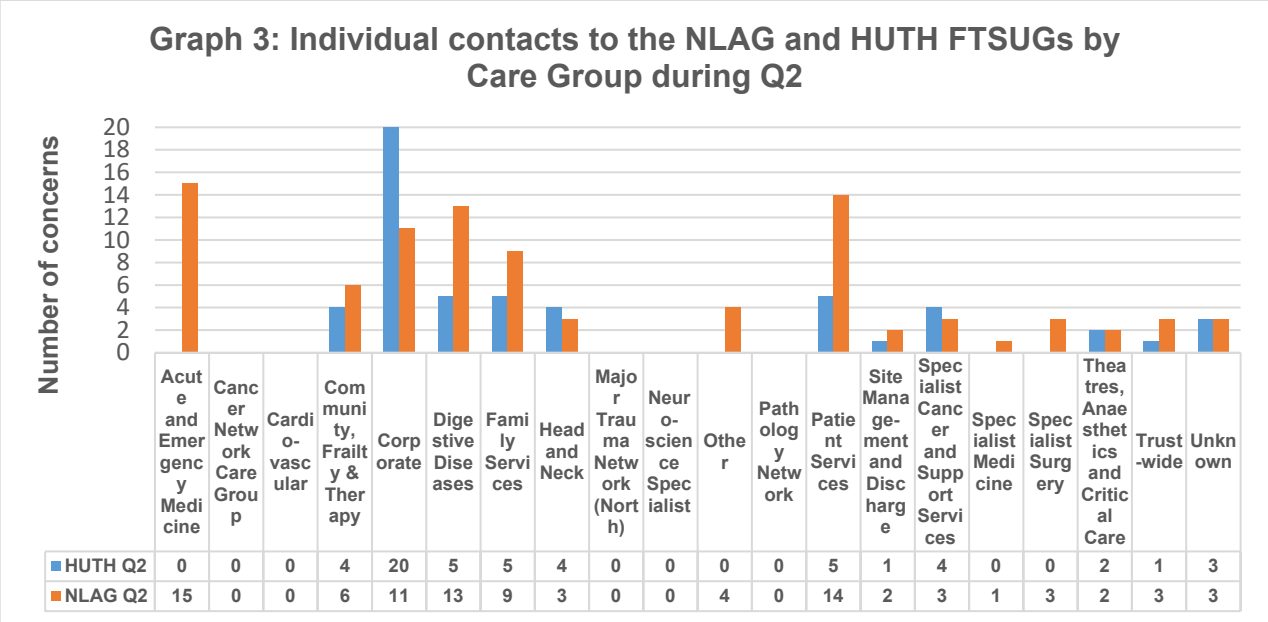
Nineteen FTSU Champions have been trained since the introduction of the role in January 2024. Quarterly meetings are held by the FTSUG for the Champions with time allocated for 'safe space' discussion and presentations by guest speakers. Feedback from them about their role has been encouraging and all are enjoying it, seeing it as a valuable role and it often compliments their substantive posts.

One champion commented: '***Working as a SU Champion has helped me to help my colleagues. Being able to guide staff to who they need to go to and support them when they see something that they wish to raise. People are often upset or scared and may not be sure where to turn, this role allows me to support them.'***

Champions are reporting that morale is very low and the impact of management, system and process changes are a factor in this.

4.9 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 3 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.



5. FTSUG activities and proactive work during Q2

5.1 A high level summary of the activities are detailed below:

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at all Trust inductions
- Attendance at Resident Doctors Forum
- Champions network meeting
- Presented to Group Health & Wellbeing Ambassador Meeting
- Internal Audit Review of FTSU ongoing
- 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.)
- Feature in NGO 100 voices story about Guardian Group Partnership working.

5.2 Future plans:

- Continue to work with HUTH FTSUG to develop FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.

- Attendance at all relevant meetings
- Activities to highlight NGO ‘Speak Up’ month in October

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend regional meetings virtually. Discussions included how Guardians in Groups work together (HUTH and NLaG FTSUG’s have featured in NGO 100 voices story), what kind of psychological support FTSUGs access and by whom, and Employment Tribunals.

6.2 National update

The National Guardian Office Strategy was published in August.
The national strategy has six strategic goals. These include: improve partnership working with key organisations to deliver change, and to use its independent voice to champion FTSU and challenge the healthcare system to do better. There is ongoing work to produce a bespoke risk assessment to identify detriment.

Data for Q1 nationally has been published and indicates that inappropriate behaviours is the most common theme reported to Guardians, this mirrors NLaG data.

7. 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 objectives of ‘Our People – we will look after the health and wellbeing of our people’ and ‘Quality & Safety – we will keep our patients safe and reduce avoidable harm’.

8. Recommendations

8.1 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.

8.2 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.

Liz Houchin
14th October 2024

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

Development areas to address in the next 6-12 months	Target date	Action owner	Progress Update
1. Board development session to get all Board members to agree a vision for Speaking Up (including role modelling values of the organisation) and to commit to it	June 2025	HRD/Vice Chair	Board development session to be planned in 2024/25
2. Discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course	June 2025	HRD/Vice Chair	Will form part of the board development session in 2024/25
3. Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme) – Review FTSU input after 12 months delivery	January 2025	OD/FTSU Guardian	All leaders undertaking the leadership development course complete 'listen up' training. Leadership training being looked at for the Group
4. Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board- review in 6 months	March 2025	HRD/CIO	FTSU information to be included in Power BI
5. Update and Communicate new policy to staff			Action Completed
6. Develop ways of measuring the effectiveness of the communications strategy for FTSU	March 2025	FTSU Guardian/Comms	Bi-monthly meetings held with Comms - ongoing

7 Ensure FTSU information on local induction check list	March 2023	FTSU Guardian/People Directorate	FTSU listed on Induction Checklist for New Starter (DCM716) Action Completed
8 Further work needed on how we can encourage managers including targeted support through cultural transformation work to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale.	March 2025	OD/HRD	FTSU information included in the Manager's monthly email Further work needed as part of leadership development for the Group

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Quarter 2 Report July to September 2024

Fran Moverley
October 2024

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 2 2024/2025

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during quarter two (Q2) of the 2024/2025 reporting year. This paper includes details of relevant regional and national updates for comparison and context. An overview of Group working within the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current HUTH Strategic Objectives of ‘Great Staff’ and ‘Great Care’.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at HUTH for staff.

2.3 Freedom to speak up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at HUTH in place that allow staff to raise concerns, including, but not limited to:

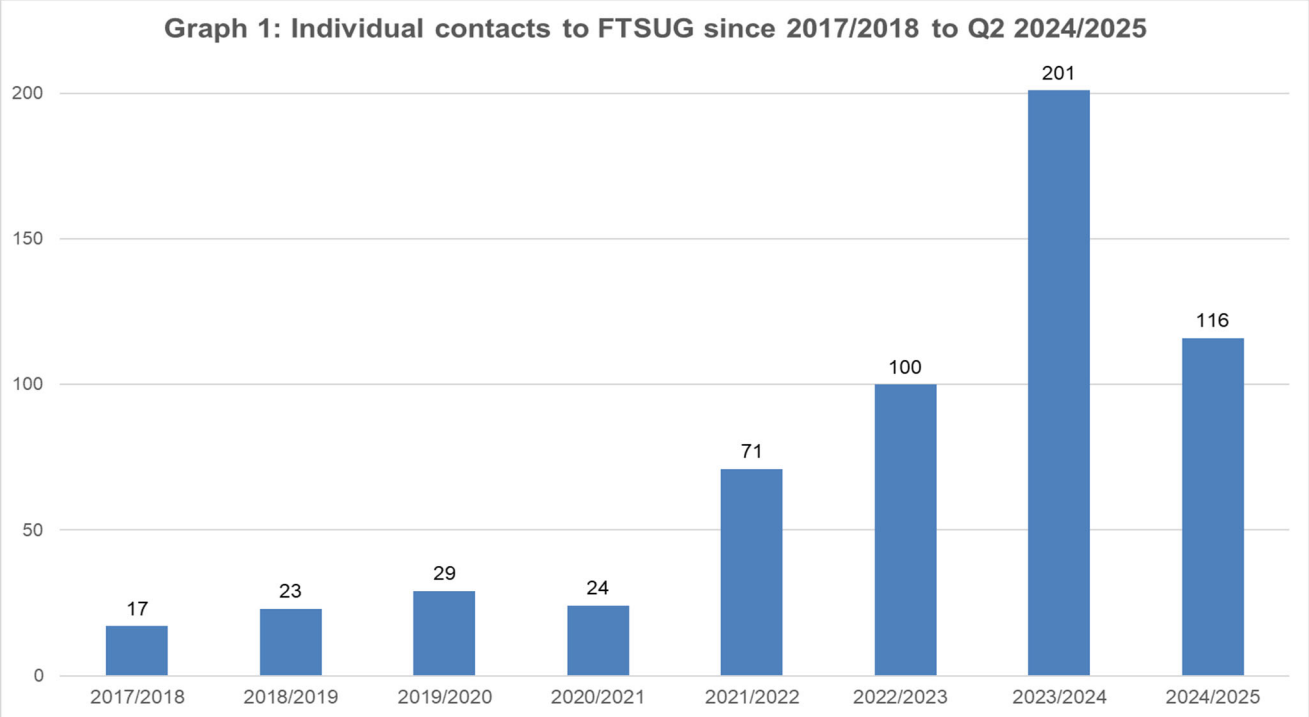
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)

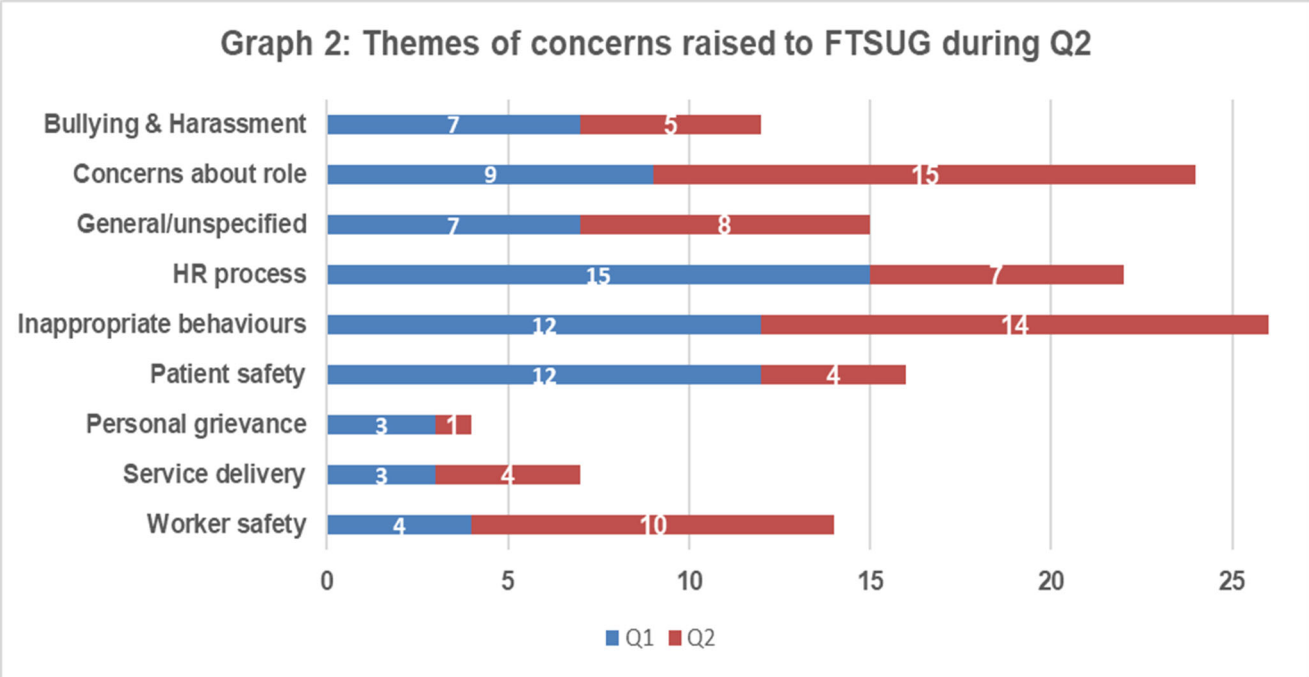
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st July 2024 to 30th September 2024 (Q2) – data, comments and assessment

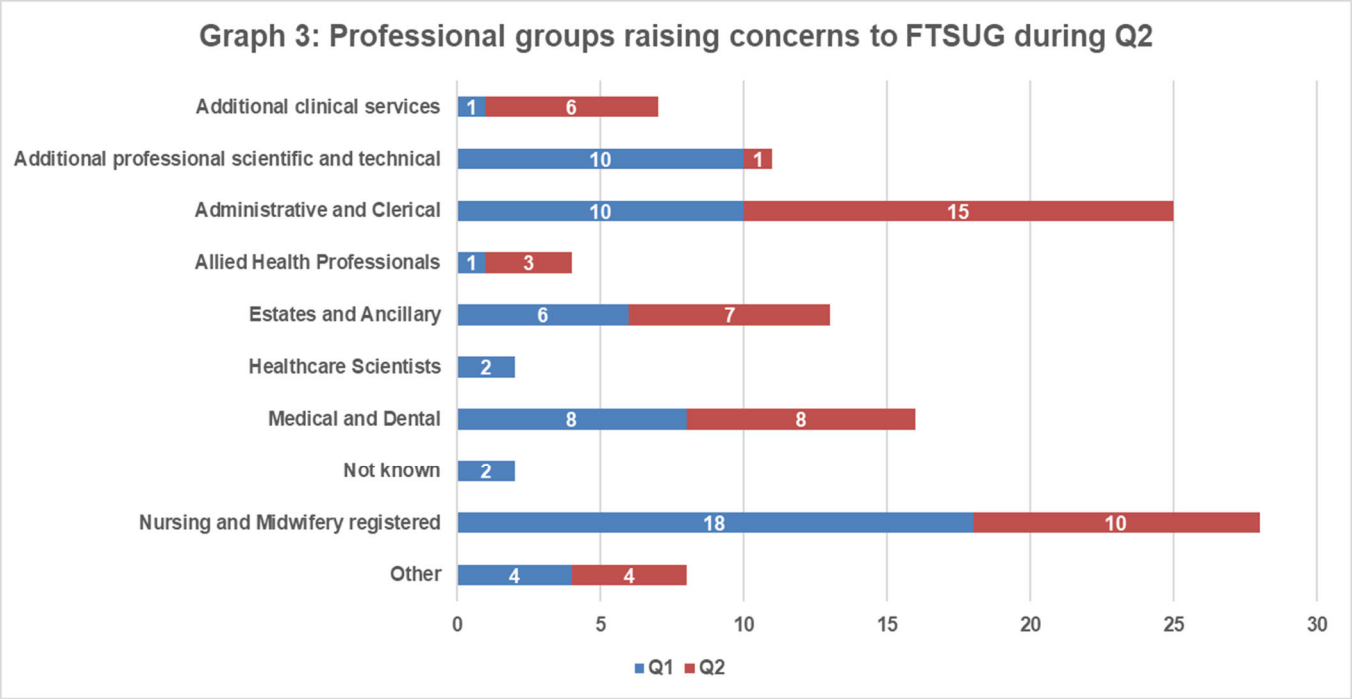
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1, 2 and 3 summarise the Q2 data:





NB. Please note some concerns may have more than one element.



4.3 Observation and comments during Q2:

- In Q2 2024/2025, 54 concerns were received. This was a reduction from Q1 (62); however higher than the same reporting period in the previous 2023/2024 year; when 38 concerns received.
- At 16.10.24. 27 concerns remain open (from Q1 and Q2) and 89 are closed.
- During Q2 no concerns were raised anonymously (where the FTSUG did not know the identity of the individual).
- 16.7% (9) individuals requested to be anonymous throughout the speaking up process (where the FTSUG knew the identity of the individuals); but did not have consent to release their identities.
- 53.7% (29) of concerns were appropriate for an individual's line manager to assist in the resolution, of which 51.7% (15) of individuals had already spoken up to their line manager, before approaching the FTSUG.
- The highest number of reasons for staff approaching the FTSUG had an element of concerns related to their role (15) followed by inappropriate behaviours (14) and worker safety (10).
- Concerns about role, inappropriate behaviours, service delivery, worker safety and general concerns had all increased in comparison to Q1 2024/2025.
- During Q2 the most common professional groups raising concerns were administrative and clerical workers (15), followed by nursing and midwifery (10), and medical and dental (8).
- 1.9% (1) staff member reported being subject to detriment and/or inappropriate behaviours after speaking up about a patient safety concern.

4.5 FTSU Guardian Feedback/Evaluation:

The FTSUG has introduced a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience.

The survey is split into two parts – firstly the worker's experience of the HUTH FTSUG, and secondly, of their experience of speaking up to the wider Trust.

The National Guardian Office guidance only requires one mandatory question to be included in the survey - *'Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'.*

During Q1, 14 responses to the survey were received and the key results related to the experience of the FTSUG included:

- 71% (10) found it very easy and 29% (4) found it fairly easy to make contact with the FTSUG.
- 71% (10) had an excellent experience and 29% (4) had a good experience
- 93% (13) of respondents would speak up to the FTSUG again; 7% (1) was unsure
- Comments included; *'Fran was very reassuring and supportive, she didn't make me feel like my concerns were irrelevant'* and *'It was really reassuring having a safe space to openly talk about what I was going through'.*
- Suggestions for improvements included implementing an online reporting system and having a final formal response to concerns; both of which will be taken forward.

Key results about workers experience of speaking up to the wider Trust included:

- 79% (11) would speak up to the wider Trust again; 7% (1) would not and 14% (2) were unsure.
- 71% (10) felt their concern was treated confidentially; 7% (1) did not, 14% (2) were unsure and 7% (1) chose not to raise their concern.
- 50% (7) felt their concern was listened to and taken seriously; 36% (5) did not, 7% (1) were unsure and 7% (1) chose not to raise their concern.
- Comments included that for some staff, resolving the concerns was lengthy or *'I went around in circles, consistently having to repeat myself multiple times'.*

It is proposed that in the 2024/2025 annual report a full review of the survey responses received is conducted, with a greater number of responses over the year.

4.6 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.

A staff member contacted the Freedom to Speak Up Guardian to discuss concerns that a patient's medical records on Lorenzo had been accessed by a staff member, who was known to the patient outside of the Trust. If this had occurred, it would be inappropriate access and a serious information governance breach.

With the staff member's agreement, the Freedom to Speak Up Guardian

contacted the Information Governance team, who quickly undertook a full audit of the patient's records. On the occasion the review indicated that the records had not been accessed inappropriately and reassurance was provided as feedback to the staff member.

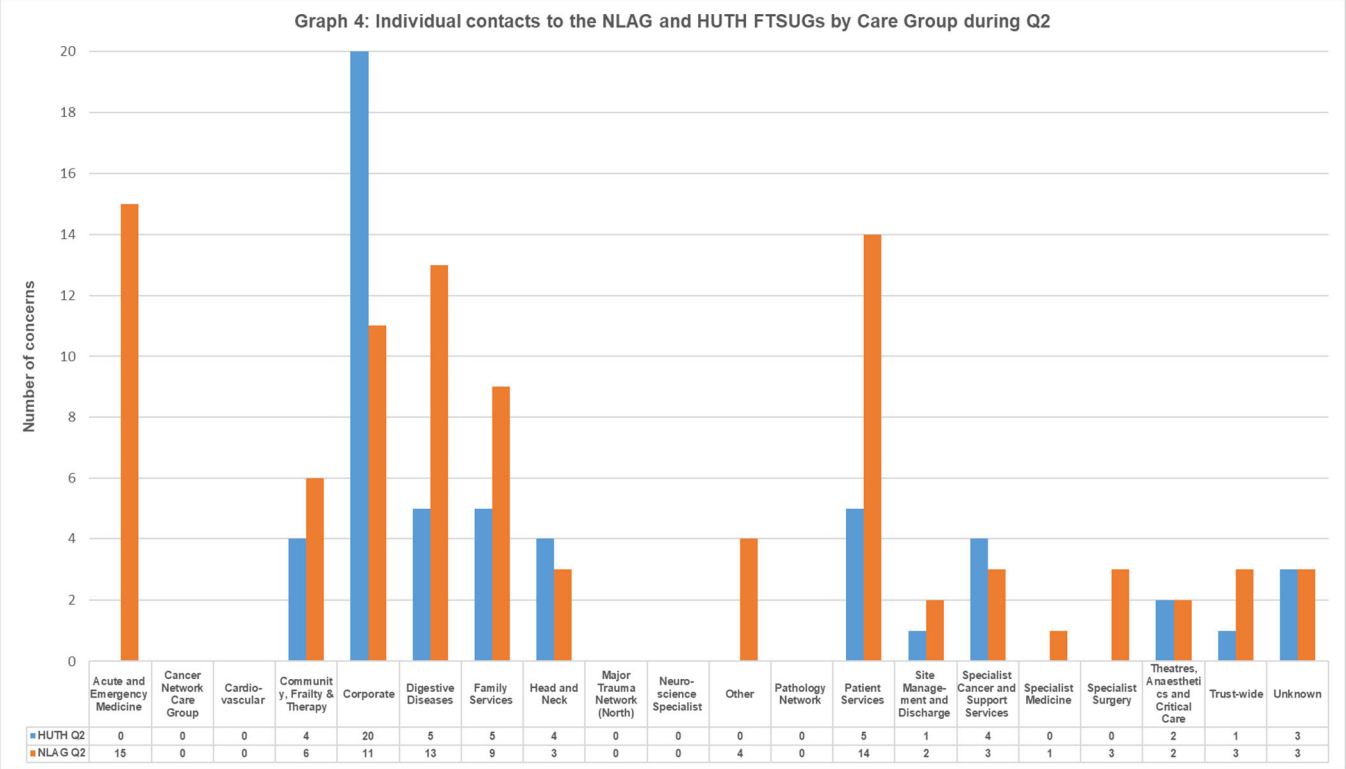
The staff member was really positive that their concern had been taken seriously and progressed.

Separately, the Freedom to Speak Up Guardian fed back to senior management the theme of access to medical records being part of the speak up concerns.

4.7 Care Groups – concerns combined

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.

At HUTH, the highest number of concerns were received regarding departments within the Corporate Infrastructure, followed jointly by Digestive Diseases, Family Services and Patient Services. Collectively as a Group, the highest number of concerns received per Care Group were regarding Corporate Infrastructure, followed by Patient Services.



5. FTSUG activities and proactive work during Q2

5.1 A high level summary of the FTSUG activities 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; two further actions have been completed and closed.

- Introductory presentation with the NLAG FTSUG at the Nursing, Midwifery and AHP Senior Leadership Team (SLT) meeting discussed ways of working, how speaking up information will be available to the SLT in the future and how the SLT can ensure the data aligns with the Quality and Safety Strategy to promote a safety culture.
- Introductory meeting with the South Site Triumvirate team to discuss Q1 themes and partnership working.
- Met with the second and third year student midwives to present the FTSUG role and the importance of speaking up.
- Commenced meeting monthly with the Recruitment, Retention and Pastoral Lead Midwife to discuss partnership working.
- Supported several Maternity listening sessions alongside the Interim Group Chief Nurse, Group Director of Midwifery and Organisational Development team.
- Induction presentations to the Internationally Educated Operating Department Practitioners (ODPs).
- Provided a teaching session on the F1 training programme about freedom to speak up and whistleblowing.
- Introductory meeting with the Group Digital Information Officer.
- Update meeting with the Local Counter Fraud Specialist, to discuss partnership working and key areas of work.
- Provided a marketing stall at the LGBTQIA+ Staff Network conference to promote speaking up.
- Introductory meeting with the new Group Health and Well Being Business Partner to discuss partnership working.
- Ongoing regular meetings with the Group Chief Executive, Group Chief People Officer and Group Chairman.
- Continued monthly support sessions to the leadership teams of the Staff Networks.
- Commenced presenting the FTSUG role and importance of speaking up at the new Group Trust Induction; this will continue on a monthly basis.
- Presented on the first day of the new first year nursing students at Hull University; alongside the Equality, Diversity and Inclusion Lead.
- Further away day with NLAG FTSUG to discuss work projects, including the planning of the Group FTSU strategy.
- Presented at the HR Senior Management Meeting alongside the NLAG FTSUG to discuss processes for providing FTSU high level data to aid triangulation.
- A further eleven Speak Up Champions were trained. Led the Speak Up Champion peer support and development session, including inviting the Head of Patient Safety and Improvement as a guest speaker to increase awareness of incident reporting and use of the Datix system.

5.2 Future plans:

- Continued work to introduce an online FTSU reporting form to assist accessibility of speaking up.
- Further work on the new Group FTSU strategy in partnership with the NLAG FTSUG.

- Preparation for national awareness month for speaking up in October.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG attends, where possible, the Yorkshire and the Humber and North East regional meetings to discuss best practice and contribute to active discussions. The recent meeting discussed FTSUG support to Group structures, what psychological support FTSUGs receive and FTSUG involvement in employment tribunals.

6.2 National update

Positively the National Guardian Office approached the HUTH and NLAG FTSUGs to request a case study to highlight their good practice of the Group partnership. The FTSUGs and the Group Communications Team produced the case study 'Group partnership at its best' which is now published and can be read by clicking here.

The National Guardian Office has refreshed its national strategy and set six strategic objectives; including developing additional support and guidance for organisational leaders and using insight to drive recommendations including challenging organisations to improve.

The National Guardian Office have released the national Q1 figures; in total 8872 individual cases were reported to FTSUGs which represented a 30% increase in comparison to Q1 in the previous reporting year 2023/2024.

Nationally in Q1 40% of cases reported to FTSUGs included an element of inappropriate behaviours (excluding bullying and harassment); in comparison HUTH reported 19%. Nationally in Q1 34% of cases included an element of worker safety and wellbeing; in comparison at HUTH 6.5% cases were reported under this category.

7. Conclusion

7.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up.

7.2 The FTSUG has continued to be active in promoting speaking up and creating partnerships with internal and external stakeholders.

7.3 The Group arrangements have been developed, with the HUTH and NLAG FTSUGs working closely together to develop consistent reporting processes and recognition at national level as good practice.

8. Recommendations

8.1 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.

8.2 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.

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

ACTIONS IN PROGRESS			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 8: Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • 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. • 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. • LGBTQ+ framework and circle group are due to go live February 2024. • 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. • 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 Group-wide. At 01/12/24: • The Circle Groups for zero tolerance to racism and LGBTQIA+ discrimination have been extended to Group wide. • Zero tolerance to ableism to be launched Group wide at the end of December. • Group Director of Learning & Organisational Development looking to implement a zero tolerance tool quarterly report to include soft intelligence and themes for learning.
Action 9: Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • 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”. • 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.
			• Currently on hold subject to the Group leadership structure.
			• New Values and Staff Charter now in place. Head of OD (South) has been tasked with creating the following Group Programme:
			  ○ Civility and Respect Campaign refresh and relaunch (bad behavior doesn't work)
			  ○ Required Learning for Leaders inc PACT
			  ○ "What's it like to be managed by me?" and "What's it like to work with me?" style content
			  ○ Cultural Ambassadors (NLAG have currently and scoping out group roll out)
			  ○ Cultural Dashboard – People metrics triangulated to give an overall picture of culture in a care group or department
			At 01/12/24:
			• As above, the bite sized leadership courses, including PACT training are now live and bookable across the Group.
			• The new staff behaviours charter to be rolled out; this will include workshops for leaders/teams and train the trainer. Managers will be trained to subsequently deliver workshops for values and behaviours and lead a conversation with their teams.

Action 13: Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8.	31/12/24	FTSUG	**Action in progress** • FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports. • January 2024 – initial discussion with NLAG FTSUG to discuss best practice and different ideas for triangulation. • 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. • Ongoing discussions with the Workforce Intelligence team to provide data to Care Group triumvirates, in conjunction with other relevant workforce data. At 16/07/24: • BI spreadsheet in development with assistance from the Workforce Intelligence team, to develop reporting data for Care Groups. At 01/12/24: • FTSUG continues to be a member of the zero tolerance to discrimination and departmental incivility circle groups, to aid triangulation.

			• HUTH FTSUG and NLAG FTSUG have co-created a Group-wide graph using speaking up data to assist in triangulating data across the Care Groups. • HUTH FTSUG and NLAG FTSUG have commenced meeting with the South site triumvirates to discuss speaking up data and aid the triumvirates in triangulating key data.
Action 16: Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/12/24	FTSUG	**Action in progress** • Initial work underway to develop a draft strategy; including reviewing other Trust's strategies. • January 2024 – discussed with NLAG FTSUG to propose a joint Group. NLAG current strategy due for renewal August 2024. • 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. At 16/07/24: • HUTH and NLAG FTSUGs have commenced the early planning of a Group wide strategy. Awaiting publication of the Group Strategy and National Guardian Office Strategy. At 01/12/24: • Version 1 of the draft strategy has been written and is currently being reviewed, in preparation for identifying stakeholders and circulating the strategy for comment, ahead of ratification.

ACTIONS COMPLETED			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 1: Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead	**Action completed** • Repeat self-assessment of the Board self-reflection will be scheduled no longer than two years from the previous assessment (February 2023). Executive Lead committed to ensuring this has been completed.
Action 2: Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG	**Action completed** • 6 further Speak Up Champions recruited and trained during March, April, May, June and July 2023. • 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.

			• Private workspace on Pattie set up for Champions to provide a central resource for key updates and resources. • Recruitment to being a Speak Up Champion continues to be promoted at local induction events e.g. internationally educated nurses, junior doctors. • At 29.01.24. 24 active Speak Up Champions trained and further 4 are booked on training. At 03/06/24: • 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 3: Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/12/24	FTSUG	**Action completed** • Bimonthly training dates booked until end of 2023. • Bimonthly training dates for 2024 are in place. • 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. • 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. At 16/07/24: • The total number of Speak Up Champions trained is 34; with further 8 trainees booked for training in September and November 2024. At 01/12/24: • Number of trained Champions increased to X. X booked on training. • Review professional groups. • 2025 dates booked and communicated. • Speak Up month webinar drop in session • Celebration event and November meeting •
Action 4: Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.	**Action completed** • 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. • 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.

			• 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. • Joint drop in session with the FTSUG and Chief Nurse scheduled for 31st August 2023. • 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. • 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. • Ad hoc communications e.g. Daily Update linked to speaking up, circulated Trust-wide. • Future - 2024 Communications Plan to be developed, where possible in conjunction with the NLAG FTSUG.
Action 5: Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances. • A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.	30/09/24	FTSUG	**Action completed** • Question about whether the individual had experienced positive behaviours when speaking up considered and included in the feedback survey. • Question about referral route and awareness of the FTSUG role included in the feedback survey. • Free text box included in the survey to include permission to share stories of speaking up. • Final amendments to the feedback survey to be made – Digital Communications team confirmed in work plan. • Questions related to protected characteristics approved by Equality, Diversity and Inclusion Committee 18.01.24. Final checks in progress and feedback survey will commence. • 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. At 16/07/24: • Feedback survey completed and live. FTSUG has commenced circulating links to staff who have spoken up since April 2024. • Questions included asking about how well the staff member felt listened to, supported and whether their concern was resolved. National mandatory question included. • FTSUG to report on results at the next Board meeting.

			At 01/12/24: • Feedback survey live and in place • Feedback included from Q2 Board and WEC reports • Propose annual review • Using free text quotes in comms to promote and encourage speaking up
Action 6: Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	30/11/24	Group Director of Learning & Organisational Development	**Action completed** • Initial discussion held between Head of Organisational Development and FTSUG to discuss incorporating existing Health Education England e-learning into line manager development. • 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. • 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. • FTSUG met with OD Facilitator to discuss including a bespoke speaking up module within the new Inclusion Academy. • 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. At 01/12/24: • New leadership bite sized courses were launched by the Organisational Development team, and all staff members are able to book on. The courses include Professional and Civility Training (PACT). • Action now closed
Action 7: Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an “internal consultant” to bring expertise into bespoke work design.	30/11/24	Group Director of Learning & Organisational Development	**Action completed** • The Maternity reporting tool is now live and Cardiology is currently in progress. • FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised. • Cardiology incivility reporting tool launched on 10th November 2023. • FTSUG continues to be involved in the monthly circle groups. At 01/12/24: • Maternity incivility tool has been relaunched; including direct staff communications via a maternity tea trolley. The tool is part of business as usual. • Action closed.
Action 10: Implementation of the new NHS England speaking up policy. To	31/12/23	FTSUG	**Action completed** • National policy transferred into HUTH template and personalised.

include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.			• Policy could not be ratified due to Workforce Transformation Committee on 20th July 2023 being cancelled. Approval sought via email approval. • Approval via email confirmed. Policy now published live on Pattie (reference CP451).
Action 11: Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG	**Action completed** • Draft policy sent to internal stakeholders for information/comment. Including Executive Lead, Director of Workforce, Head of Workforce, Head of HR, Disability Staff Network Chair, BAME Staff Network Chair, LGBTQ+ Staff Network Chair, JNCC Chair, LNC Chair, Equality Diversity & Inclusion Trust Lead.
Action 12: Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.	31/05/23	FTSUG	**Action completed** • Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training.
Action 13: 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** • Self-reflection and planning tool reviewed and shared with NLAG FTSUG. • 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. • HUTH results compared to NLAG. Copies of improvement plans requested from two other acute NHS trusts for comparison. • Contact made with Mid Yorkshire Teaching NHS Trust and Group (Kettering General Hospital and Northampton General Hospital). At 03/06/24: • Reviewed the self-reflection and improvement tool from Cambridge Community Trust, previously rated as the highest in the FTSU Index.
Action 15: Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.	31/03/23	FTSUG	**Action completed** • 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 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** • Self-reflection and planning tool reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • 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. • 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. • Additional update at 16/07/24: FTSUG being approached by FTSUGs at other trusts with requests to discuss the Group arrangements with NLAG. HUTH and NLAG FTSUGs involved in national discussions regarding the arrangements.

3.3.2 - ESTABLISHMENT REVIEW OF SAFE STAFFING PROGRESS UPDATE

Amanda Stanford, Group Chief Nurse

REFERENCES

Only PDFs are attached

BIC(24)238 - Establishment Review of Safe Staffing Progress Update.pdf

Boards in Common Front Sheet

Agenda Item No: BIC(24)238

Name of the Meeting	**Trust Boards in Common**
Date of the Meeting	Thursday 12 December 2024
Director Lead	Amanda Stanford, Group Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Director of Nursing – South Tracy Campbell, Director of Nursing – North
Title of the Report	**Annual Nurse Safer Staffing Establishment Review progress update**
Executive Summary	The annual nurse safe staffing establishment review has been conducted in line with national guidance and requirements. This is the first nurse safe staffing review to take place across the Group, and included adult and paediatric inpatient areas, and Emergency Departments (EDs). The Group used licensed Safer Nursing Care Tool (SNCT) software to review seventy-nine wards and departments across all hospital sites. This is the first time the SNCT methodology has been used in HUTH. The data collection period for inpatient wards was during August 2024 when elective activity and therefore occupancy was lower than other months which will have had an impact on activity levels. Community nurse staffing has not been formally reviewed however an updated Community Nursing Safer Nursing Care Tool (CNSST) is expected to be released imminently and it is recommended that a full community nursing establishment review is undertaken as soon as the tool is available. The review has highlighted gaps and additional work is required to further prioritise and risk assess recommendations, this work is ongoing. The SNCT data is being collected again in November 2024 and the Spring of 2025 which will provide additional data points and further evidence on which to base recommendations. This will also account for seasonal variation and support development of workforce and investment plans for 2025/2026, 2026/27 and 2027/28. Health Care Support Work costs have been costed at Band 2 and it is recognised that this is a risk given the changes to the national profile and work being led by the Deputy Chief Nurse for Workforce and Education. It is recommended that a review of headroom is undertaken across the Group and headroom set in line with national recommendations. It is recommended that consideration is given to allocating the ‘enhanced care’ budget to wards on the north bank where high

	levels of 1c and 1d patients were recorded indicating that additional nursing resource is routinely required. However, further work is needed develop our enhanced therapeutic model and to understand the impact of this to ensure temporary staffing spend doesn't increase in other areas to support enhanced care. The key professional elements to consider are the increase of supernumerary time for our clinical leaders on the south bank as a minimum standard to 15 hours per week 12 months of the year. The impact of increasing ward managers time on improving patient care and staff retention should not be underestimated.
Background Information and/or Supporting Document(s) (if applicable)	Safe Staffing for Nursing in Adult Acute Wards in Acute Hospitals (NICE 2014) Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board 2016) Developing Workforce Safeguards (NHSI 2018) Nursing Workforce Standards (Royal College of Nursing 2021) Safer Nursing Care Tool – the Shelford Group
Prior Approval Process	
Financial implication(s) (if applicable)	Yes - TBC
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Supports the Group to work towards equitable safer staffing levels across the Group.
Recommended action(s) required	☐ Approval ☐ Information ✓ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

1. Introduction

The purpose of this paper is to provide the Board with the annual nurse safe staffing review in line with the guidance and requirements as cited by the National Quality Board (NQB) (July 2016) and Developing Workforce Safeguards (NHSI 2018).

As part of the NQB requirements regarding the monitoring of sustainable safe staffing levels on inpatient wards, the Board are required to receive an annual review and approve any changes to nursing establishments. The guidance:

- Sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable, and productive services, including introducing the care hours per patient day (CHPPD) metric.
- Identifies three updated NQB expectations that form a 'triangulated' approach (Right Staff, Right Skills, Right Place and Time) to staffing decisions.

Developing Workforce Safeguards (NHSI 2018) supports previous documents and requirements, building on the triangulated approach to safe staffing needs as described by the NQB guidance from 2016. It is based on patients' needs, acuity, dependency, and risks. A safe staffing review should be reported to the Board twice a year, based on evidence-based tools, outcomes, and clinical judgements. Compliance will be assessed through the Single Oversight Framework and through a statement provided in the Trust's Annual Governance Statement.

2. Methodology

This is the first nurse safe staffing review to take place across the Group, and included adult and paediatric inpatient, and Emergency Departments (EDs). The Group used licensed SNCT software.

The Safer Nursing Care Tool (SNCT) is a NICE endorsed evidence-based tool currently used in the NHS. Primarily used by the nursing workforce, the development of these tools has been led by a core group of experienced professional leaders and leading academics. The SNCT suite includes tools for the following settings:

- Adult inpatient wards in acute hospitals (updated 2023)
- Adult acute assessment units (updated 2023)
- Children and young people's inpatient wards in acute hospitals
- Emergency departments
- Community nursing

These tools support chief nurses to determine optimal nurse staffing levels helping NHS hospital staff measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tools can also support organisations to deliver evidence-based workforce plans to support existing services or to develop new services.

The SNCT allows managers and practitioners to challenge historical staffing and address inequities. The care levels and multipliers facilitate judgements and are an integral part of the applied methodology. The SNCT multipliers are based on empirical data and the national best-practice dependency/acuity database. This tool is based on 7 levels of care and has recently been updated with levels 1c and 1d to reflect the needs of patients who require additional intervention to mitigate risk and maintain safety (see below). The SNCT takes into account a recommended minimum headroom of 22% (headroom in the tool cannot be reduced below 22% - the Group headroom is 21.6%). It is advised that the SNCT is not used on small units of less than 10 beds.

SNCT Levels of Care:

Level 0	*Patient requires hospitalisation. Needs met by provision of normal ward cares.*
Level 1a	*Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.*
Level 1b	*Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.*
Level 1c	*Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and*

maintain safety.

Level 1d *Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety, (two staff out of ward budget).*

Level 2 *May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility /unit.*

Level 3 *Patients needing advanced respiratory support and/or therapeutic support of multiple organs.*

The process involves collecting the SNCT data over a period of 30 days on each ward area to establish patient need and dependency. Data is also collected around patient movements, including discharges, transfers, admissions, direct and indirect care, and occupancy.

As HUTH staff had not used the inpatient SNCT before and the adult inpatient SNCT was updated in 2023, now includes two additional multipliers and requires a 30-day data collection, a training programme was implemented across the Group. Approximately 240 staff were trained to use the tool relevant to their clinical area to ensure data collection was robust. Senior nurses were also trained to validate the data a minimum of four times during the collection period. The training included a clinical competency element based on the levels of care, including an assessment by those who have been trained by members of the national team.

Although ED SNCT had been trialled at DPOW ED in 2023, training for all EDs was implemented to provide consistency in the use of the tool across all three EDs in the Group. The data collection for ED is collected twice a day for 12 days, starting at 12 noon and midnight on the first day, then moving forward by one hour each day to capture the 24-hour period.

Use of the Community Nursing Safer Staffing Tool (CNSST) was paused in April 2024 by the national team therefore a data collection has not taken place. It is anticipated that the tool will be re-released imminently, and data collection will commence.

Within NLAG there have been seven SNCT data collections data collections over recent years, enabling the Trust to develop more understanding of seasonal trends and workforce patterns and this supports a continuous review of safe staffing against patient acuity and dependency. Within HUTH the annual review was, until this year, undertaken using the Allocate SafeCare deployment system which has been used in conjunction with professional judgement to triangulate data.

3. Ward Review Process

As part of the new annual review, seventy-nine wards and departments across all hospital sites for adult and children inpatients were reviewed. A rolling process has been put in place by the Chief Nurse to ensure a six-monthly data collection and reviews takes place to reflect potential seasonal changes or demographic changes to wards.

The ward review group consisted of the Ward Manager, Matron, Care Group Deputy and Nurse Director, Finance Business Partner, Directors of Nursing - North and South and the Head of Nursing for Workforce. It is essential to include the Ward Manager in the ward review process as they are the accountable leader and meetings were arranged to accommodate their attendance. The ward review considered a triangulation of elements for each ward, including a financial review.

Information was taken from review of the nursing dashboard and included:

- Information from the SNCT review
- A review of ward budgets and establishments, with a clear breakdown of staffing budgets at each band
- Agency and bank use
- Roster management
- HR benchmarks including vacancy, sickness, appraisals rates, mandatory training compliance
- Occupancy and fill rates
- National benchmarking of CHPPD data using the Model Hospital
- Quality and safety nurse sensitive indicator data

The review included a celebration of what is going well on the ward areas which highlighted good practice and exceptional leadership.

For each ward, an average daily number of patients per level is calculated for the period of the survey and added into the tool. The default RN to HCA ratio in the tool is 72:28. On a number of wards, particularly in NLAG, the RN:HCA ratio is 50:50 and this has been deemed appropriate given the high number of patients who are dependent on nursing care and frequently requiring more than one nurse to meet most or all of their activities of daily living (level 1b). However, it needs to be acknowledged that many of the B2 HCSWs in NLAG undertake physiological observations, ECGs etc. which supports a ratio of 50:50.

SNCT output does not include time for transfer/escort activity which is particularly high on assessment units and was considered in the reviews with Ward Managers.

At the end of each ward review a discussion was held to ensure the review group agreed on the recommendations that would be put forward. Recommendations have subsequently been prioritised by the Directors of Nursing – North and South.

4. Findings

Consistent themes raised by the Ward Managers at NLAG included:

- Complexity and dependency of patients remains high.
- Activity does not reduce overnight. Night shifts predominately commence at 7pm or 7:30pm for a twelve-hour period and at this time flow and activity are still high throughout the Trust. The transfer of patients and movement of staff was a clear feature of ward review discussions as the majority of this took place out of hours. The movement of patients continues to be an issue in the out of hours period.
- Care Navigator (CN) role insufficient – some wards would benefit from 7-day CN.
- Ward Manager supervisory time to lead time insufficient (on most ward is 2 days per week for 8 months and 1 day per week for 4 months).
- Concerns regarding Band 2 national job profile change and the impact to ward areas now and when this is implemented.
- The redeployment of staff to meet challenges elsewhere and the impact of this on morale and staff well-being.

Consistent themes raised by the Ward Managers at HUTH included:

- Complexity and dependency of patients is high.
- Activity does not reduce overnight. The transfer of patients and movement of staff was a clear feature of ward review discussions as the majority of this took place out of hours. The movement of patients continues to be an issue in the out of hours period.
- Low Nurse to patient ratio particularly evident overnight.
- Poor shift fill rate in some areas, particularly at night with limited bank and agency uptake.
- Daily boarders add an additional pressure on ward and department staff – between 1 and 3 patients in temporary escalation spaces in corridors on many wards.
- Patient Discharge Assistant (PDA) role inconsistent with some based on the wards and other provided from a central team. Some wards would benefit from 7-day input.
- The redeployment of staff to meet challenges elsewhere and the impact of this on morale and well-being.
- Inability to cover maternity leave putting additional pressure on staff.

CHPPD data has been collected for acute and acute specialist providers since April 2016 and for community and mental health Trusts since April 2018 following publication of Lord Carter's report on their productivity. CHPPD has since become the principal measure of nursing, midwifery and HCSW deployment on inpatient wards.

Shift fill rates have an impact on the CHPPD. Throughout the review it was noted that shift fill rates are generally higher in NLAG than HUTH which is reflected in the use of temporary staffing. It is anticipated that fill rate will improve in both Trusts once the newly qualified nurses are in post and out of their supernumerary period. The shift fill rate target is 95%.

The Model Hospital data is used to compare our CHPPD metrics against national peers since November 2018. It does not take into consideration elements within our model of delivery and benchmarking against the nominated peers list does not always provide a good comparator and is therefore more useful to look at ward demographics.

The Model Hospital data from August 2024, shows the total NLAG CHPPD value 9.1 (quartile 3) compared to the Peer median of 8.3 and provider median of 8.7. During the SNCT data collection period in August, increased levels of consultant leave and reduced occupancy on surgical wards were seen, particularly at Goole, which has an impact on CHPPD. The acuity of the service delivery model at the Trust is currently not considered, i.e., multi-sites of HOBS with increased CHPPD. Additionally, changes to ward configurations/ specialties have impacted on the overall data submitted and ability to benchmark.

The HUTH CHPPD value was lower at 7.7 (Quartile 1) compared to the Peer median of 8.3 and provider median of 8.7. Again, during the SNCT data collection period higher levels of consultant leave was noted in August with reduced occupancy on elective surgical wards affecting CHPPD. Validation work at HUTH has been undertaken to ensure that non-clinical roles e.g., ward-based housekeepers are not being included in the data submitted.

Headroom

The Auditor General (2002), Hurst (2003), Healthcare Commission (2005) and RCN (2006) all recommend flexible headroom allowances ranging from 22% to 25%. The SNCT tool has 22% time-out allowance included in the multipliers and establishment. The Carter review (2016) recommended between 22% - 24%.Headroom is a judgement about allowing clinical staff time away from the clinical area to complete their professional and mandatory training requirements. A review of headroom at NLAG in 2021 resulted in the headroom being reduced from 22.6 to 21.6% in line with HUTH.

Additionally, consideration needs to be given to the high levels of trained required in some department e.g., ED where it is felt that the education and training allowance should be increased. SNCT headroom for ED is recommended at 27%, currently the headroom for EDs across the Group is set at 21.6%.

Review of how the headroom is calculated has identified that there is a difference across the two Trusts. In NLAG a decision was made to include the headroom that covers additional bank allowance for Sickness and Absence in the budget. This could be removed and added to a Bank budget in wards and departments to support temporary staffing spend but it is not recommended that it is removed from budgets.

It is recommended that headroom across the Group is at least 22% on the wards in line with the national recommendations, with a higher headroom in ED and other department where additional mandatory training is required e.g. ICU.

Emergency Department Establishment Reviews

The EDs across the Group continue to see an increase in attendances. This is across both ambulance arrivals and self-presenters. It has been identified that there has been a shift in acuity of a cohort of those patients who self-present and who are classified as ED majors' patients, and it is important for the EDs to be resourced to provide timely triage to safely manage this risk.

Overcrowding is a challenge that all the Group EDs face, and this adds additional challenge in providing care for patients when the footprint of the ED grows to accommodate the risk and the difference in the care required to be delivered for those patients who are waiting in our EDs for a ward or assessment bed. This is having a particular impact on the Emergency Care Area (ECA) in HRI which is seeing an increased number of patients through the day and is supporting patients waiting for beds, often with an occupancy of between 50-80 patients.

ED SNCT guidance advises only to score a patient once if they are in the department over 12 hours. Concerns that have been raised by providers with the Shelford Team about the often-significant number of patients in departments over 12 hours who require care and treatment whilst waiting for a bed. This is reflected in the ED SNCT data where the recommended establishment is below the current establishment on the south bank, with the north bank being largely reflective of current establishment. It should be noted that as described, the SNCT does not account for patients in the department over 12 hours, the footprint of the departments and staff allocation requirements to safely manage patients, this required professional judgement to be applied. An enquiry has been raised with the national team and a response is awaited.

The default percentage headroom in the ED SNCT is 27% and is an average of the EDs in the SNCT database

and there is a recommendation that the percentage headroom does not fall below 25%. The Trust headroom in ED is below this at 21.6% and is insufficient to support all the additional training and development required reviewed by nursing staff in ED (approximately 10 days). It is recommended that headroom is reviewed.

It is common for HRI ECA to reach a patient number that averages between 40-80, inclusive of lodged patients. The current RN establishment can give a staff to patient ratio during peak periods that is too high to safely manage this number of patients especially when factoring in caring for a cohort of patients waiting admission. There is also the added risk of having a large waiting area and the ability to safely observe this for patient deterioration. It is recommended, based on the occupancy and acuity that a temporary uplift in RN hours is required to improve safety, quality and patient experience in the ECA. Based on the occupancy it is recommended to increase the staffing in the ECA by 2 Band 5 RNs and 2 Band 3 CSWs plus 1 Band 2 HCSW 24/7.

To enable the EDs at NLAG to safely manage the increase in attendances and the overcrowding, different models of care are being developed. These include the use of Clinical Decision Units (CDU) in the EDs in SGH and DPOWH that enable better flow through the departments and supports capacity within the majors area. Additional Registered Nurse resource is currently being used to deliver the CDUs and it is recommended that these posts are made substantive to provide a stable staff model to continue to grow this service – Band 5 RN Long Day SGH and Band 5 RN Long Night DPOW.

5. Recommendations

This is the first Group Safer Staffing paper and the first time the SNCT has been used at HUTH. The SNCT has highlighted gaps (appendix 1) and additional work is ongoing to further prioritise and risk assess recommendations. The SNCT data has been collected again in November 2024 and will provide an additional data point and further evidence on which to base recommendations. This will also account for seasonal variation and support development of workforce and investment plans for 2025/2026, 2026/27 and 2027/28. This will support a phased approach to recruitment which is primarily likely to be reliant on newly qualified nurses.

It is acknowledged that the HASR recommendations on the south bank and the new Group structure will have further implications on ward configurations and recommendations will need to continue to be prioritised across the Group.

There are several risks and benefits identified within this review which need to be considered:

- Improved morale of nursing teams
- Improved patient safety and experience
- Better use of resources by having flexibility to redeploy staff for supportive care and manage sickness at short notice
- Investment in leadership and staffing enhances reputation to attract staff

Health Care Support Work costs have been costed at Band 2 and it is recognised that this is a risk given the changes to the national profile and work being led by the Deputy Chief Nurse for Workforce and Education. It is recommended that a review of headroom is undertaken across the Group and headroom set in line with national recommendations.

It is recommended that consideration is given to allocating the ‘enhanced care’ budget (currently in the Chief Nurse budget) to wards on the north bank where high levels of 1c and 1d patients were recorded indicating that additional nursing resource is routinely required. However, further work is required to develop our enhanced therapeutic model and to understand the impact of this to ensure temporary staffing spend doesn’t increase in other areas to support enhanced care.

The key professional elements to consider are the increase of supernumerary time for our clinical leaders as a minimum standard to 15 hours per week 12 months of the year. The impact of increasing ward managers time on improving patient care and staff retention should not be underestimated.

First Draft Costs

SNCT Ward Reviews 24/25 - Nursing

Caregroup	Financial request £000s
Digestive Disease	-1,786
Family Serives	-143
Head and Neck	-300
MT	-3
TACC	-210
Cardiovascular	-756
Specilist Cancer	-650
AEM	-1200
Neurosciences	-902
Specialist Medicine	-1036
Community, Fraility & Therapy	-1590
Specialist Surgery	-624
	-9,200

6. Conclusion

In conclusion, it is recommended that:

- The Boards-in-common recognise that the data collection period was during August 2024 when elective activity and therefore occupancy was lower than other months due to high levels of annual leave across the consultant workforce which will have had an impact on activity levels.
- The Boars-in-common recognise that the SNCT has not been used nor reviewed at HUTH in this way historically, therefore this process will require further data collection points to ensure that the data is consistent.
- Further data has been collected in November 2024 and is being processed. This will allow three data points and seasonal variation to be compared in Q1 2025/26 to support development of 3-year workforce and investment plans. As per best practice, data will be collected, and establishments reviewed and reported to Board twice per year going forward.
- The Boards-in-common acknowledge that the SNCT has highlighted gaps, and that additional work is ongoing to further prioritise and risk assess recommendations.

Appendix 1

Recommendations have been prioritised and are summarised in the table below. Use of the SNCT has highlighted a gap and additional work is required to further prioritise and risk assess recommendations, this work is ongoing. The SNCT data has been collected again in November 2024 and is being analysed. This will provide an additional data point and further evidence on which to base recommendations. This will also account for seasonal variation and support development of workforce and investment plans for 2025/26, 2026/27 and 2027/28.

For NLAG, the cost of recommendations for ED and increasing ward manger time to lead can largely be offset by the recommended reductions outlined below.

RISK	WARD	RECOMMENDATION	COST	COST REDUCTION
Very high priority/ Immediate risk		NIL		
High	ED SGH	RN LD	-114	
	ED DPOW	RN LD	-124	
Moderate	Amethyst	HCA 24/7	-196	
	Disney - Paediatrics	RN 07.30-17.30 Friday for dental list	-57	
	DPOW Stroke	RN Night and then reduce late shift to 8pm from 10pm end	-102	
Low	SGH Stroke	HCA Night	-106	
	25 - Endo	RN Late	-57	
	29 - Acute Surgery	Replace B2 24/7 with B5 (60:40 skill mix)	-40	
	B3 - Emerg Surgery	B4 NA Early M-F	-52	
	C2 - Gastro	B4 NA 24/7	-208	
	SGH ICU	HCA Night	-106	
	SGH & DPOW ICU	Increase headroom to 9 study days (in line with HUTH)	-44	
		Increase B7 to 5 days supernumerary	-54	
	SGH Stroke	B3 Care Navigator 5 days	-30	
	25 - Endo	B3 Care Navigator 5 days	-30	
	22 - Frailty	HCA Night	-109	
	16 - Frailty	B4 NA 24/7	-208	
	C6 - Frailty	HCA Night	-106	
Cost saving/ cost neutral	28 - Elective Surgery	HOBS - Replace RN 24/7 with HCA 24/7	0	37
	Goole NRC	Increase RN and reduce RSW LD if cost neutral	-21	(18 offset by C1)
	DPOW ICU	Remove 1 WTE B2 as not required 7 nights	0	106
	A1	Remove RN Night	0	121
	SGH Stroke	Move RN early to late 7 days - immediate	0	
			-1682	**264**

Ward manager time to lead to 2 days
12/12 at £3k per ward - NLAG

28	
29	
B7	
B3	
C2	
HDU	
ICU DPOW	
ICU SGH	
Goole - ward 6	
C1G	
5	
23	
A1	
C3	
Stroke SGH	
Stroke DPOW	
17	
25	
C5	
Amethyst	
22	
16	
Goole - 3	
C6	
B6	
27	
26 wards	**Total £78k**

As discussed, this is the first SNCT data for HUTH which has highlighted a gap and further work is required to quantify risks and prioritise recommendations for the Board.

RISK	WARD	RECOMMENDATION	COST	COST REDUCTION
Very high priority/ Immediate risk	C16 - H&N, Breast, Plastics	Increase RN M-Thur L, Sat L, Sun LD, night 7 days Increase HCA Sun LD, Mon- Fri Night	-300	
	H70 Rheum + GIM	HCA Night	-106	
	ED - ECA	2 x RN + 2 x B3 CSW 24/7 + B2 HCA 24/7	-1054	
	H100 - gastro	RN 24/7	-236	
	H6 - acute surgery	RN 24/7	-236	
	H60 - acute surgery	RN Early	-71	
		RN Night	-124	
	C14 UGI & Max Fac	RN Night	-124	
	C10 Colorectal	HCA Night	-106	
	C11	HCA Night Mon - Fri	-66	
	C27 - Cardiac	HCA Late and Night for HOBS	-152	

	Surgery			
	H39 - Cardiology	RN Night for SDEC beds (open since Nov 22)	-124	
	H7 - Vascular	HCA Night	-106	
	C30 - Oncology	B5 Tue for brachytherapy	-39	
		HCA LD 7 days	-93	
High	C31 - Onc inc H&N	HCA Night 7/7	-106	
	C32 - Onc - GI & CUP	HCA Night for 7 days	-106	
	H11 Stroke & Neuro	HCA 24/7	-196	
	H110 Stroke	HCA 24/7 for HASU	-196	
	H4 Neurosurgery	RN Night	-124	
	H10 Endo	HCA Night	-106	
	H70 Rheum + GIM	RN Night + HCA LD	-214	
	H37 RSU	RN 24/7	-236	
	H9 Frailty	HCA 24/7	-196	
	FAU	RN Night	-122	
	H80 Acute Frailty	RN LD (being used) and HCA 24/7	-310	
	H130W	HCA Night	-106	
	H130E	RN LD (E currently used) and HCA 24/7	-310	
	C9 - ortho & neuro	HCA Night	-106	
	H12 Trauma ortho	HCA 24/7	-196	
		B7 Ward Manager 2 days supernumerary time	-3	
	H120 Trauma ortho	RN late and HCA on night	-106	
	H20 - Woodland/PAU/PHD	Uplift B5 to B6 so B6 on duty 24/7 across floor	-11	
	C29 - Med Oncology	HCA Night	-106	
	C31 - Onc inc H&N	RN Late M-F -to extend coordinator role	-47	
	C32 - Onc - GI & CUP	RN Late M-F -to extend coordinator role	-47	
	C33 - Haem, TYA & transplant	Increase B6 to 24/7 cover - uplift B5	-60	
	FAU	RN LD	-114	
	H100 - gastro	HCA Night	-106	
	H6 - acute surgery	HCA Late	-46	
Moderate	H60 - acute surgery	RN Late	-56	
	C14 UGI & Max Fac	HCA Night	-106	
	C10 Colorectal	4th RN M-F	-45	
		Don't drop at W/e other than RN on Early	-19	
	C11	HCA LD Sunday	-58	
		HCA N Sat & Sun	-40	
	H39 - Cardiology	HCA Night for SDEC beds (open since Nov 22)	-106	
	H4 Neurosurgery	HCA Late	-46	
	H12 Trauma ortho	RN Late	-57	
	H120 Trauma ortho	HCA LD	-93	
Low	H30 - Gynae	B7 to 3 management days - B5 backfill	-9	
	HICU1&2	1 HCA 24/7	-196	
	CHH ICU	1 HCA Night 7/7	-106	
	H7 - Vascular	RN 24/7	-236	
	C29 - Med Oncology	RN Early Sat & Sun	-26	
	C30 - Oncology	Uplift B5 to B6	-11	
	C7 - IDU	Increase B7 supernumerary time to 3 days	-9	
	AMU	Add headroom to PDA posts	-20	

	H50 - Renal H11 Stroke & Neuro H20 - Woodland/PAU/PHD	Increased B6 coordinator cover to 7am - 8pm Mon-Fri HCA LD x 1 1 day management time for B6	-79 -93 -11	
Redutions/ cost neutral	C1 - Complex Rehab	Convert 3rd RN Early to B7 supernumerary for 5 days	0	18
To be reviewed	H60 H20 - Woodland/PAU/PHD H7 - Vascular	Budget B6 24 hours short to cover roster Establish unfunded HCA LD M-F B3 07.00-17.00hours for 4 days (3 years)	-72 -55 -29	
Potential Business Case Requirement	C15 Urology	The ward is funded non recurrently in 24/25 for 35 beds	TBC	

3.4 - CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Gill Ponder and Helen Wright, Non-Executive Director Committee Chairs

REFERENCES

Only PDFs are attached

BIC(24)239 - Capital & Major Projects Committees-in-Common Highlight Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24) 239

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 December 2024
Director Lead	Gill Ponder and Helen Wright, Capital and Major Projects CIC Chairs
Contact Officer / Author	Gill Ponder and Helen Wright, Capital and Major Projects CIC Chairs
Title of Report	Capital and Major Projects CIC Highlight Report
Executive Summary	This report sets out the items of business considered by the Capital and Major Projects Committees-in-Common at their meeting(s) held on 29 October 2024 and 26 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Any financial implications will be highlighted in the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

	12 December 2024
	Capital and Major Projects Committees in Common
	29 October 2024 and 26 November 2024
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Capital and Major Projects Committees-in-Common at their meeting(s) held on 29 October 2024 and 26 November 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:

- *Board Assurance Framework and Risk Register Report*
- *Group Capital Plan Funding and Delivery*
- *Review and evaluation of new Business Cases, Investments and Dis-Investments within Delegated Limits and/or endorsement for Trust Board Approval – Allam Building Internal Fit Phase 2*
- *Post Project Evaluation*
- *Capital Contract Approvals*
- *Humber Acute Services Review – including Key Risks*
- *Goole Hospital Options Appraisal (not included below as already discussed at Board Development)*
- *Community Diagnostic Centre Programme – including Key Risks*
- *Digital Plan Delivery – Including Key Risks*
- *Group Capital Committee Meeting Minutes*

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) Slippage of £16.5m on the Group Capital Programme was presented, mostly due to slippage on the CDC programme for reasons outside the Group's control, such as planning issues, unforeseen building complications and Procurement delays. Cabinet had reviewed capital schemes to be brought forward from the 2025/26 draft plan to offset the slippage from the 2024/25 plan, to create the headroom in funding in 2025/26 to complete the delayed works. The revised Capital Plan for 2024/25 and the draft 2025/26 Capital Plan were due to be received at the November 2024 Committee meeting; amendments to the 2024/25 plan were presented and it was confirmed that around £12m of the slippage would still be spent by the end of the year. Further details were requested on the remaining £4.5m and on the items being brought forward from the draft 2025/26 capital plan and those papers were circulated to Committee members after the meeting for further assurance. The CIC noted the underspend on the capital programme but were reasonably assured that plans were in place to ensure that the Group would not be underspent on Capital by year-end and that bringing items forward from the 2025/26 plan would result in there being sufficient headroom in the 2025/26 capital budget to complete all slipped schemes from 2023/24.

b) Business Case Endorsement – The Committees endorsed the Allam Building Internal Fit Phase 2 contract extension proposal for Board approval. There remains ongoing review to ensure activity within the building can be optmised, however the project requires completion. The 1st and 2nd floors in relation to Phase II have a clear purpose for accommodation and education.

c) The Committees received the first 2 Post Capital Project Evaluations, using the standard NHSE templates. The Committees felt that this was a significant step in the right direction to ensure that benefits projected in business cases were actually delivered and that lessons were learned to improve future programmes, but felt that there would be further benefits from the inclusion of more data and evidence to underpin the responses in each section in future evaluations. One of the key lessons learned was to be more realistic on timelines. The projects reviewed were in line with financial evaluation, however delays were noted. There is often pressures to meet specific completion deadlines that may not be realistic. It was agreed that these difficult conversations need to be held up front. Revenue plans are adversely impacted through continual delays.

d) Group HASR – Concerns raised about the programme by system partners were being dealt with by the local resolution process or direct referral to the Secretary of State. Planning for implementation could continue in parallel with these processes, but there might be a need to pause if the Secretary of State called in a programme due to any referrals. In the meantime, efforts were continuing with Local Authorities to find solutions to items raised including transport issues, which were one of the main concerns. A package of mitigations had been prepared for Cabinet and submission to a full North Lincolnshire Council meeting due to be held on 5 December. Nothing would be implemented until after that meeting had taken place.

e) Group Digital Plan – The Digital Strategy engagement programme is now complete and a report detailing feedback would be presented to Group Cabinet in December. The team had engaged with 600 members of staff regarding the digital service and how it could be improved and the main themes that had emerged were around the basic functionality of equipment, Lorenzo and WebV, plus the benefits of an EPR. The EPR outline business case is still with NHSE and the Treasury for approval. There is

still a £14.5m gap to close to enable the Group to obtain tender responses from suppliers in the mid financial range of the market.

Badgernet had been successfully implemented and the feedback had been positive. Work is ongoing to align patient led booking initiatives, contracts and processes across the Group by rolling out Dr Doctor across HUTH, followed by NLAG. This would improve patients' ability to manage their own appointments, whilst retaining the existing benefits from the current Patients Know Best system. The Uninterrupted Power Supply (UPS) had been installed for the Scunthorpe Data Centre and the EPRR team are revising Business Continuity plans and planning to test those plans with a table-top Group-wide Cyber Security exercise. The Windows 11 draft business case is complete and requires £2.5m capital and £500k in supporting costs, which could be covered by the existing capital budget and EPR funding. The business case would be presented to Group Cabinet in 2024/25.

In view of the level of grip and control over programmes, the CIC gave significant assurance and praised the longer-term vision and view of expenditure.

4.0 Matters on which the committees have requested additional assurance:

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

a) Group CDC – There were a number of key risks presented which included unforeseen build requirements, planning permission delays and delays to high voltage power and water connections. All of the CDCs are experiencing slippage and the revised expected dates for go live were now:

- Hull and East Riding would be 14/04/25
- Scunthorpe would be 02/12/24 (with MRI and CT still March 2025 as planned)
- Grimsby would be early January 2025 in a phased approach
- ERCH Phase 2 Ophthalmology end of March or beginning of April 2025

These delays had an impact on activity and would create a potential loss of income in 2024/25, but steps were being taken to mitigate this risk by carrying out additional work in alternative locations. The aim is to achieve the H2 revenue targets despite the delays.

There were further financial risks from a potential total CDC income loss to the ICB of £2.3m and the deficit from the mobile scanners which had been transferred to the HUTH Balance Sheet, but could not carry out the volume of work planned due to lost time setting up each time a scanner was moved to a new location. The CFO is pushing to ensure efforts are being undertaken to minimise this loss within the York & Scarborough trust.

As there were detailed mitigation plans for all risks, the Committees were assured. An assurance rating of Significant was considered, but the Committees agreed that the level would be Reasonable in view of the number of risks that were outside the Group's control. The Committees also requested a paper on the financial impact of the various risks and mitigations in place.

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

5.1 The new Board Assurance Framework was presented and the strategic risks relating to Digital and Strategic Capital Investment were discussed. The risk ratings agreed at the Board Development session in October 2024 were presented and there had been no changes since. The risk descriptions had been updated and the controls and gaps in controls were easier to view. Actions in place to address the gaps were also shown. The Committees liked the new format of the BAF, but would like to see the journey to get to a tolerable score for each strategic risk.
The high-level risk report was presented alongside the BAF. The Committees requested that this was tailored to each CiC, that mitigations for each risk were clearly included and that the impact of mitigations was clear by having a pre and post mitigation score for each high-level risk.

Both the BAF and the high level risk register were to be presented together on a quarterly basis in the future. The CIC workplan would be updated accordingly.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the matters for escalation in item 3.1 above.
- Approve the Allam Building Internal Fit Phase 2 contract extension

Helen Wright, Non-Executive Director/CIC Chair, HUTH

Gill Ponder, Non-Executive Director/CIC Chair, NLAG

26 November 2024

4 - GOVERNANCE & ASSURANCE

4.1 - BOARD ASSURANCE FRAMEWORK & STRATEGIC RISK REGISTER - NLAG & HUTH

David Sharif, Group Director of Assurance

REFERENCES

Only PDFs are attached

BIC(24)240 - Board Assurance Framework (BAF) & Strategic Risk Register - NLaG & HUTH.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Meeting name	Boards-in-Common
Meeting date	12 December 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Board Assurance Framework (BAF)
Executive Summary	The following report highlights the Q2 risk ratings for: • BAF risk 1 – Staff Support – Current risk score = 20 • BAF risk 2 – Performance – Current risk score = 20 • BAF risk 3 – Patients – Current risk score = 20 • BAF risk 4 – R&I – Current risk score = 12 • BAF risk 5 – Partnerships – Current risk score = 12 • BAF risk 6 – Digital – Current risk score = 16 • BAF risk 7 – Capital – Current risk score = 15 • BAF risk 8 – Financial Sustainability – Current risk score = 25

For these risks, both individually and in combination more generally for all strategic risks, robust management and oversight is required to preserve and nurture the Group's reputation and credibility for patients and broader stakeholders.

Executive leads have reviewed their risks' content following the October 2024 Boards-in-Common meeting. This work has given the content of the BAF a more strategic focus and enabled the assurance directorate to develop the BAF reporting providing colleagues access to a BAF dashboard via Teams. This approach enables colleagues to explore the BAF more dynamically, reviewing controls, assurances, risk appetites and actions across all risks.

To avoid duplication, the format of this report uses extracts from this BAF dashboard, whilst preserving all the sections from the prior format. We would welcome feedback on this format.

Recommendations:

The Boards-in-Common are asked to:

- Note and review the BAF risks
- Note that the risks have been recalibrated.
- Note the high-level Risks aligned to the BAF risks contained in this presentation.

Background information and/or Supporting Document(s) (if applicable)	Further on this agenda is the quarterly risk register report which provides further detail on the high-level risks and range of operational, in-year risks.	
Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each Committees-in-Common, with final receipt and approval agreed at the Board.	
Implications for equality, diversity and inclusion, including health inequalities	No immediate EDI Concerns	
Financial implication(s)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group	
Recommended action(s) required	☑ Approval	☑ Information
	☐ Discussion	☐ Review
	☐ Assurance	☐ Other

Board Assurance Framework
Boards-in-Common

Purpose of the report

The purpose of the report is to update the Boards-in-Common regarding the Group's strategic risks.

The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

Overleaf, a table summarises the current assessment for each risk:

- The risk description;
- The risk owner/s;
- The current risk score (and whether a change from the previous report);
- The target score (the maximum acceptable);
- The optimum score; and
- The risk appetite category.

The subsequent pages additionally set out, by each risk (over three pages each):

#1

- The strategic risk description;
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information).

#2

- The controls and assurances and their respective gaps

#3

- The actions being taken to mitigate the current gaps;
- An estimated completion date; and
- The lead officers involved.

Within the limitations of current systems, a list of high-level risks is provided relevant to these Committees-in-Common after the above details. Further on this agenda is the quarterly risk register report which provides further detail on the high-level risks' actions and mitigations and a range of further operational, in-year risks.

Board Assurance Framework
Current assessment

The table below summarises the current assessment for each risk.

The following pages provide further detail for each risk.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk
1	Staff support	WEC	We aim to support our staff. However, if we fail to embed a compassionate leadership and address poor working conditions, then a failure to act in the long-term and develop our leaders, will result in worsening retention rates and higher levels of disengagement from staff surveys.	Simon Nearney, Group Chief People Officer	20		07/10/24	Balanced	12	8
2	Performance	PEF	We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.	Clive Walsh, Group Chief Delivery Officer	20		23/10/24	Open	16	4
3	Patients	QS	We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.	Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse	20		09/10/24	Cautious	9	4
4	Research and innovation	QS	We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts.	Kate Wood, Group Chief Medical Officer	12		29/10/24	Balanced	12	4
5	Partnerships	TB	We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward-facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.	Jonathan Lofthouse, Group Chief Executive, Ivan McConnell, Group Chief Strategy & Partnerships Officer	12		06/11/24	Balanced	12	4

Board Assurance Framework
Current assessment

The table below summarises the current assessment for each risk.

The following pages provide further detail for each risk.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk
6	Digital	CAMP	We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.	Kate Wood, Group Chief Medical Officer	16		25/10/24	Open	9	6
7	Capital	CAMP	We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands and access issues for our patients.	Mark Brearley, Group Chief Financial Officer	15		23/10/24	Open	9	4
8	Financial sustainability	PEF	We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.	Mark Brearley, Group Chief Financial Officer	25		23/10/24	Open	15	9

Risk #1 – Staff Support

The tables below and opposite provides score

Strategic objective
Supporting our teams today

Strategic risk category	Current score
Staff support	20

Strategic risk

We aim to support our staff. However, if we fail to embed a compassionate leadership and address poor working conditions, then a failure to act in the long-term and develop our leaders, will result in worsening retention rates and higher levels of disengagement from staff surveys.

Committee

Workforce, Education and Culture

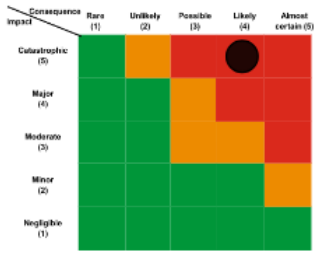
Lead

Simon Nearney, Group Chief People Officer

Last review date

Monday, October 07, 2024

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 8 (L:4, C:2)

Appetite statement

Our staff are the most important aspect is delivering safe, effective care and a good experience to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.

Control	Tier
Annual Care Group Workforce plans	1
CESR Programme	1
EDI Steering Group	2
Group Senior Management Team (was EMC) will receive escalation reports from the Group Workforce Transformation Committee	2
HR Directors Chairs meeting (NHS Employers)	2
HUTH People Strategy (2024 expiry)	1
International recruitment drives	1
Leadership Strategy	2
NLAG People Strategy (2024 expiry)	1
Required Learning Steering Group	2
Site IPR meetings	1
Talent management team for international recruitment	1
Workforce Transformation Committee	1

Assurance	Tier
Annual Safer Staffing Report	2
Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	2
Integrated Performance Report	1
Junior Doctor Rostering Internal Audit Report	2
Smart Cards Internal Audit Report	2
Workforce Report to HNY and Care Partnership ICB Workforce Board	2
Workforce Report to Pay and Agency meetings	2

Gaps in control (and Action ID)	5	6	7	8	Total
Hard to recruit roles in medical specialities	1	1	1		3
Healthcare Assistant issues, not enough grip and high turnover	1	1			2
Sufficient attraction, to recruit and retain staff to work in the area	1	1	1	1	4
Total	3	3	2	1	9

Assurance gaps (and Action ID)	5	6	7	Total
Consultant vacancy position		1	1	2
Frequent culture and staff experience measures			1	1
Plans to address ageing workforce profile	1			1
Total	1	1	2	4

ID	Action	Completion date	Update	Update date
5	Group People Strategy 2025-28 to be developed and launched 2025	01/01/25		08/10/24
6	Launch new recruitment drives using the Group name to attract high calibre candidates	31/10/24		08/10/24
7	Cultural Transformation action plan development	31/10/24		08/10/24
8	Group Leadership network and training programme - November 2024	30/11/24		08/10/24

Board Assurance Framework
Risk #2 - Performance

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Achieving upper quartile performance

Strategic risk category	Current score
Performance	20

Strategic risk

We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.

Control	Tier
Annual Winter Plan with clear safe escalation processes	1
Planned Care Board	1
Site IPR meetings	1
Urgent Care Board	1

Assurance	Tier
Integrated Performance Report	1
Planned Care Board reporting to Performance, Estates & Finance CiC	1
Urgent Care Board reporting to Performance, Estates & Finance CiC	1

Committee

Performance, Estates and Finance

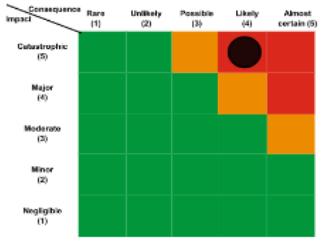
Lead

Clive Walsh, Group Chief Delivery Officer

Last review date

Wednesday, October 23, 2024

Current score and risk appetite (Open)



Tolerable score = 16 (L:4, C:4)

Optimal score = 4 (L:2, C:2)

Gaps in control (and Action ID)	19	20	21	28	31	Total
Absence of a comprehensive demand and capacity model		1				1
Data quality issues in supporting metrics					1	1
Lack of timely / realtime performance reporting (eg weekly dashboard)	1					1
Lack of trajectory setting to support robust performance management	1			1		2
Weak culture of improvement/change management			1			1
Total	**2**	**1**	**1**	**1**	**1**	**6**

Assurance gaps (and Action ID)	31	Total
Absence of routine data quality monitoring	1	1
Total	**1**	**1**

Appetite statement

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

ID	Action	Completion date	Update	Update date
19	Closer working with BI to produce performance reports			
20	Strategic Bed Review (based on optimum LoS)	30/06/25		
21	Embed QI Methodology	31/01/25		
28	Work being monitored via South and North Site Reviews (SS, OA2 - expected impacts from key actions in UEC improvement plan to KPIs (four hour performance, Doctor 1 Seen time, ambulance handover)and NS OA6 - FDS for cancers			
31	Delivery of BI investment and data quality strategy	31/05/25		

Board Assurance Framework
Risk #3 - Patients

The tables below and opposite provides score and further

Strategic objective
Listening to our patients and keeping them safe

Strategic risk category	Current score
Patients	20

Strategic risk

We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.

Committee

Quality and Safety

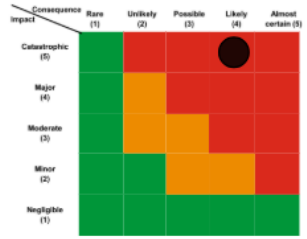
Lead

Amanda Stanford, Group Chief Nurse
Kate Wood, Group Chief Medical Officer

Last review date

Wednesday, October 09, 2024

Current score and risk appetite (Cautious)



Tolerable score = 9 (L:3, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement

Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.

Control	Tier
Accrediation Frameworks	1
Freedom to Speak Up Guardian	1
Incident Reporting culture	2
Infection Control Committee	2
Maternity and Neonatal Assurance Group	1
National Best Practice	1
National Guidance	1
Nurse Training and Education	1
Patient Experience and Learning	1
Patient Safety and Learning Group	2
Peer Review Process	2
Professional Standards - LNC	1
Quality Improvement Strategy	1
Risk and Compliance Group	1
Safe Staffing Models	1
Site IPR meetings	1
Statutory and Mandatory Training	1
Strategic Safeguarding Board	1

Assurance	Tier
Annual Safer Staffing Report	2
Complaint levels	1
CQC Action Plan	1
CQC findings and reports	1
Friends and Family Test reporting	1
Incident reporting	1
Integrated Performance Report	1
Maternity Neonatal Assurance Group	2
Ouputs from QI Programme	2
Risk Management metrics	1
Statutory and mandatory compliance levels	1
Ward accreditation metrics	1

Gaps in control (and Action ID)	12	13	14	15	16	30	To
Absence of Group Clinical Strategy						1	
Comprehensive safety culture	1	1		1			
Data quality issues in supporting metrics	1						
Lack of consistent basic hygiene compliance				1			
Low midwife establishment		1					
Maternity telephone triage					1		
Robust EQIA process			1				
Strong speak up and reporting culture				1			
Total	**2**	**2**	**1**	**3**	**1**	**1**	

Assurance gaps (and Action ID)	11	12	13	15	Total
Poor regulatory status		1	1		2
PSIRF Processes not embedded		1		1	2
Risk Management process not fully embedded	1				1
Total	**1**	**2**	**1**	**1**	5

ID	Action	Completion date	Update	Update date
11	Develop and publish Risk Management strategy	01/04/25		09/10/24
12	Develop and publish Quality and Safety Strategy	01/01/25	1st Draft	09/10/24
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/04/25	1st Draft	09/10/24
14	Embed EQIA process (outlined in six-month finance report for 2024-25)	01/04/25	PA Consulting support being explored	24/10/24
15	Develop and embed a Peer Review process	31/03/25		10/10/24
16	Reconfigure existing triage resources and devise options for provision across obstetrics and neonatal services	13/12/24		10/10/24
30	Develop and publish Clinical Services strategy	31/01/25	Obstetric, Paeds and Neonatal review to	01/11/24

Board Assurance Framework
Risk #4 – Research and Innovation

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Developing research and innovation capabilities

Strategic risk category	Current score
Research and innovation	12

Strategic risk

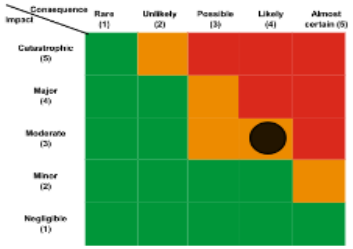
We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts.

Committee
Quality and Safety

Lead
Kate Wood, Group Chief Medical Officer

Last review date

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

Control	Tier
Available research service capacity eg labs	1
Business cases	2
Financial clarity over existing research resources	2
Innovation infrastructure	1
Protected time	1
Research and innovation strategy	1
Research Committee	1
Senior research team	1

Assurance	Tier
External agency reviews	1

Gaps in control (and Action ID)	29	Total
Lack of compelling research and innovation strategy	1	1
Lack of extensive collaboration and credibility	1	1
Total	2	2

Assurance gaps (and Action ID)	29	Total
Lack of available protected time for research and skilled resources to develop innovation	1	1
Total	1	1

ID	Action	Completion date	Update	Update date
29	Develop and publish research and innovation strategy	31/01/25	draft by end of November, Cabinet in December	29/10/24

Board Assurance Framework
Risk #5 - Partnerships

The tables below and opposite provides score and further

Strategic objective
Playing an active role in our health and care system

Strategic risk category	Current score
Partnerships	12

Strategic risk

We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward-facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.

Committee

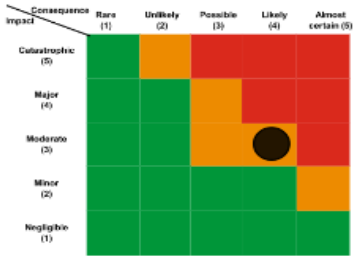
Lead

Ivan McConnell, Group Chief Strategy & Partnerships Officer
Jonathan Lofthouse, Group Chief Executive

Last review date

Wednesday, November 06, 2024

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

Control	Tier
Humber and North Yorkshire Collaboration of Acute Providers	1
Integrated Care Board	1
Place Boards	1

Assurance	Tier
Positive Task and finish participation	1

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	1	1
Inconsistent and shallow engagement across region	1	1
Lack of partnership strategy and identification of common opportunities and priorities	1	1
Variable quality of engagement with Place Boards	1	1
Total	**4**	**4**

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	1	1
Total	**1**	**1**

ID	Action	Completion date	Update	Update date
32	Develop and publish partnership strategy	31/12/24		

Board Assurance Framework
Risk #6 - Digital

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Developing our digital infrastructure

Strategic risk category	Current score
Digital	16

Strategic risk

We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.

Committee

Capital and Major Projects

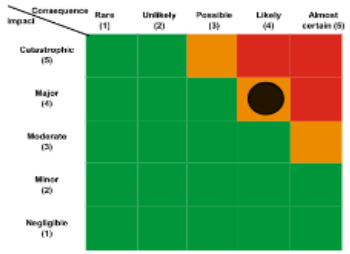
Lead

Kate Wood, Group Chief Medical Officer

Last review date

Friday, October 25, 2024

Current score and risk appetite (Open)



Tolerable score = 9 (L:3, C:3)

Optimal score = 6 (L:2, C:3)

Appetite statement

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

Control	Tier
Digital Strategy	1
EPR Business case	1
Executive digital governance	1
Financial management education for directors and budget holders	2
Financial Strategy	1
ICB Digital Governance	1
Long term Financial Model	1
Supplementary business cases eg DrDoctor, Electronic Document Management System	1

Assurance	Tier
Internal audit reviews eg arising from the National Cyber Security Centre's Cyber Assessment Framework (CAF) and the Data Security and Protection Toolkit	1
Self-assessment of CAF	2

Gaps in control (and Action ID)	25	Total
Lack of comprehensive oversight of all digital investment and management	1	1
Weak commercial and contractual grip and control	1	1
Total	**2**	**2**

Assurance gaps (and Action ID)	25	26	Total
Gaps in financial tracking and funding	1		1
Lack of technical expertise from the Board		1	1
Total	**1**	**1**	**2**

ID	Action	Completion date	Update	Update date
25	Produce and publish Digital Strategy - covering governance, staffing, resourcing, and engagement necessary to achieve objectives	31/01/25	draft to be presented to CEO at Cabinet by December	25/10/24
26	Board development programme and use of external expertise	31/12/25		

Board Assurance Framework
Risk #7 - Capital

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Using major capital effectively

Strategic risk category	Current score
Capital	15

Strategic risk

We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands and access issues for our patients.

Committee

Capital and Major Projects

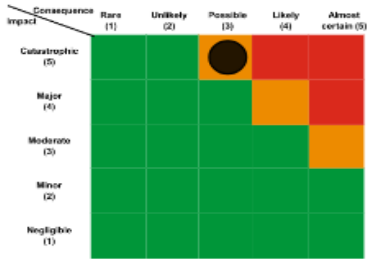
Lead

Mark Brearley, Group Chief Financial Officer

Last review date

Wednesday, October 23, 2024

Current score and risk appetite (Open)



Tolerable score = 9 (L:3, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

Control	Tier
Business cases	2
Effective E&F governance structures	1
Effective management of operational estates risks	1
Financial management education for directors and budget holders	2
Financial Strategy	1
Long term Financial Model	1
Qualified and accreditated engineers	1
Regulatory frameworks	1

Assurance	Tier
Compliance outcomes from regulators	1
Riddor performance	2
Status of operational estates risks and actions from risk register	1

Gaps in control (and Action ID)	24	Total
Absence of comprehensive Estates Strategy	1	1
Total	**1**	**1**

Assurance gaps (and Action ID)	Total
Total	

ID	Action	Completion date	Update	Update date
24	Develop Group estates strategy	28/02/25		

Board Assurance Framework
Risk #8 – Financial Sustainability

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Achieving financial sustainability

Strategic risk category	Current score
Financial sustainability	25

Strategic risk

We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.

Committee

Performance, Estates and Finance

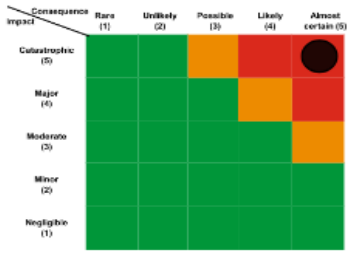
Lead

Mark Brearley, Group Chief Financial Officer

Last review date

Wednesday, October 23, 2024

Current score and risk appetite (Open)



Tolerable score = 15 (L:3, C:5)

Optimal score = 9 (L:3, C:3)

Appetite statement

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

Control	Tier
Board capability and education	2
Budgetary control system	2
Business cases	2
Cash management controls	2
Cost Improvement Programme	1
Financial management education for directors and budget holders	2
Financial Planning Improvement Board	2
Financial Strategy	1
High functioning Finance department advice and guidance	2
ICS finance model	3
Long term Financial Model	1

Assurance	Tier
Budget control reports	1
Exception reporting on Standing Financial Instructions and Standing Orders compliance	2
Internal audit review of key financial systems	1
In-year operational plan progress	2

Gaps in control (and Action ID)	22	23	Total
Absence of Group Finance Strategy founded on clinical and estates strategies		1	1
Out of date Long Term Financial Model	1		1
Total	1	1	2

Assurance gaps (and Action ID)	Total
Total	

ID	Action	Completion date	Update	Update date
22	Develop five-year long term financial model	31/03/25		23/10/24
23	Develop comprehensive finance strategy	31/03/25		23/10/24

Board Assurance Framework
High-level risks

Any high-level risks being captured in Datix and Ulysses from across the Group would be highlighted here. There are no current high level risks linked to Partnerships.

Risk ID	Risk Opened Date	Corporate Function/Care Group	Risk Handler	Risk Title	Risk Rate Score
3217	29/06/23	Specialist Cancer And Support Services	Ruth Kent	Breast Imaging workforce depletion	20
3325	25/04/24	Family Services	Vijayalakshmi Hebbar	Delays in Children being reviewed in Cardiac Clinic	20
3983	29/06/21	Specialist Cancer And Support Services	Colley, Mr Peter	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	20
4032	21/12/21	Specialist Cancer And Support Services	Colley, Mr Peter	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	20
2244	20/06/17	Cancer Network	Neil Rogers	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	16
2245	20/06/17	Specialist Surgery	Greg Haire	Risk to Overall Performance : Non compliance with RTT incomplete target	16
2592	17/09/19	Specialist Surgery	Greg Haire	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	16
2898	30/03/21	Acute And Emergency Medicine	Victoria Marshall	Medical Staff - Mandatory Training Compliance	16
3808	02/12/20	HUTH Improvement Programme - Corporate Functions	Krstenic, Mrs Wendy	CDB TSSNSI: Time limited, externally funded posts	16
3810	02/12/20	HUTH Improvement Programme - Corporate Functions	Krstenic, Mrs Wendy	CDB TSSNSI: Staffing Resource	16
3840	11/12/20	HUTH Improvement Programme - Corporate Functions	Dyble, Mrs Debra	CDB NOP MDT: Future investment	16
3842	11/12/20	HUTH Improvement Programme - Corporate Functions	Dyble, Mrs Debra	CDB NOP MDT: Inadequate Local Resource	16
3918	03/03/21	Acute And Emergency Medicine	Weerasekera, Dr Chaminda	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	16
3919	03/03/21	Digital Services	Faruqi, DR		16
4130	23/11/22	Specialist			
4148	30/11/22				
4343					

Board Assurance Framework
Next steps and recommendations

Next steps

Each CiC will receive a quarterly update on the BAF for review and approval.

The management of the high-level risks will continue to be assessed through the Care Groups, the Risk and Compliance Group and the escalation processes in place.

The Executive Team will continue to review their strategic risks between CICs and the Group Cabinet Risk and Assurance Committee will recommend any changes to risk ratings or BAF risks to the CICs. Final decisions will be made at the Boards-in-Common.

Recommendations

The Boards-in-Common are asked to:

- Note and review the BAF risks.
- Note that the risks have been recalibrated.
- Note that this strategic risk relating to Partnerships has not been presented or reviewed by any of the CICs.

5 - OTHER ITEMS FOR APPROVAL

5.1 - EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) REGULATORY REPORT

Clive Walsh, Interim Site Chief Executive (North Bank)

REFERENCES

Only PDFs are attached

BIC(24)241 - Emergency Preparedness, Resilience & Response Regulatory Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)241

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th December 2024
Director Lead	Clive Walsh, Interim Group Chief Delivery Officer
Contact Officer / Author	Matt Overton, Group Operations Director (EPRR)
Title of Report	Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report 2024
Executive Summary	The Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report is a new combined report which encompasses the previous annual compliance report with the NHS England Core Standards for EPRR and the previous Annual Report for EPRR. The 2024/25 NHS England Core Standards for EPRR self-assessment assurance process has been progressed in line with the national timeline and has included an ICB acute provider peer review process, ICB review of evidence submitted, ICB to Trust Accountable Emergency Officer review, and final scrutiny at the H&NY Local Health Resilience Partnership on 19th November 2024. The results for each Trust for 2024/25 are: **NLAG** Self-Assessment Assurance Rating: Substantially Compliant; Percentage Compliance: 90% Number of core standards applicable: 62; Fully compliant: 56; Partially compliant: 6; Non-compliant: 0 This is an increase for NLAG from last year's compliance of 40% to 90%. **HUTH** Self-Assessment Assurance Rating: Non-compliant; Percentage Compliance: 69% Number of core standards applicable: 62; Fully compliant: 43; Partially compliant: 19; Non-compliant: 0 This is an increase for HUTH from last year's compliance of 18% to 69%. There are action plans in place for the partially compliant core standards for each Trust and the governance oversight of these is included within the report. All five of the EPRR Team objectives for 2024/25 have been

	achieved or are in progress and on track to be delivered by the end of March 2025. Four of the five requirements for exercising have been fully met with one partially met with plans to address. The report includes a breakdown of the progress made on meeting the training requirements within the NHS England Minimum Occupational Standards for EPRR and the collaborative working with multi-agency partners through training and exercising. The Trust Boards in Common is asked to: • Approve NLAG's Statement of Compliance for the NHS England Core Standards for EPRR 2024/25 (Appendix A) • Approve HUTH's Statement of Compliance for the NHS England Core Standards for EPRR 2024/25 (Appendix B) • Note the assurance on EPRR arrangements in place to meet our regulatory requirements for exercising (Section 7.1) • Note the current top EPRR risks identified by the Local Health Resilience Partnership (Section 10) • Note the incidents that have taken place during the reporting period and the ongoing assurance of Medical Oxygen Delivery Systems and Monitoring for NLAG (Section 11)
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Emergency Preparedness, Resilience and Response Board
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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Group Chief Delivery Officer

Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report 2024

Report Date:	11th November 2024 (Updated 26th November 2024)
Version:	1.1
Number of Pages:	29
Report Author:	Matt Overton, Group Operations Director (EPRR)
Executive:	Clive Walsh, Interim Group Chief Delivery Officer (Accountable Emergency Officer)

1.0 Purpose of Report

The Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report is a new combined report which encompasses the previous annual compliance report with the NHS England Core Standards for EPRR and the previous Annual Report for EPRR (detailing a summary of the planning, training, exercising and collaborative working that has taken place).

It will include both Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) detailing the specific core standards compliance for each Trust as they are required to be assessed and submitted separately as individual legal entities to the Integrated Care Board (ICB) and NHS England.

This Regulatory Report cover the reporting period of 1st November 2023 to 31st October 2024 and the compliance statement for 2024/25 core standards to be approved by the Trust Boards in Common in December 2024. Some content within this report may be duplicated from the most recent discontinued Annual Report for EPRR as the reporting periods overlap in transition to the new reporting format.

2.0 Background

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Social Care Act 2022. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

HUTH and NLAG are both classed as Category One responders under the Civil Contingencies Act 2004. As a Category One responder there is a statuary duty for each organisation to:

- Assess risks
- Plan for emergencies
- Undertake business continuity management
- Warn, inform and advise the public
- Cooperate with partner agencies
- Share Information with partner agencies

2.0 NHS England Core Standards for EPRR

2.1 Last Year's 2023/24 NHS England Core Standards for EPRR

NHS England has a responsibility to gain assurance on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to delivery critical services.

This is achieved through the EPRR Annual Assurance process which assesses each NHS provider's current compliance against the NHS England Core Standards for EPRR. NLAG and HUTH are required to submit separate submissions as they are individual legal entities.

Each year the NHS England Core Standards for EPRR are reviewed and revised by the national team prior to circulation to commence the assurance process. Last year (2023/24) there was a significant change to the assurance process for the North East Region. Trusts were required to complete a self-assessment against the updated core standards for 2023/24, including an expanded set of additional compliance requirements provided in an 82-page pack. Alongside the completion of the self-assessment Trusts were required to upload all documentation as evidence cross-referenced to each core standard. For NLAG alone this involved uploading and cross-referencing 3,450+ pages of evidence across 220 individual documents.

NHS England and independent ICB colleagues then reviewed the uploaded evidence against the self-assessment compliance ratings as part of a check and challenge process and provided back a list of challenges with Trusts given a five working day deadline to review these challenges and provide further additional evidence or accept the revised compliance ratings.

At the end of October 2023 each Trust received the final outcomes of the check and challenge process from NHS England and the annual assurance process concluded with each Trust's Statement of Compliance for 2023/24 being presented to the Trust Board in December 2023. For HUTH, this resulted in an overall rating of non-compliant with 18% of the core standards graded as fully compliant. For NLAG, this resulted in an overall rating of non-compliant with 40% of the core standards graded as fully compliant. For context, all NHS providers within our ICB experienced significant compliance reductions as part of last year's assurance process, with NLAG's 40% the highest provider compliance rating against the new process.

NHS England acknowledged the reduction in compliance ratings experienced by all NHS providers within the North East, including HNY ICB, and stated it recognised that Boards may be concerned by the reduction in compliance ratings, however, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

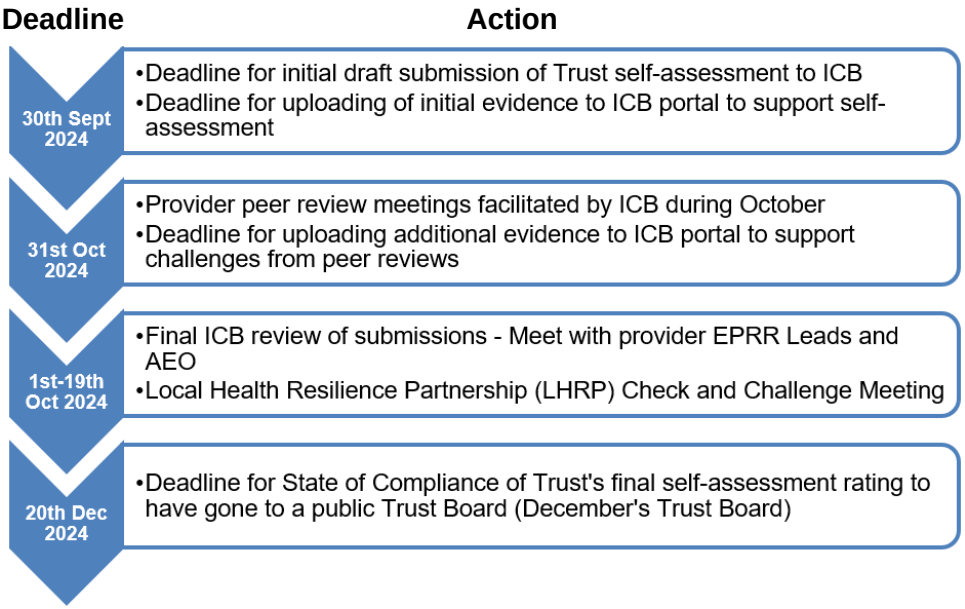
Action plans were developed to improve compliance across all organisations, and a regional planning group was established by the ICB to support a collaborative approach to improvement and sharing of best practice.

2.2 2024/25 NHS England Core Standards for EPRR

The NHS England Core Standards for EPRR 2024/25 Assurance process commenced in July 2024 with the EPRR Team reviewing the new core standards, collating evidence, and populating the self-assessment spreadsheet. For this year, the North East Region is moving towards re-aligning with the national approach, and as such has implemented a reduced evidence workload for 2024/25.

The ICB has still completed a detailed check and challenge of the Trusts' self-assessment submission, alongside provider peer reviews, but each Trust was only required to upload evidence for core standards that were assessed as partially or non-compliant during last year's assurance process. This has reduced the quantity and burden of evidence cross-referencing and uploading to the online portal without losing the external critique and challenge.

The timeline for this year's assurance cycle is displayed below, including the various check and challenge steps and concludes with the Statement of Compliance being presented to the Trust Boards in Common for approval by the deadline of 20th December 2024.



There are a total of 62 applicable core standards that HUTH and NLAG were assessed against. Each core standard was assessed against the expanded requirements and rated as either 'Fully Compliant', 'Partially Compliant', or 'Non-Compliant'. Only core standards assessed as fully compliant contribute towards the Trust's overall compliance rating.

NLAG			
Self Assessment Assurance Rating:	Substantially Compliant	Percentage Compliance:	90%
Number of core standards applicable	Fully compliant	Partially compliant	Non compliant
62	56	6	0

HUTH			
Self Assessment Assurance Rating:	Non-compliant	Percentage Compliance:	69%
Number of core standards applicable	Fully compliant	Partially compliant	Non compliant
62	43	19	0

The assurance rating thresholds for the overall compliance rating are:

- Fully Compliant = 100%
- Substantially Compliant = 89-99%
- Partially Compliant = 77-88%
- Non-compliant = 76% or less

Although there were no core standards identified as non-compliant in either Trust, partially compliant core standards do not count towards the overall compliance rating. For this reason, NLAG received an overall compliance rating of 90% while HUTH received an overall compliance rating of 69%.

This is a significant improvement for both Trusts compared to last year's overall compliance ratings (HUTH = 18%, NLAG = 40%) and exceeds the EPRR strategic objective for 2024 to improvement compliance by at least 20% per Trust. The improvements seen for NLAG and HUTH are greater than other provider's within our ICB and the EPRR Team will continue to share our best practice with other providers in support of collaborative working. The table below shows a breakdown of the core standards compliance split by domain area for last year (2023/24) versus this year (2024/25).

NLAG							
Core Standards by Domain	Total Standards Applicable	2023/24			2024/25		
		Fully Compliant	Partially Compliant	Non Compliant	Fully Compliant	Partially Compliant	Non Compliant
Governance	6	3	3	0	6	0	0
Duty to risk assess	2	1	1	0	1	1	0
Duty to maintain plans	11	3	8	0	8	3	0
Command and control	2	1	1	0	2	0	0
Training and exercising	4	1	3	0	4	0	0
Response	7	6	1	0	7	0	0
Warning and informing	4	1	3	0	4	0	0
Cooperation	4	3	1	0	4	0	0
Business continuity	10	3	7	0	8	2	0
Hazmat / CBRN	12	3	9	0	12	0	0
TOTAL	62	25	37	0	56	6	0

HUTH							
Core Standards by Domain	Total Standards Applicable	2023/24			2024/25		
		Fully Compliant	Partially Compliant	Non Compliant	Fully Compliant	Partially Compliant	Non Compliant
Governance	6	1	5	0	6	0	0
Duty to risk assess	2	0	2	0	2	0	0
Duty to maintain plans	11	2	9	0	7	4	0
Command and control	2	1	1	0	2	0	0
Training and exercising	4	1	3	0	4	0	0
Response	7	1	6	0	5	2	0
Warning and informing	4	0	4	0	4	0	0
Cooperation	4	1	3	0	4	0	0
Business continuity	10	1	9	0	5	5	0
Hazmat / CBRN	12	3	9	0	4	8	0
TOTAL	62	11	51	0	43	19	0

2.3 Improvement in Compliance

Each Trust has made significant progress and improvements against last year's action plans.

These improvements were achieved through the review and revision of multiple plans and policies, a new EPRR work programme and training needs analysis, and improving the capturing of evidence of the collaborative work we do with partner agencies. This work included:

- New EPRR Work Programme encompassing the additions of a central location for capturing action plans, lessons learned from exercise and incidents alongside the work plan and training schedule
- EPRR Policy updated
- Full and Partial Evacuation Plan updated
- Lockdown Plan reviewed and tested through an exercise
- New Excess Fatalities Plan developed
- EPRR Communications Plan updated
- NLAG's Business Continuity Policy updated
- CBRNe/HAZMAT Plan updated
- Adverse Weather Plan updated
- Attendance and participation at multiple multi-agency exercises
- Delivery of exercises (table top, workshop and live)
- Launch of the new Health Commander Portfolios (Strategic, Tactical and EPRR Specialist Advisors)
- New Training Needs Analysis (TNA) covering the latest Minimum Occupational Standards for EPRR
- New process for capturing evidence of collaborative working and engagement with partner agencies for emergency plan development and consultation

The NLAG action plan for the partially compliant core standards from last year's assessment was progressed with actions for five remaining core standards still in progress. This resulted in an update report to Audit, Risk and Governance Committees-in-Common in October 2024 of 91.9% compliance against last year's core standards action plan. This is in line with this year's self-assessment with the remaining actions carrying over to this year's action plan in addition to newly identified actions from this year's self-assessment and ICB feedback.

The HUTH action plan for the partially compliant core standards from last year's assessment was progressed with actions for nine remaining core standards still in progress. This resulted in an update report to Audit, Risk and Governance Committees-in-Common in October 2024 of 85.5% compliance against last year's core standards action plan. However, during this year's self-assessment there are additional gaps in compliance which have been identified, predominantly against the Hazmat / CBRN domain where only partial compliance could be achieved. These additional gaps have been identified through the lessons learned from the live CBRN exercise held during 2024 and the external CBRN audit carried out by Yorkshire Ambulance Service (YAS) with areas for improvement highlighted in their recent report.

While significant progress was made against these action plans, the EPRR Team has been challenged by the multitude of internal and external incidents and operational planning, not least the unprecedented number of industrial action periods that have taken place over the past 17 months. Reviewing and revising of emergency plans is also more complex due to harmonisation of approaches from two separate Trusts into single Group-wide documents, extending the time it takes to review each plan / process. Any outstanding actions from the 2023/24 action plans have been carried over into the 2024/25 action plans, as the latest revised core standards self-assessment supersedes the previous years.

2.4 Oversight of Core Standards Action Plans

Any core standards assessed as partially compliant have an identified action to turn them compliant within the next 12 months. These required actions are included in the Core Standards Action Plan for 2024/25 for each Trust (Appendix C for NLAG and Appendix D for HUTH).

The ICB established a provider collaborative working group last year that met each month to focus on a different domain of the core standards. This meeting was also used by the ICB as their progress review mechanism for oversight of progress being made against the submitted action plans. It is expected that the ICB will take the same approach for oversight of this year's provider action plans. There are themes of partial compliance against certain core standards which require a collaborative approach to resolve (e.g. mass casualty planning across the ICB) and HHP has actively engaged with partner organisations on addressing these which remain work in progress.

NLAG and HUTH have also benefited from the roll out of a joint EPRR Team as part of the new operational group structure which has enabled shared learning and joint development / review of plans. While this has improved the team's ability to share best practice and improve our plans, it also means that the reviewing of each plan takes longer as we harmonise two separate plans and approaches into one new joint consistent approach.

The below table displays the governance oversight of the action plans.

Meeting	Oversight	Frequency
EPRR Group	Group-wide monthly meeting that has operational oversight of the detailed progress of the action plans	Monthly
EPRR Board	Group-wide meeting chaired by the Group Chief Delivery Officer with strategic oversight of the completion of the action plans	Quarterly
ICB Progress Review Meeting	ICB-chaired collaborative working group used to monitor progress against each provider's action plan	Monthly
Audit, Risk and Governance Committees-in-Common	A Regulatory Report submitted each year aligned to the national submission requirements, supported by a six-monthly progress report (newly established going forward)	Six Monthly

2.5 Deep Dive Subject for 2023/24 Core Standards

Each year alongside the main NHS England Core Standards for EPRR self-assessment process there is also a national deep dive subject. This year's deep dive subject was cyber security and IT related response. The deep dive subject is not incorporated into the same check and challenge process as with the main core standards but is a solely self-assessment process.
The Trusts reviewed the eleven standards within this deep dive and rated ten of the standards as fully compliant and one as partially compliant. The one partially compliant standard relates to cyber security and IT related incident response roles being included in the organisation's training needs analysis. The action to address this is included in each Trust's Core Standards Action Plan.

3.0 EPRR Audits

3.1 Annual CBRN Preparedness Audit

As part of the annual EPRR assurance cycle and in line with NHS England contractual standards to support the EPRR Framework, Ambulance Trusts conduct audits on Acute Trust's Chemical, Biological, Radiological and Nuclear (CBRN) preparedness. The audit encompasses emergency plans and procedures in place, specialist training provided by the Trust to staff, and maintenance of equipment.

East Midlands Ambulance Service (EMAS) conducted the audit at DPOWH and SGH in March 2024 with the report provided in August 2024. The report raised no concerns in planning or preparedness. The report advised minor estates work to the decontamination room doors and suggested additions to widen the training needs analysis scope.

Yorkshire Ambulance Service (YAS) undertook the audit at HRI in August 2024 with the report provided in September 2024. The report raised multiple concerns regarding the ED's planning and preparedness against each of the CBRN core standards. The report provided a breakdown of assessed compliance against each CBRN element and is reflected within the self-assessment compliance against the relevant CBRN core standards. The recommendations highlighted in the report have been integrated into the existing HRI CBRN action plan.

3.2 Internal Audit of EPRR Arrangements

As part of a three yearly internal audit process, contracted external audit companies have completed the in-depth internal audit reviews at both NLAG and HUTH within the required timeframes and formal reports have been received providing the following assurance:

Trust	Audit	Assessor	Date of Last Audit Report	Assurance Rating
NLAG	EPRR Arrangements	Audit Yorkshire	October 2022	Significant Assurance
HUTH	Business Continuity and EPRR Arrangements	RSM UK Risk Assurance Services	October 2023	Substantial Assurance

4.0 EPRR Strategic Objectives

The EPRR Team has a set of strategic objectives for each year which are aligned to the team's three year strategic strategy.

The EPRR Team objectives for 2024/25 is displayed below:

EPRR Team Objectives 2024/25

Strategic Intent
To develop, implement, promote and maintain plans, procedures, training and exercising in order to ensure compliance with the Trust's obligations under the Civil Contingencies Act 2004, NHS England, CQC and other performance management standards at local, regional and national levels.

NHS England Core Standards

To increase the overall compliance with the NHS England Core Standards for EPRR by at least 20% for each Trust during the 2024 assurance cycle

EPRR Team Structure

To complete a restructure of the EPRR Team to fully integrate the previous North Bank and South Bank EPRR Teams into one high performing and resilient team

Health Commander Training

To launch the new Health Commander portfolio structure across the Group, including a compliance and governance mechanism

Principle EPRR Plans

To review, revise and implement an integrated approach across the new Group structure for the principle EPRR plans: EPRR Policy, Major Incident Plan, and the Incident Coordination Centre Standard Operating Procedures

Live Exercises

To deliver a live exercise on the North Bank and South Bank during 2024/25 that tests and validates an emergency plan and provides a practical training opportunity for relevant staff

All five of the strategic objectives for this current financial year have been achieved or are in progress and on track to be delivered by the end of March 2025. Updates covering the five objectives are covered within this report.

5.0 EPRR Governance

As part of the transition to the new HHP group structure, the EPRR governance structure has been fully reviewed and relaunched. From April 2024 the new EPRR governance structure commenced, with a further amendment from August 2024 changing the reporting line from Performance, Estates and Finance Committee-in-Common to the Audit, Risk and Governance Committee-in-Common.

The current EPRR governance structure is displayed below:

The EPRR Group is responsible for the development, implementation, promotion and maintenance of plans, procedures, training and exercising to deliver the EPRR Work Programme. The EPRR Group will ensure that all relevant information is shared with Care Groups for inclusion in emergency plans, supplementary documents and business continuity plans. The EPRR Group is chaired by the Group Operations Director, meets monthly and formally reports to the EPRR Board.

The EPRR Board provides oversight and assurance of the development, implementation, promotion and maintenance of plans, procedures, training and exercising in order to ensure compliance with each Trusts obligations. The EPRR Board is chaired by the Group Chief Delivery Officer (Accountable Emergency Officer), meets quarterly and formally reports to the Group Executive Cabinet and for assurance to the Audit, Risk and Governance Committees-in-Common.

6.0 EPRR Team

As part of the transition to the new HPP Group structure, the NLAG EPRR Team and HUTH EPRR Team started to work more closely from December 2023. The Group Operations Director for Emergency Planning, Business Continuity, Discharge and Flow started to provide strategic leadership across both EPRR Teams reporting directly to the Group Chief Delivery Officer, who is the designated Accountable Emergency Officer for both Trusts.

An integration plan commenced to start bringing the working practices and planning approaches into line between both Trusts. This included the launch of a single shared EPRR mailbox and communication links, consistent approach to issuing of weather alerts, heatwave alerts, NHS notifications and the review and relaunch of the EPRR governance across the HHP.

A systematic review of each Trust's emergency plans is underway, starting with the core principle plans such as the EPRR Policy, the Incident Coordination Centre Standard Operating Procedures, and the Major Incident Plans, before progressing across all emergency plans to synchronise how the organisations plan for, and respond to, emergencies.

One of this year's strategic objectives for the EPRR Team is to complete a restructure of the EPRR Team to fully integrate into a single team structure, providing clarity and parity of roles and responsibilities across both Trusts. This will provide the same level of support and expertise across both North Bank and South Bank. The formal consultation period commenced on 5th November 2024 and has an expected implementation date of the new structure in January 2025.

All existing posts within the EPRR Team are substantively filled, however, there has been a significant period of long-term sickness (11 months and remains ongoing) within the team that has negatively impacted on the team's capacity and work programme, particularly on the pace of the business continuity refresh and relaunch.

As part of the EPRR Team's continuous professional development the team has engaged in a mix of training, workshops, and evaluating/observing partner agency exercises. The team regularly attends EPRR meetings at local, regional and national level, including engagement with the National Performance Advisory Group EPRR Network. Some members of the team are currently undertaking formal qualifications such as the Diploma in Health EPRR and the Level 7 Senior Leader Apprenticeship. In addition to the above, the requirement for all EPRR Specialist Advisors to maintain a Portfolio of evidence to demonstrate compliance with the national minimum occupational standards for EPRR was implemented in April 2024 which details the mandatory and optionally recommended training to be undertaken. This portfolio applies to three members of the EPRR Team and is covered within section 7.3 of this report.

7.0 Exercising, Training and Collaborative Working

7.1 Exercises

As Category One responders, both HUTH and NLAG must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agency plans.

The NHS EPRR Framework 2022 provides the minimum exercising requirements that NHS providers must adhere with to meet their obligations under the Civil Contingencies Act 2004 and associated guidance. The table below shows the exercise frequency requirement and the exercises undertaken by HHP. It should be noted that if an organisation activates its plan for response to a live incident, this replaces the need to run an exercise, providing lessons are identified and logged as part of a post-incident debrief.

Exercise Type	Required Frequency	Exercises (Lead Facilitator)	Compliance
Communications systems exercise (Test the organisation's ability to contact key staff and other NHS and partner organisations 24/7)	Every six months	• 25/09/2023 – Out of hours Major Incident Cascade Test • 28/11/2023 – In hours Major Incident Cascade Test • 31/01/2024 – Exercise Buckthorn: Media Centre • 18/05/2024 – Exercise Virgo: Live CBRN exercise at HRI ED including out of hours incident cascade test • 02/08/2024 – In hours Major Incident Cascade Test	Requirement Fully Met
Table top exercise (Bring together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. They work through a scenario and can help validate a new or revised plan	Every 12 months	• 01/11/2023 – Major incident table top exercise (NLAG) • 09/11/2023 – Exercise Pickle: Loss of utilities (HUTH) • 14/11/2023 – Exercise Blackthorn: Loss of catering supplies (HUTH) • 20/11/2023 – Exercise Ash: ICU loss of staffing (HUTH) • 12/12/2023 – Exercise Box: Cardiology evacuation (HUTH) • 09/04/2024 – HNY Vulnerable Persons exercise (ICB) • 06/09/2024 – ICS Cyber Security Exercise (ICB/NHSE) • 09/09/2024 – Humber Nitazene Preparedness Plan Workshop (Humber LRF) • 23/09/2024 – Humberside Airport Port Health Exercise (UKHSA) • 01/10/2024 – Escalation and Surge Workshop (HHP)	Requirement Fully Met
Live play exercise (Live test of arrangements and includes the operational and practical elements of an incident response: for example, simulated casualties being brought to an emergency department)	Every three years	• 18/05/2024 – Exercise Virgo: Live CBRN exercise at HRI ED (HHP) • 20/06/2024 – Live lockdown exercise of Family Services at DPOWH (HHP) • 26/09/2024 – Exercise Chile:	Requirement Fully Met

		Live HAZMAT exercise at SGH ED	
Command post exercise (The command post exercise tests the operational element of command and control and requires the setting up of the incident coordination centre (ICC))	Every three years	• 13/03/2023 – Junior Doctor industrial action with physical ICC setup (4 days) • 11/04/2023 - Junior Doctor industrial action with physical ICC setup (5 days) • 14/06/2023 - Junior Doctor industrial action with physical ICC setup (3 days) • 18/05/2024 – Exercise Virgo: Live CBRN exercise at HRI ED (HHP) including physical ICC setup	Requirement Fully Met
ICC equipment test (The functionality of equipment used in an ICC must be tested)	Every three months	• 04/12/2023 – CHH ICC • 08/01/2024 – HRI ICC • 10/05/2024 – SGH ICC • 30/05/2024 – DPOWH ICC • 21/05/2024 – HRI ICC • 31/05/2024 – HRI ICC • 05/06/2024 – CHH ICC • 18/07/2024 – HRI ICC • 19/07/2024 – CHH ICC • 26/09/2024 – SGH ICC • 31/10/2024 – SGH ICC	Requirement Partially Met

The gaps in ICC equipment testing are now incorporated into an exercise schedule table of required dates as part of the EPRR Work Programme which is used through the EPRR Team meetings to ensure these are undertaken on time and will be reported to the EPRR Group for monitoring.

ED Staff in Powered Respiratory Protective Suits (PRPS) as part of the live HAZMAT exercise at SGH

ED Staff decontaminating a non-ambulant dummy patient as part of the live CBRN exercise at HRI

NHS England wrote to all ICBs and Trusts in August 2024 regarding their intentions to reinvigorate the National Exercise Programme through a seven-year exercise programme covering 2024 to 2030. Their intention is that the programme will enable routine, systematic testing in a coordinated manner across the NHS creating a more holistic learning environment. They will set seven exercise themes for NHS organisations to exercise in turn on a yearly basis:

- Casualty and mass casualty
- HAZMAT and CBRN
- Business continuity
- Cyber and digital
- Infectious disease and pandemics
- Adverse weather
- Security, shelter and evacuation

NHS organisations, including ICBs, and NHS England regions will need to work together to plan, exercise and report on their capabilities within each theme, with consideration of their risk profiles and exercise requirements. NHS England will be publishing further details on the roll out of this new exercising programme structure alongside launching a space on the FutureNHS platform for NHS organisations to share post-exercise reports and resources.

7.2 Collaborative Working with Partner Agencies

A critical part of the EPRR Team's work programme is the engagement in collaborative working with partner agencies, both NHS and wider, in the development of plans, training and exercising.

HHP is represented by the EPRR Team at the Humber Local Resilience Forum (LRF) and the HNY Local Health Resilience Partnership (LHRP), as well as associated sub-groups. HHP participates in joint planning and testing of regional plans and regularly attends multi-agency exercises to evaluate response plans and identify lessons to be learned that can be incorporated into internal and external plans.

As part of the close working relationship with the Humber LRF, a series of training sessions have been made available for HHP's Strategic Health Commanders, Tactical Health Commanders, and EPRR Team to attend including Joint Emergency Services Interoperability Principles (JESIP) training, LRF Strategic/Tactical Coordinating Group training, Regional multi-agency capabilities events, and evaluator/observer slots on LRF partner live exercises.

An example of this was during September/October 2024 when a rare opportunity became available for Yorkshire Ambulance Service and Humberside Fire and Rescue Service to carry out combined training within a derelict 11 floor high rise building in Hull and to expand the learning and development opportunity Health Commanders from HHP were invited to observe.

11 floor high rise building in Hull used for the evacuation exercise

JESIP prinicples being used to brief HART prior to deployment in smoke filled flats

This provided our Health Commanders and EPRR Team the chance to not only learn more about our partner agency's capabilities and working techniques, but to also immerse themselves into the action to see firsthand the challenges frontline responders face at the scene of a high-rise fire and evacuation, including pre-hospital treatment. Health Commanders got the opportunity to discuss how sharing of pre-hospital information from the scene supports the hospital's decision making and risk assessments in preparing to receive casualties from a major incident. The exercise used the command principles and integrated learning from the Grenfell Tower Fire in London.

7.3 Principles of Health Command Training

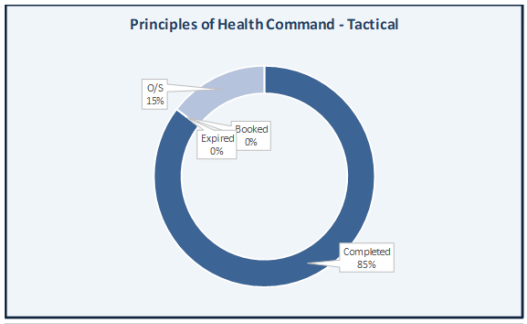
In July 2022, new EPRR national guidance was published by NHS England for all NHS organisations which included the NHS England Minimum Occupational Standards for EPRR. This new guidance now mandates set minimum competencies that all leaders and managers involved in leading an incident response, or part of the decision-making process, must achieve and maintain. These roles are referred to as Strategic Health Commanders, Tactical Health Commanders, Operational Health Commanders, and EPRR Specialist Advisors. It should be noted that the national team has not yet launched the Operational Health Commander elements as the national decision was taken to focus on the Strategic and Tactical implementation first.

The two mandated elements include:

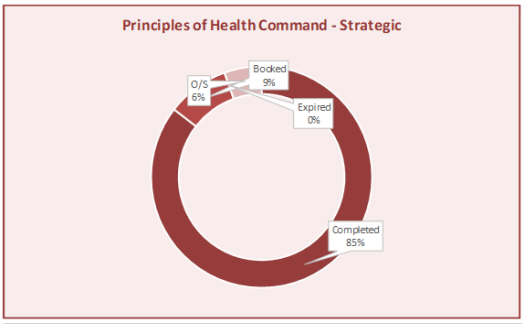
- All Strategic Health Commanders, Tactical Health Commanders and EPRR Specialists must attend the relevant national Principles of Health Command Course at their relevant level (e.g. Strategic On-Call rota participants must attend the strategic level)
- All Strategic Health Commanders, Tactical Health Commanders and EPRR Specialists must maintain a Personal Development Plan (PDP) portfolio with evidence of their continuous professional development to meeting the National Occupational Standards (NOS) for their role

There are currently 55 individuals who are required to undertake Strategic Health Commander training and maintain a portfolio, 55 individuals who are required to undertake Tactical Health Commander training and maintain a portfolio, and three individuals who are required to undertake EPRR Specialist training and maintain a portfolio.

The first element above (Principles of Health Command) was launched ahead of the portfolios and there is a locally agreed target with the ICB to achieve 80%+ compliance with both Strategic and Tactical levels by the end of December 2024. The charts below show that at the end of October 2024 the current compliance is 85% of Strategic Health Commanders have completed the training with a further 9% booked to attend a course before the end of December 2024. For Tactical Health Commanders, 85% have completed the training so far. We are on track to exceed the target for both by the end of the year.



	Total	Completed	Booked	Expired	O/S
Principles of Health Command - Tactical	55	41	0	0	7



	Total	Completed	Booked	Expired	O/S
Principles of Health Command - Strategic	55	47	5	0	3

The second element is the Personal Development Plan (PDP) portfolio. The portfolio was developed by NHS England North and was launched within HHP in July 2024 to all Strategic and Tactical Health Commander and EPRR Specialists.

The portfolios are part of a three year cycle and the compliance and assurance will be reported through the EPRR Group, with oversight from the EPRR Board and externally through the North of England Commander Portfolio Oversight Board (CPOB).

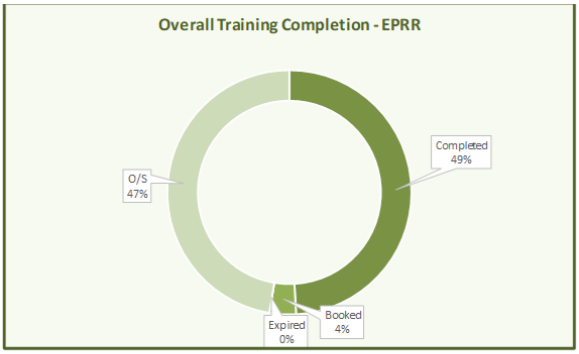
The training requirements within the portfolios include new training which most providers have previously not routinely incorporated into their training programmes (e.g. EPRR legal awareness, media training, working with your loggist etc). While the full training programme is being developed collaboratively across the ICB, the estimated time commitment to complete and maintain the portfolio over a three year period is 21 hours for Tactical Health Commanders, 33 hours for Strategic Health Commanders, and 204 hours for EPRR Specialist Advisors.

The charts below show the current compliance of required training as recorded centrally. All Health Commanders are completing the portfolios and training within their individual portfolios so the only compliance captured within the charts below so far are training courses which have been booked through the EPRR Team. These charts are expected to increase in compliance as portfolios are reviewed throughout the three year cycle. The current compliance percentages are reported to the ICB quarterly and are in line with other NHS provider portfolio roll outs across the ICB.

	Total	Completed	Booked	Expired	O/S
Overall Training Completion - Tactical	55	41	7	0	447

	Total	Completed	Booked	Expired	O/S
Overall Training Completion - Strategic	55	67	5	0	533

The chart below shows the current compliance of required training for the EPRR Specialists. All EPRR Specialists are completing their individual portfolios as part of the three year cycle. The required training for each EPRR Specialist is more onerous than the Health Commanders with additional requirements.



	Total	Completed	Booked	Expired	O/S
Overall Training Completion - EPRR Team	3	28	2	0	27

The training that is mandated or recommended as part of the portfolio compliance is delivered through a mix of formal external training courses, internal training sessions and exercises. Some examples of training include:

- Principles of Health Command (national course delivered by NHS England)
- Legal Awareness Training (E-Learning package and/or NHS England course delivered by Barrister)
- Media Training (Training provider being sourced)
- Working with your Loggist (E-Learning)
- Joint Emergency Services Interoperability Principles (JESIP) Training (Delivered through multi-agency LRF training day)
- Joint Decision-Making Awareness (Delivered through JESIP E-Learning)
- EPRR Communications Awareness (mix of training and through exercise application)
- Incident Response plan / Command and Control Familiarisation (Delivered through exercises)
- Defence Contribution to Resilience (Delivered by LRF Military Liaison Officers)
- MAGIC / MAGIC-Lite (Delivered through College of Policing)
- Local Resilience Forum Awareness (Delivered through LRF SCG/TCG Training)
- Diploma in Health EPRR (For EPRR only – Delivered by UKHSA)
- Structured Debrief Training (For EPRR only – Delivered by UKHSA, EPC, or College of Policing)
- CBRN Training including PRPS Instructor (For EPRR only – Delivered by ambulance service)
- Business Continuity Training (For EPRR only – Delivered by EPC)
- Senior EMERGO Training (For EPRR only – Delivered by UKHSA)

Major Incident Table Top Exercises provide the opportunity for training and validation of emergency plans

Multi-agency capabilities events across the region's three Local Resilience Forums to promote collaborative working and planning

As all NHS providers are now mandated to ensure their Strategic Health Commanders, Tactical Health Commanders and EPRR Specialists achieve, evidence and maintain compliance with the minimum occupational standards it should be noted that there is not yet enough capacity

across all the required training to meet the demand. The EPRR Team are working collaboratively across the ICB to try and secure suitable training opportunities for our leaders.

8.0 Business Continuity Management System

Both Trusts have a well embedded Business Continuity Management Strategy which includes a policy, guidance and plans at both Directorate and service-level. There are service-level business continuity plans (BCPs) across HHP, covering all areas. Each plan identifies critical and non-critical functions within each service that would be required to be maintained during an incident, or that can be stood down to support critical functions. Each plan is required to be reviewed on an annual basis by the nominated service lead with compliance monitored through the EPRR Group. Plans can get reviewed and updated more regularly if required when new threats or risks are identified. Internal audits have been carried out on both Trusts' business continuity managements systems providing substantial assurance (see section 3.2).

As HHP continues with the harmonisation these directorate and service-level BCPs are being re-aligned to reflect the new Care Group structure including a review of the nominated owners for each plan. During the HHP restructure to the Care Groups, the compliance rating with service-level BCP reviews reduced significantly and currently stands at 50% reviewed within the last 12 months. Now that re-alignment of the BCPs to the new structure has taken place, Care Groups are reviewing and refreshing their BCPs and this will be further progressed through the newly established BCP Working Group.

Local Requirement	Target	Current Position	Compliance
Group-wide BCP in place	BCP in place	BCP in place	Requirement Fully Met
Group-wide BCP within review schedule	Reviewed within last 12 months	Reviewed and approved 05/09/2024	Requirement Fully Met
Service-level BCPs in place	BCPs in place	BCPs in place on Trust intranets	Requirement Fully Met
Service-level within review schedule	90% or more reviewed within last 12 months	50% reviewed within the last 12 months (50% overdue)	Requirement not met
Service-level BCPs tested or activated for live response	90% or more tested or activated within last 12 months	BCPs implemented for real for: • Industrial action (multiple dates between March 2023-July 2024 • Electrical transient fault at SGH resulting in loss of power to IT servers (05/10/2023)	Requirement Fully Met

Service-level BCPs have been implemented over the last year as part of the industrial action response and several plans were also implemented as part of specific incidents, such as the electrical transient fault at SGH resulting in a loss of power to the IT servers and all digital systems going down across DPOWH, SGH and GDH. Any lessons to be learned from the exercise/incident is captured as part of the exercise/incident debrief and included in an action plan. At present there is no formal process for the testing of individual service-level BCPs, as these are tested during EPRR training or exercises (e.g. table top, multi-agency exercises). As we move forward we will be expecting each owner to incorporate testing into their review schedule of the plans which will be fed back through the EPRR Group for assurance.

Following on from the feedback received by both Trust's from the NHS England Core Standards for EPRR review in 2023, a revised BCP template has been developed and is now available for Directorates and Care Groups to use as part of their scheduled BCP reviews. It will take up to 12 months for all service-level BCPs to transition to the new revised template.

To support the ongoing focus on the quality, consistency and testing of BCPs, a BCP Working Group was established in October 2024 for the new template roll out transition period. This is chaired by the EPRR Team and can provide a collaborative working environment for Care Groups to develop their BCPs and identify and capture interdependencies between plans.

9.0 EPRR Work Programme

The EPRR Work Programme provides a central location for the EPRR Team to record work undertaken, in progress and scheduled. The EPRR Work Programme captures:

- Emergency plans, SOP and Policy review schedule
- EPRR Training schedule
- EPRR Exercise schedule
- EPRR Incidents log
- Action tracker for post-incident and post-exercise action plans
- BCP review and testing monitoring
- External EPRR actions

All documents have a set review schedule but often plans are reviewed more regularly due to activation of the plan (to incorporate learning from the incident or exercise) or to incorporate the latest national guidance or developments. A list of all emergency plans and their current review schedule is at Appendix E. Reviewing and revising of emergency plans is also more complex due to harmonisation of approaches from two separate Trusts into single Group-wide documents, extending the time it takes to review each plan / process.

10.0 EPRR Top Risks

The EPRR Team, in conjunction with external EPRR Leads from the ICB and partner agencies, uses the nationally and locally identified risks to inform the focus of scenarios for the training and exercising schedules. The National Risk Register feeds into the local Humber Community Risk Register, developed and maintained through the Humber Local Resilience Forum (LRF). The Local Health Resilience Partnership (LHRP) maintains an ICB-wide EPRR Risk Register which focuses on health specific risks linked with both LRF and LHRP planning.

The current top risks for NHS providers within the North East and Yorkshire region are:

Risk Area	Detail	Comments
Flooding	Tidal surge, raising river levels, flash floods	Due to the extent of coastline and the volume of water that drains into the Humber basin we are at higher risk than some of our neighbouring ICBs of a flood incident
Energy Supply Failure	Gas, Electric	Oil not seen as a risk at present
Digital Technology	Cyber attack IT Failure Mobile Telecommunication systems	Possibly no high risk than neighbours, but cross boundary flow and complexities of Yorkshire/North Lincs divide increases the risk Telecomms can be problematic due to geography and, if total failure will cause significant challenges due to ICB footprint
Infectious diseases	HUTHT is local Infectious Disease Centre Currently experiencing outbreaks of: • Flu • Noro • Covid • Avan Flu • Monkeypox • (and the rest)	As well as planning for our internal infectious disease outbreak we need to consider wider outbreaks which may impact upon HUTHT and HUTHT's capacity to manage local infectious disease outbreaks
Industrial Action	Both internal and external action	Planning for impending industrial action across the NHS is ongoing Wider industrial action may impact on transport/supplies/etc.
Public Disorder/Mass Casualties	Across the footprint we have a variety of venues which attract large crowds, when this occurs in multiple venues within a close geographical area the risk of one or more mass casualty events escalates	With the City of Hull and the City of York there are multiple large venues which can all be in use at the same time. The capacity within associated Health Facilities may be limited and quickly escalate to a scenario where multiple locations are required to support both within and outside of eth ICB There are smaller areas, which are more isolated e.g. Whitby; where significant public gatherings occur on a regular basis
Major Social Care Provider Failure	The impact of social care constraints has already been felt	If a major social care provider fails, this will have significant impact across all systems
COMAH Sites	Throughout the Humber there are multiple sites which, if an incident happens, will require significant Health input	Impact not just restricted to site; smoke plumes of other airborne particles may be distributed over a significant geography dependant upon the climate conditions at the time. Flow of chemicals, etc into water course may cause wider health impacts if get into drinking water.

**Comments column populated by NHS England / ICB.*

Both Trusts have an internal EPRR Risk Register which is currently under review to align the approach to HHP Group-wide risk assessments.

11.0 Live Incidents / Response

11.1 Declared Incidents during Reporting Period

During the reporting period of 1st November 2023 to 31st October 2024 there were no declared Major, Critical, or Business Continuity Incidents for either NLAG or HUTH.

Both Trusts did respond to Major Incidents declared by other agencies (e.g. Public Disorder in August 2024) but there was not the need for our Trust(s) to declare an incident to support the response to these.

11.2 Live Incidents / Reponses during Reporting Period

Although there were no declared incidents during the reporting period, the following live internal or external incidents were responded to. The EPRR Framework principles were applied to varying degrees in response to these incidents, which range from on-call Health Commander structures, response through normal operational mechanisms or utilising EPRR principles of command and control establishing a physical or virtual Incident Coordination Centre (ICC). Any lessons learned from these incidents were captured as part of post-incident debriefs where applicable.

Date	Incident	Trusts Involved	Incident Coordination	Trust Declared EPRR Incident
01/11/2023	Storm Ciaran (precautionary LRF TCG)	HUTH NLAG	LRF, EPRR Team	No
05/12/2023	Petrol Tanker (LRF TCG)	HUTH NLAG	LRF, EPRR Team	No
20/12/2023	Junior Doctor industrial action	HUTH NLAG	IA Planning Group established. Virtual ICC in place during strike	No

03/01/2024	Junior Doctor industrial action	HUTH NLAG	IA Planning Group established. Virtual ICC in place during strike	No
01/11/2023	Storm Isha (precautionary LRF TCG)	HUTH NLAG	LRF, EPRR Team	No
23/01/2024	CHH Network Outage	HUTH	IT, Estates	No
12/02/2024	Self-presenting contaminated casualties at DPOWH ED requiring dry decontamination	NLAG	ED	No
24/02/2024	Junior Doctor industrial action	HPP	IA Planning Group established. Virtual ICC in place during strike	No
26/02/2024	Op Carbon Steeple (readiness)	HUTH	ED	No
04/03/2024	Self-presenting contaminated casualties at SGH ED requiring wet decontamination	NLAG	ED	No
08/03/2024	Legacy Funeral Directors incident	HUTH	Mortuary, Comms Team	No
17/03/2024	Op Maysong DPOWH Mortuary incident	NLAG	ICC established. Police established a Gold Command Cell	No
19/05/2024	Self-presenting contaminated casualty at SGH ED requiring wet decontamination	NLAG	ED	No
27/06/2024	Junior Doctor industrial action	HHP	IA Planning Group established. Virtual ICC in place during strike	No
19/07/2024	Microsoft IT Global Outage	HHP	IT	No
25/07/2024	National Amber Alert for Blood Shortages	HHP	Emergency Blood Shortage Group established	No
29/07/2024	Midwifery Support Workers Industrial Action at DPOWH	NLAG	IA Planning Group established. Virtual ICC in place during strike	No
01/08/2024	GP Collective Action commenced	HHP	ICB Planning Group established. Internal HHP Planning Group established	No
03/08/2024	Public Disorder Incidents	HHP	Police Major Incident declared with LRF Strategic Coordinating Group and Tactical Coordinating Group established with HHP participation	No
21/08/2024	Bomb Threat at HRI	HUTH	Security, Estates	No
27/08/2024	Midwifery Support Workers Industrial Action at DPOWH	NLAG	IA Planning Group established. Virtual ICC in place during strike	No
28/08/2024	Self-presenting contaminated casualties at DPOWH ED requiring wet decontamination	NLAG	ED	No

Both Trusts have responded to an unprecedented number of industrial action periods over the past 17 months from Junior Doctors, Consultants and Midwifery Support Workers. Through planning and response arrangements both Trusts have managed to maintain critical services throughout the periods of industrial action by the implementation of service-level BCPs and coordination through physical and then later virtual ICC.

11.3 Medical Oxygen Delivery Systems and Monitoring

On 7th November 2020 there was an incident declared at NLAG to respond to a potential risk of Trust's oxygen supply infrastructure being unable to meet the patient demand for piped oxygen. As part of the post-incident investigation a series of operational plans and assurance checks were put in place to ensure the potential risk is routinely monitored and managed.

The Audit, Risk and Governance Committees-in-Common asked for the ongoing assurance that the measures and procedures put in place remain effective. NLAG has a number of operational and emergency plans that are used to prevent and respond to an oxygen delivery incident. These include the Oxygen Provision Monitoring and Alarm Activation Plan (DCM488), flow rates and WebV information, and the Estates Emergency On-Call Manual.

In addition to the operational plans the monitoring of the oxygen delivery flow rate to ward areas is monitored by the NLAG Operation Centres to ensure that ward areas that are pulling a higher demand are highlighted at the earliest opportunity and can be reviewed to ensure the pull on the ring is not exceeding the maximum flow rate. If it is noticed that the oxygen flow rate is exceeding the stated flow rate for an area, this is raised with department staff to check for accuracy and then escalated to Estates.

The NLAG Operations Centre have access to the flow meters live teleweb on the Hub which allows live data feedback. If flow rates were to cause an issue within a ring, then the early warning local alarms would sound to alert staff in the area of a potential issue. Designated Nursing Officer (DNO) training was expended to include all Site Matrons to provide further resilience 24/7 onsite within Operations.

The Medical Gas Committee has a standing agenda item for Medical Oxygen which includes national and BOC supplier information, project updates, oxygen demand and capacity review, equipment update, training update, alerts, risks and incidents. All works relating to the Medical Gas Pipeline System and changes involving medical gas cylinders are brought to the meeting for discussion and to ensure compliance with Health Technical Memorandum 02-01: Medical Gas Pipeline Systems (Part A and Part B) and NHS C0871 Performance of Healthcare Cryogenic Liquid Oxygen Systems Nov 2021. Any derogations from the above are discussed and, where supported, are raised with the Quality and Safety Committee for consideration. Where derogations are not supported assurance is sought that changes are made to ensure compliance. A Quality Control Assessment is undertaken as part of commissioning and works sign off.

12.0 Trust Boards in Common Action Required

The Trust Boards in Common are asked to:

- Approve NLAG's Statement of Compliance for the NHS England Core Standards for EPRR 2024/25 (**Appendix A**)
- Approve HUTH's Statement of Compliance for the NHS England Core Standards for EPRR 2024/25 (**Appendix B**)
- Note the assurance on EPRR arrangements in place to meet our regulatory requirements for exercising (**Section 7.1**)
- Note the current top EPRR risks identified by the Local Health Resilience Partnership (**Section 10**)
- Note the incidents that have taken place during the reporting period and the ongoing assurance of Medical Oxygen Delivery Systems and Monitoring for NLAG (**Section 11**)

North East and Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-25

STATEMENT OF COMPLIANCE

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, NLAG will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed: 19/11/2024

12/12/2024	12/12/2024	Will be included in 2024/25
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

North East and Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-25

STATEMENT OF COMPLIANCE

Hull University Teaching Hospitals NHS Trust (HUTH) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, HUTH will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-Compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed: 19/11/2024

12/12/2024	12/12/2024	Will be included in 2024/25
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix C

NLAG Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The trust has a risk registor and this is reviewed on a regular basis and reflects the LHRP and the Humber community risk register At present the register is in need of a further review so we are not altering the rating from last years, so no further evidence is being uploaded.	Partially compliant	A full review of the Trust EPRR Risk register against the latest LHRP, Humber Community and the national Risk register to be completed. Also a new process of recording the Trusts risks to be implemented	Senior EPRR Team	01/02/2025
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NLAG does not have a stand alone policy in repsonse to new and emerging pandemics but has several policies that covers response actions and the IPC team continue to follow national guidence https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/	Partially compliant	Development of a new and emerging pandemic plan to be produced as a group wide approach for the IPC team	IPC Team	01/05/2025
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Further development of the Major incident plan to a Incident response plan which will also include a separate mass casualty plan, while the plan is in development the current Major incident plan covers how to respond to a mass casualty event. The emergency department has the Tag system for arriving casualties and recieve training during the CBRN/HAZMAT training annually.	Partially compliant	Development of a new Incident response plan is in progress which will also require the development of several supporting plans including mass casualty plan	Senior EPRR Team	01/03/2025
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	A review of the BCP template is taking place to incorporate the layout for both the North and South Bank templates and ensure it is aligned to the national framework. This is now planned for Q3, with this review still awaiting to take place the rating is been reviewed as partial which is the same as last years so no additional evidence has been uploaded.	Partially compliant	A review of the NLAG and HUTH BCP template to be completed and a joint Humber Health Partnership joint BCP template to be produced and rolled out across HHP	Senior EPRR Team	31/07/2025
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	A new work plan is now in place that incorperates the BCP monitoring system which shows when plans have been tested, but at this time due to this onlt been implemented recently I do not feel we have enough evidence to show the fully compliant rating, so will be rating this the same as last year so no further evidence has been uploaded.	Partially compliant	Continue to upload evidence of the use of BCP during exercises, and or live incidents within the new work programme and ensure post exercise/incidents reports include which BCP's have been activated during the reposnse. These to continue to be shared with the Group EPRR meetings for learning etc.	Senior EPRR Team	On-going
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.		Although the EPRR TNA does not specifically cover digital/IT training programmes, staff who would respond to a digitial incident as a commander are included with commander specific and supporting training needs identified. All staff are required to complete information governance training.	Partially compliant	Digital/Cyber Response TNA required. Digital//IT specific cyber incident training programme	Digital Team / EPRR Team	31/05/2025

Appendix D

HUTH Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG	Action to be taken	Lead	Timescale
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Incident Response Plan - Needs a supporting plan for Burns and Mass Casualty to be developed	Senior EPRR Team	01/03/2025
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Partially compliant	Need to ensure relevant plans are updated to include all requirements of countermeasures process	Senior EPRR Team	31/03/2025
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Develop a Mass Casualty Plan to reflect specific MC requirements and how to create capacity requirements	Senior EPRR Team	01/03/2025
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Partially compliant	Update BC Policy to reflect national BC toolkit, feeding through to other plans as appropriate	Senior EPRR Team	31/07/2025
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Partially compliant	Undetake a capacity assessment for loggists and review the process for deployment to ensure ability to meet assessed capacity	Senior EPRR Team	31/03/2025
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Partially compliant	BC Policy to be updated to reflect the BC toolkit requirements and the locally agreed requirements	Senior EPRR Team	31/07/2025

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG	Action to be taken	Lead	Timescale
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Partially compliant	EPRR Policy to be updated with the new guidance requirements. BC Policy to be updated to reflect the BC toolkit requirements, BC Plans to be updated with BC toolkit requirements	Senior EPRR Team	31/07/2025
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Partially compliant	EPRR Policy to be updated with the new guidance requirements. BC Policy to be updated to reflect the BC toolkit requirements, BC Plans to be updated with BC toolkit requirements	Senior EPRR Team	31/07/2025
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Partially compliant	HHP Digital action plan in place to progress towards full compliance with the DPST	Digital team	31/08/2025
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Partially compliant	EPRR Policy to be updated with the new guidance requirements. BC Policy to be updated to reflect the BC toolkit requirements, establish KPIs for BCMS	Senior EPRR Team	31/07/2025
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Partially compliant	CBRN plan to be updated following livex, comments from HFRS and YAS, risk assessment to be updated with staff who should not work with contaminated patients (departmental risk assessment)	ED CBRN Lead / Senior EPRR Team	31/03/2025
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes	Partially compliant	CBRN plan to be updated following livex, comments from HFRS and YAS, provision of suits framework, CBRN TNA to be developed	ED CBRN Lead / Senior EPRR Team	31/03/2025

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG	Action to be taken	Lead	Timescale
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Partially compliant	CBRN plan to be updated following livex, comments from HFRS and YAS, provision of suits framework, CBRN TNA to be developed	ED CBRN Lead / Senior EPRR Team	31/03/2025
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Partially compliant	SOP for specialist equipment use (patient conveyor to be developed, update CBRN risk assessment, develop inventory for derobe/rerobe kits, central store of equipment records to be identified)	ED CBRN Lead / Senior EPRR Team	31/03/2025
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Partially compliant	Full PPM schedule for all equipment, process for disposal of equipment to be documented and escalation process for equipment issues, alternative decon process to be clear if failed equipment (eg buckets and sponges)	ED CBRN Lead / Senior EPRR Team	31/03/2025
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Partially compliant	CBRN TNA to be developed, train the trainer resource to be updated following attendance at YAS course, assessment of numbers required to be trained, training programme documented	ED CBRN Lead / Senior EPRR Team	31/03/2025

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG	Action to be taken	Lead	Timescale
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Partially compliant	CBRN TNA to be developed, train the trainer resource to be updated following attendance at YAS course, assessment of numbers required to be trained, training programme documented, general staff awareness of CBRN to be included in corporate induction, information sessions to be scheduloed when CBRN plan updated	ED CBRN Lead / Senior EPRR Team	31/03/2025
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Partially compliant	Safe systems of work to be worked through to determine minimum staffing numbers, detailed CBRN TNA to be developed, allocation of roles to temp staff to be included,	ED CBRN Lead / Senior EPRR Team	31/03/2025
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	Partially compliant	Digital/Cyber Response TNA required, Digital/IT specific cyber incident training programme	Digital Team / EPRR Team	31/05/2025

Appendix E

EPRR Work Programme – Plans and Policies

EPRR Work Programme 2023-24				
Subject	**Scope**	**Task**	**Current Version**	**Deadline/ Review Date**
Plans/Policies Review				
Adverse Weather Plan	HHP Group	Routine Review of content	June 2024 V1.0	Jun-25
CBRNe/HAZMAT Plan	HUTH	Routine Review of content	Dec 2023 V4	Dec-25
	NLAG	Annual Review of content	June 2024 V4.3	Aug-26
Communication Policy / Protocol - EPRR Communication Plan	HHP Group	Reference in Incident Response Plan	Aug-24	Aug-25
SOP for Establishment of Media Centre at HRI	HUTH	Reference in Incident Response Plan	Aug-24	Aug-25
MLO Reference Guide	HUTH	Reference in Incident Response Plan	V2 revised in July 2024	Jul-25
Full and Partial Evacuation Plan	HUTH	Routine Review of content	Nov 2023 V1.4	Nov-25
	NLAG	Routine Review of content	Sept 2023 V1.4	Sep-26
Incident Coordination Centre SOP	HHP Group	Routine Review of content	V1.1 July 2024	Jun-25
Lockdown Plan	HUTH	Routine Review of content	Nov 2023 V3	Nov-25
	NLAG	Routine Review of content	March 2022 V1.4	Mar-25
Incident Response Plan	HHP Group	Routine Review of content	Approved Nov-24	Nov-25
EPRR Policy	HHP Group	Routine Review of content	July 2024 V1.1	Jun-25
Excess Deaths Plan + Mass Fatalities Plan	HHP Group	Routine Review of content	May 2024 V1	May-25
Pandemic Influenza & Other Respiratory Plan CP461	HUTH	IPC managed document	Nov-23	Nov-26
Pandemic Plan	NLAG	Annual Review of content	April 2023 V1.5	Apr-26
Seasonal Influenza Plan Nov 2023 CP411	HUTH	IPC managed document	Nov-23	Nov-26
Trust Wide Business Continuity Policy CP419	HUTH	Annual Review of content	July 2023 V4	Aug-25
Trust Wide Services Business Continuity Plan	HUTH	Annual Review of content	July 2023 V4	Aug-24
North Bank Escalation and Surge Plan (Including Full Capacity Protocol)	HUTH	Annual Review of content	Approved Nov-24	Nov-25
South Bank Escalation and Surge Plan (Including Full Capacity Protocol)	NLAG	Annual Review of content	Approved Nov-24	Nov-25
Mass Vaccination Plan	NLAG	Annual Review of content	July 2022 V1.3	Jul-25
Lincolnshire 4x4 Response	NLAG	Annual Review of content	April 2022 V1.3	Apr-25
Oxygen Provision Monitoring and Alarm Activation	NLAG	Annual Review of content	March 2024 V1.1	Feb-25
Plan to Support Evacuation in the Community Rest Centre Plan	NLAG	Annual Review of content	June 2021 V2.1	Jun-24
SOP Bomb Threat	HUTH	Annual Review of content	V8 Draft	In Draft
Policy and Procedure for Bomb Threats and Suspect Packages	NLAG	Annual Review of content	Jun-24	Jun-27

5.2 - HEALTH TREE FOUNDATION TRUSTEES' COMMITTEE TERMS OF REFERENCE

David Sharif, Group Director of Assurance

REFERENCES

Only PDFs are attached

BIC(24)242 - Health Tree Foundation Trustees' Committee Terms of Reference.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)242

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 December 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Neil Gammon, Independent Trust Chair Health Tree Foundation Charity
Title of Report	Updated Terms of Reference for the Health Tree Foundation Trustees Committee.
Executive Summary	Minor changes have been made to the Health Tree Foundation Trustees Committee terms of reference and these have been highlighted in red within the document. The main change is the use of nominated deputies if Executive Directors are not available. **Recommendation** The Boards in Common are asked to note and approve the changes in the document.
Background Information and/or Supporting Document(s) (if applicable)	N/A
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 ☐ Discussion ✓ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

HEALTH TREE FOUNDATION TRUSTEES COMMITTEE

Membership and Terms of Reference

Reference:	DCT041
Version:	3.6
This version issued:	09/10/24
Result of last review:	Changes to incorporate Executive nominated deputies
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Health Tree Foundation Trustee's Committee /Boards-in-Common
Date for review:	August,2025
Owner:	Group Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	8 (including front sheet)
Author / Contact:	Neil Gammon, Independent Trust Chair

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.

1.0 Purpose

1.1 The Trustees' Committee is tasked with overseeing and managing the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds. The working name of the Charity is The Health Tree Foundation.

1.2 The Trustees' Committee must ensure that the Charity acts within the terms of its declaration of trust, and all appropriate legislation, on behalf of the Trust Board as Corporate Trustee.

2.0 Authority

2.1 The Trust Board exercises its role as Corporate Trustee through its review and control over the Terms of Reference of the Trustees' Committee, and through its powers to appoint to the Trustees' Committee.

2.2 The Trust Board delegates authority to receive, manage and utilise charitable funds to the Trustees' Committee.

2.3 Expenditure commitments must be approved in line with the delegation limits set out in Appendix A. The final decision on any expenditure rests with the Trustees' Committee.

2.4 Investment and disinvestment decisions remain the preserve of the Trustees' Committee.

2.5 The Trust Board will review the working of the Trustees' Committee through the reporting arrangements set out in section 3, in order to perform its role as Corporate Trustee.

2.6 The members of the Trustees' Committee shall act independently of the Trust Board when making decisions about expenditure.

2.7 The Trustees' Committee must ensure that the expenditure decisions are granted only to further the charity's purposes for the public benefit and for no other purpose.

3.0 Accountability & Reporting Arrangements

3.1 The Trustees' Committee is established as a formal committee of the Trust Board, under the Trust Constitution Part IV Section 6.8 d. These Terms of Reference shall have effect as if incorporated into the Trust's Constitution and shall only be amended by agreement of the Board.

3.2 The minutes of the Trustees' Committee will be formally recorded and submitted to the Trust Board once agreed by the Committee.

3.3 The Trustees' Committee will supply the Trust Board with a highlight report following each meeting, outlining investment and disinvestment decisions, and material expenditure commitments, in line with limits set out in Appendix A. The

highlight report will also include key items of activity that Trustees wish the Trust Board to be aware of.

3.4 The Trust Board shall have access to all reports and papers of the Trustees' Committee. These must include regular comprehensive financial reports and progress updates.

3.5 The Trustees' Committee must ensure that accounts for Charitable Funds are completed in line with regulatory standards and deadlines and made available to the Trust Board and Audit Risk and Governance Committee.

4.0 Responsibilities

The responsibilities of the Charitable Trustees' Committee are to:

- Manage the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust Charity within the terms of its declaration of trust and appropriate legislation including that of the Charity Commissioners of England and Wales
- Implement procedures and policies ensuring that accounting systems are robust, donations are received and coded as instructed and all expenditure is reasonable, clinically and ethically appropriate.
- Ensure funding decisions are appropriate and are consistent with the Trust's objectives and to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by Exchequer funds.
- Maintain engagement and monitoring arrangements for major projects utilising significant funding provided by the Charity.
- Monitor and review fund balances, and where appropriate amend the structure of individual funds (e.g. merging, deleting, rationalising)
- To manage the investment of funds in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf.
- Maintain a proactive approach to fund raising, including charitable giving, legacies, and publicity as well as arranging appropriate communications on all matters associated with the Charity.
- Review and agree audited Annual Report & Accounts
- Review and update these Terms of Reference annually, recommending any changes to the Trust Board
- Evaluate its own membership and performance on an annual basis.
- Expenditure will be in line with the objectives of the charity and the wishes of donors.

5.0 Membership

5.1 Core membership

The Trust Board acts as Corporate Trustee of the Charity. The Trustees' Committee shall be appointed by the Trust Board from amongst the Non-Executive and Executive members of the Trust Board and the local community, and shall consist of the following voting members:

- An independent Chair
- 2 Non-Executive Directors
- Executive Directors :
  - Group Chief Executive
  - Group Chief Medical Officer
  - Group Chief Financial Officer
  - Group Chief Strategy & Partnership Officer
  - Nominated deputies for Executives will be accepted in exceptional circumstances and will form part of the core membership (voting).

5.2 Partnership In attendance:

- Health Tree Foundation Charity Manager
- Representative from HEY Smile Foundation's Executive Team
- Group Director of Estates
- Group Chief People Officer
- Communications Assistant
- Deputy Chief Nurse
- Chief Financial Accountant
- Assistant Director of Finance, as required
- Deputy Director of Assurance
- Governor Representative

- Investment Representatives, as required
- Other Trust staff and stakeholders as required

5.3 Charitable Funds Executive Clinical Champion

The Trustees' Committee shall have one Charitable Funds Executive Clinical Champion, the Group Chief Medical Officer. The role of the Clinical Champion is to provide expert clinical opinion on all HTF matters where appropriate, particularly around the question of the impact of HTF wishes on patient experience. They will also be responsible for approving expenditure between £5001 - £25,000 as per Appendix A.

6.0 Procedural issues

6.1 Frequency of Meetings

The Committee shall meet no less than four times a year, although at more regular intervals should the Committee so determine. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Charitable Trustees' Committee not less than five working days before the date of the meeting.

6.2 Independent Chair and Trustees

The Independent Chair and Trustees shall be appointed by the Trust Board.

6.3 Secretarial Support

Secretarial support to the Health Tree Foundation Trustees' Committee will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Permission for Trustees to Nominate Deputies

In the absence of the Chair, a Non-Executive Committee member will be nominated by the Chair to perform this role. Other Trustees may nominate non-voting deputies to act on their behalf.

6.4.2 Attendance by Trustees

All Committee members will be required to attend 75% of meetings. The Trustees' Committee will maintain and publish annually a register of attendance.

6.5 Quorum

6.5.1 The Committee will be quorate when:

- A minimum of four Trustees are in attendance.
- At least two Independent external or Non-Executive Trustees are in

attendance, and

- At least one Executive Director Trustee (or nominated deputy) is in attendance.

6.5.2 Where the Group Chief Financial Officer is unable to attend the Committee, they remain responsible for ensuring that appropriate technical advice and support is still available to the Committee in order to support effective execution of its duties.

6.6 Administration and Minutes of Meetings

6.6.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No late papers will be accepted on the day of the meeting without the express agreement of the committee chair.

6.6.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.6.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.6.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report.

6.7 Review

The Terms of Reference will be published on the Trust Intranet and will be reviewed annually.

7.0 Equality Act (2010)

7.1 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.

7.2 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.

7.3 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.

7.4 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, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation, or transgender (Equality Act 2010).

Appendix A

CHARITABLE FUNDS – DELEGATION LIMITS

1.	Up to £250	Authorisation from Health Tree Foundation Charity Manager
2.	Between £251 - £5,000	As above plus further authorisation from the Fund Guardian
3.	Between £5,001 - £25,000	As above plus further authorisation from Fund Guardian and from the Charitable Funds Executive Clinical Champion, i.e. the Group Chief Medical Officer
4.	Above £25,000	As above, plus further authorisation from the Trustees' Committee

The Trustees' Committee will exercise final authority over all decisions, and will set out appropriate guidelines, as required; to support this delegated decision-making process.

All investment and disinvestment decisions relating to the funds held by the Charity will require the authorisation of the Trustees Committee.

The Committee is required to approve expenditure above £25,000, but all expenditure items above £1,000 will be reported to the Committee.

Individual expenditure commitments above £50,000 in value, and all investment or disinvestment decisions, will be reported for oversight purposes to the Trust Board as Corporate Trustee, through the regular Highlight Report.

Expenditure will be in line with the objectives of the charity and the wishes of donors.

6 - ITEMS FOR INFORMATION / SUPPORTING PAPERS

REFERENCES

Only PDFs are attached

- BIC(24)247 - Performance, Estates & Finance Committees-in-Common Minutes - September & October 2024.pdf
- BIC(24)248 - Workforce, Education & Culture Committees-in-Common Minutes - August & October 2024.pdf
- BIC(24)249 - Guardian of Safe Working Hours Annual Report.pdf
- BIC(24)260 - Guardian of Safe Working Hours - Quarter 2 Report.pdf
- BIC(24)252 - Trust Boards & Committees Meeting Cycle - 2025 & 2026.pdf
- BIC(24)250 - Capital and Major Projects Committees-in-Common Minutes - June, August & December 2024.pdf
- BIC(24)251 - Integrated Performance Report - NLaG and HUTH.pdf
- BIC(24)243 - Quality & Safety Committees-in-Common Minutes - August 2024.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)247

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12th December 2024
Director Lead	Helen Wright / Gill Ponder, Non-Executive Directors / Chairs of Performance, Education and Finance Committees-In-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common meeting held on Wednesday 25th September and Wednesday 30th October
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	**The minutes attached are for information.**
Prior Approval Process	Performance, Estates and Finance Committees-in-Common In October and November.
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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 25th September 2024 at 09:00 to 12:30 hours in the Main Boardroom at Diana Princess of Wales Hospital, Grimsby

For the purpose of transacting the business set out below:

Present:

Core Members:

Helen Wright	Non-Executive Director (HUTH) - Chair
Gill Ponder	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG) (Virtual)
Mark Brearley	Interim Group Chief Financial Officer
Neil Rogers	Managing Director (North)
David Sharif	Group Director of Assurance
Ivan McConnell	Group Chief Strategy and Partnerships Officer
Jane Hawkard	Non-Executive Director (HUTH)

In Attendance:

Adam Creeggan	Group Director of Performance
Jennifer Granger	Head of Compliance & Assurance (NLaG)
Leah Coneyworth	Head of Quality Compliance (HUTH)
Craig Hodgson	Group Deputy Director of Commercial and Facilities Services (NLaG)
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (Minutes)
Julie Beilby	Associate Non-Executive Director (NLaG)
Helen Knowles	Director of People Services
Phillipa Russell	Deputy Director of Finance

Observers

Linda Jackson	Vice-Chair (NLaG)
Mike Bateson	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, Helen Wright, welcomed those present to the meeting. Apologies for absence were noted for Paul Bytheway, Interim Group Chief Delivery Officer (Neil Rogers deputy), Ian Reekie, Lead Governor (NLaG) (Mike Bateson deputy), and Dr Kate Wood, Group Chief Medical Officer.

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 August 2024

The minutes of the meeting held on the 28 August 2024 were accepted as a true and accurate record.

1.4 Matters Arising

No items were raised.

1.5 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Action	Comments
1.5	Deep Dives	Deep dives will now be discussed within the IPR report to remove the need for an additional paper whilst still allowing a more detailed discussion on the deep dive topic. Closed.
3.1	BAF Report	David Sharif confirmed this is now complete and can be closed.
3.1	BAF Report and Risk Register	David Sharif stated this would be reflected in October's report.
3.3.1	Jennifer Granger to ensure the table within the NLaG CQC report is updated to correctly reflect the timescales for production of the clinical strategy and the financial strategy.	Financial Strategy will follow the clinical strategy which is due December 2024, so timescale for completion set as February 2025 by action lead.

3.3.1	Brian Shipley to include a finance strategy update within the finance report section at future meetings, to update on current position, the challenges anticipated in the next five years and when a financial strategy will be available.	Mark Brearley updated that this would be available in October's report.
3.3.1	Paul Bytheway to discuss with Amanda Stanford the requirement for reports to have appropriate executive signoff.	Paul Bytheway had met with Amanda and a process was put in place to prevent this happening. Action closed.
3.3.1	Leah Coneyworth to forward TW4 detail and confirmation of the Ops lead for the CQC actions report to Paul Bytheway.	Leah Coneyworth updated that the actions had been sent to Paul Bytheway and would catch up with him on his return from annual leave.
3.3.1	Additional column to be added to update on estimated completion timeframe in addition to original targeted completion date	It was agreed that this action could be closed with a plan to monitor this going forward.
4.5	Simon Tighe to confirm if the Co2 tonnes saved are cumulative or annual.	This was covered in the report. Action can be closed.
4.5	Simon Tighe to update and re-present the north bank and south bank fire action plans.	Simon Tighe updated this would be brought back in Novembers report.
5.2/5.3	Lauren Rowbottom to feedback the difficulties with formatting of north bank & south bank site reports to their authors.	Format difficult to change due to amount of information. Team engine struggles with large excel to PDF files. Uploaded as an excel to help with viewing. Action can be closed.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Helen Wright 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. He expressed there were no overdue risks allocated to this Committee. This was reliant on manual allocation of the items on both risk registers and he and Rob Chidlow were working in the background for a more systemised process. The BAF report still had the original finance risk, this would be changed and refreshed on the next BAF report in October.

Linda Jackson queried whether the target of 5 for finance was reasonable. Mark Brearley responded that the target is what we aspire to, adding that few NHS trusts are achieving this. David Sharif stated the BAF report in October would be split by delivering to plan and delivering financial sustainability. Gill Ponder agreed with Linda Jackson, adding the Group had a gap to plan with no associated agreed actions to close the gap, so 5 appeared to be an unrealistic risk score for the current year end.

David Sharif stated there was still work ongoing to align and mitigate actions and assurances.

Julie Beilby queried the progress with the Group Risk Manager post. David Sharif explained that Amanda Stanford was having internal conversations around the scope and the post would be filled by existing resources.

3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s) as referred from the Audit, Risk & Governance Committee (ARG CiC)

There were no external or internal audit reports & recommendations to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances(s) as appropriate

There were no external reports, recommendations or assurances to note.

The agenda was taken out of order at this point.

4.1 Annual Planning (Operation and Financial, including CIP) Timetable for 2025/2026

Ivan McConnell took the report as read. He noted that the planning priorities were set out and was keen to hear everyone's views on the priorities. Funding was agreed for additional Programme Management Officer (PMO) support.

Adam Creegan explained that going forward in 2025/2026, the Group was in a better position due to aligned processes across the organisation. There had been a planning meeting on 24 August 2024 with the Care Group Triumvirates and the planning process had begun much earlier this year. There was robust governance in place. A task and finish group had been established which had monthly oversight from the Senior Operational Steering Group. Adam Creegan added that they would be going through a rigorous process with Care Groups and they would be challenged on performance against baseline.

Neil Rogers added that this had landed well with the Care Groups and was positively received. He stated he would be having a conversation with Paul Bytheway to help create two site plans that merge together.

Jane Hawkard praised the Annual Planning work to date. She stated she had some anxiety around the post service development template and questioned how much money would need to be invested. Ivan McConnell voiced that there were some differences in what the service developments may be. These were system led and work needed to be done to create a substantive change. Philippa Russell added that a strong process was required to help focus on the things that do need support.

Simon Parkes stated that productivity was perceived to be an issue nationally. There had been no increase in funding which posed a risk of going in circles, posing the question of how do we get a significant improvement in financial position. Adam Creegan agreed and stated the organisation does not have a clear direction or process that states the criteria, but this was being developed. Funding had been approved at Cabinet on 24 September.

Gill Ponder welcomed the structured process and added that having a plan at the start of the year was important, as it would help Care Groups to manage their budgets and be accountable from month one. She also expressed concern about the risks of planning further additional activity to generate additional revenue, when the Group were not achieving the activity levels in the current year's plan.

Julie Beilby wondered if planning assumptions should be bolder and Adam Creegan advised that 24/25 levels would be delivered as a minimum. Adam Creegan stated the plan was a replication of what the Group currently does, but agreed the wording was not robust and could be worked on.

Jennifer Granger and Leah Coneyworth joined the meeting at 9.31am.

The agenda returned to order from this point.

3.3.1 CQC Actions Report – Group

NLaG

Jennifer Granger took the report as read. She went over some updates that had changed since the report was written.

The Clinical Strategy was due for completion by December 2024, with a completion date of February 2025 for the Financial Strategy.

Jennifer Granger stated there was a Trust wide performance action and it was agreed this could be closed. Adam Creegan expressed there was still more to do but there was a new IPR and report in place to support this.

Linda Jackson stated that the report said that there was a lack of capacity within the Clinical Operations teams to deliver the plan and asked if there were any indications that this was getting better. Jennifer Granger assured that since the new structure was formed everything now appeared to be in place and all Care Groups were on board and aligned.

At the PEF CiC in July, a plan for the Quality Improvement (QI) team to re-establish the data streams for End of Life (EOL) had been discussed, but this data had not yet been restored. Gill Ponder was unclear as to why the EOL data was being collected and then stopped, given the importance of this data to patient care and wondered what the delay was in getting this re-established. Jennifer Granger explained that it was originally stopped as the QI team were re-deployed to other projects. The Business Manager for the EOL service had escalated and chased, but no timescale for resolution had been obtained.
Adam Creegan agreed to take this away as an action and speak to the relevant teams.

Action: Adam Creegan to review the EOL data CQC action and plan a meeting for those involved to ensure that this CQC action could be closed.

HUTH:

Leah Coneyworth took the report as read. She updated that all actions were now updated for all the projects happening within HUTH currently and these had been sent to Paul Bytheway. All action owners had been assigned.

Maternity triage was being monitored in meetings chaired by Jenny Hinchliffe and this has been sustained around 80%. The action remained open, as it still linked to staffing challenges in Maternity.

Helen Wright said that a further review of the structural changes will help with timescales and Adam Creegan added that the revised governance will help give future assurance.

Group CQC actions were now more embedded in the Care Groups and good progress was being made. However, the CQC action on End of Life Data had not been completed. This issue would be reviewed and a report would

be presented to the next meeting of the CIC. Limited assurance was agreed, as actions were not yet embedded and sustained.

Jennifer Granger and Leah Coneyworth left the meeting at 9.45am.

COMMITTEE SPECIFIC BUSINESS ITEMS

4. Joint Business Items

4.2 Finance Report (Including year-end forecast and cash position)

Phillipa Russell took the report as read. The year-to-date position was £35.4 million which was £1.2 million adverse to plan. The key driver of this was the industrial action. Funding for the industrial action would help cover these costs if the Group received an allocation. The financial position had been supported by the earlier than planned release of some reserves at HUTH.

The Elective Recovery funding was behind plan at Month 5 and a dip was seen in July and August due to annual leave. Phillipa Russell added that the Group would expect to see an improvement as some schemes agreed through Cabinet were set to start in October and November 2024.

Temporary staffing showed an improvement compared to 2023. The Group had spent £22.5 million on agency, bank and overtime. This was £4.9 million less than the same period in 2023/2024 and was below the target of 3.2%. Phillipa Russell added that the vacancy rate was increasing, but this was expected.

The Groups cash balance at month 5 was £39.5 million. This was weighted towards NLaG. Phillipa Russell noted that deficit funding should be made available within the coming weeks, but cash pressures would increase if the gap to plan was not closed.

Jane Hawkard questioned the Cost Improvement Plan (CIP) which showed a dramatic increase in March and queried what was going to be done and when do we begin to declare the possibility that we may not achieve all the improvements planned. Phillipa Russell explained that the mitigation of risks had been called out and the teams were aware that the plan was more challenging in the second half of the year. Helen Wright queried who was having the debates regarding the end of year forecast. Mark Brearley stated he would be having those discussions with the ICB, along with internal conversations with Jonathan Lofthouse and the Care Groups. He further added that the Group only has 2 Site Managing Directors to cover all the Care Groups, comparing to most Groups having a large Project Management Office (PMO).

Gill Ponder said that over the last 3 years the Group had hit their plan and CIP. Ivan McConnell recognised that the Group position was slipping, but extra support

through a new PMO would help support Operational colleagues. Neil Rogers supported the need for a PMO.

Gill Ponder questioned what was being done to control overspend. Phillipa Russell stated that there was going to be a focus on bank and agency reductions as well as grip and control. She reiterated that there was definitely more that could be done.

Gill Ponder commented that the Elective Recovery Funding (ERF) was at 99% total for the Group due to annual leave in July and August, but that this was well known every year. She questioned why the teams were not trying to increase capacity beforehand, rather than attempting to recover following predictable events such as holiday periods. Mark Brearley agreed, adding that the key was to discuss managing their budgets with the Care Groups, but pointed out that they would see an improvement in the next months which would help deliver ERF.

Mark Brearley stated he would be starting a discussion around ERF income over delivery and would like to see the income split to support specialities. Ivan McConnell added that a contract would be done in 2 weeks alongside a scoping exercise, but the PMO support would not be immediate. He voiced that he did not want to replace the great work the finance team were doing, but wanted to complement and help deliver it.

Helen Wright asked about the finance restructure and whether it was now completed. Phillipa Russell stated that it was still ongoing, but once completed would contribute to the CIP delivery for the year.

Julie Beilby emphasised that when planning for the following year, the Group needed to shift their thinking around current and recurrent savings.

4.2.1 ICB Position – Update from Grant Thornton work

Mark Brearley took the report as read. Grant Thornton had been doing a lot of working collecting information and there would be a Summit on Friday 27 September 2024 to cover the delivery plan for 2025. Grant Thornton was looking at harmonising a range of things with providers in the ICB, such as waiting list incentives.

Ivan McConnell added that Grant Thornton (GT) came up with 10 work streams co-ordinated across ICB colleagues, alongside multiple workstreams to support. The underlying work streams were moving at different speeds and the ICB had a requirement to undertake an assurance review.

There was a parallel piece of work being done through acute providers by KPMG and this would help target elective recovery and fragile services to accelerate delivery.

Helen Wright questioned if we were seeing any overlap between KPMG and GT. Ivan McConnell reassured that they were both working on different areas.

Jane Hawkard praised the work from Grant Thornton and expressed the importance of recognising the positive direction.

The Committees-In-Common agreed limited assurance, but appreciated that the teams were doing everything they possibly could to mitigate the risks and that there is commitment to delivery of the annual plan. The ICB had acknowledged that the Group's CIP was further developed than elsewhere in the system. The team were praised for this ongoing effort, but it was recognised that there was much more to do to deliver the target financial performance.

4.3 / 4.3.1 Group Integrated Performance Report & Deep Dive – Length of Stay(LOS)/Beds and Elective Care Deep Dives

Neil Rogers took the report as read and highlighted the following points. The Group achieved the national requirement for zero 78 week waits by the end of June 2024. The 65 week waits showed a deterioration. There was a requirement to hit zero 65 week waits by the end of September and which would be not be achievable. Whilst the failure to hit the September deadline was disappointing this reflected the position of most Trusts nationally and the Group position for September was comparatively very good. There was confidence of achieving zero by the end of October. There was a paediatrics ADHD service now in place, but there were concerns around community dental, plastic surgery and complex breast reconstruction. Additional capacity had been sourced and an agreement had been reached with plastic surgeons to work at weekends during October.

Elective
Since the Lorenzo roll out, the waiting lists growth at NLaG had been mitigated and the PTL was now back to its pre-Lorenzo state. HUTH has seen a 7% increase in their PTL and a 22% increase in their over 52 week waits.

Neil Rogers updated that there had been a 3.4% increase in GP referrals and a 9.8% increase in suspected cancer referrals, but that increase had not resulted in increased numbers of patients requiring treatment. This compared to the operational plan, which had shown a 3% reduction in GP referrals, whereas there had been an overall increase of 6%.

Gill Ponder questioned why there was an increase in pathway outcome recording delays at HUTH. Adam Creegan replied that this was true in part, due to HUTH RTT employees being deployed to help colleagues at NLaG with post-Lorenzo deployment PTL validation, which had resulted in 3,500 extra cases being added to the PTL on that site.

Gill Ponder observed that the theatre timetable reductions in July and August were predictable due to annual leave and was there any plans to encourage spreading annual leave through the year. Adam Creegan stated the plan was reflective of historic activity and the Group was seeing a reduction of activity beyond normal annual leave patterns.

Gill Ponder brought attention to the increase in GP referrals by 25% and a 45% increase in ‘other’ referrals. She queried what classified as ‘other’. Adam Creegan responded that they tend to be advice and guidance referrals.

Gill Ponder questioned why patients were being marked as patient choice breaches after being given unreasonable offers for admissions. Neil Rogers explained that there was an access policy to help with giving patients enough notice and ideally patients should be given three weeks’ notice when offered an admission date. Gill Ponder felt if less notice was given, that this should not be classified as a patient choice breach.

Gill Ponder wondered why they were so many theatre overruns. Neil Rogers stated there was a piece of work underway with the Acute Provider Collaborative on standardising cancellation reasons as this was not consistent between HUTH and NLaG.

Jane Hawkard brought attention to the 2 week wait referrals at 10%. Adam Creegan explained that they had received a number of ED referrals who may have been referred on a suspected pathway. Neil Rogers added that they were trying to avoid emergency admissions so SDEC were creating referrals to specialities on an outpatient basis. Jane Hawkard questioned whether colleagues in primary care would agree with the numbers.

Julie Beilby queried where the discussions around referral growth were discussed. Adam Creegan expressed that cancer referral growth did not correspond with increased conversion to cancer treatment, hence further engagement via the ICB was required to ensure appropriate use of cancer referral pathways.

Simon Parkes noted there were so many measurements and questioned how the teams could manage and focus on areas where they needed to improve with so much going on.

Linda Jackson praised the work that had taken place to ensure that the NLaG PTL was accurate following the Lorenzo issues.

Cancer

Neil Rogers updated that currently HUTH were at 49.7% of patients treated in 62 days and there had been an improvement at NLaG with 54.8%. Performance overall had shown a dip through the Summer and this was being looked into to understand why; particularly breast and skin did not perform well over the summer months. He added that there had been workforce issues in those 2 tumour sites, but these had been resolved and were on track for September.

Lower GI was another tumour site which had struggled due to colonoscopy capacity, but there was improvement work ongoing in this service.

Neil Rogers also updated that there had been specific capacity issues in Urology due to a shortage of Cancer surgeons. Discussions with other providers were ongoing.

Gill Ponder brought attention to the 62-day performance at HUTH which showed no real improvement since September 2022 and questioned if there was any evidence of what was being done to help sustain improvements. Adam Creegan assured the CIC that all mitigations were in place, but due to the sheer amount of work required it was not clear when sustained improvements would be embedded as these required significant pathway management changes.

Simon Parkes observed that they appeared to be improvements followed by slip backs in performance. Adam Creegan agreed that compliance was inconsistent and actions being embedded to reduce time between pathway events were designed to sustain performance.

Urgent Emergency Care (UEC)

Gill Ponder questioned the narrative around the Time to Initial Assessment data, stating if discharges on the ward rounds happened more frequently this would help improve flow and length of stay. Ivan McConnell responded that ward rounds are being completed but there was no standardised system. He stated that work was required with the Care Groups in creating a standardised system, alongside Criteria Led Discharge.

Jane Hawkard expressed that she was anxious around the closure of the 13th floor at Hull Royal Infirmary and requested an update on this. Adam Creegan updated that SDEC activity was increasing and this was helping with less occupied bed days, adding that if HUTH is not in a position to shut the 13th floor it would not happen. Ivan McConnell further added that Rossmore was now at 48% occupancy, going from 6 patients to 20 per day. This was an improvement of 90% which he emphasised would be sustainable.

Linda Jackson queried whether we would see an end to stranded patients as we go into the Winter period. Adam Creegan stated this was an ongoing issue for years as external flow was difficult to fix, but the number of patients with No Criteria to Reside had reduced from circa 200 to 100 at HUTH. Simplified front end ED pathways had been introduced and the Urgent Treatment Centre (UTC) was impacting on numbers. Focus on the 3 identified priorities had resulted in the best 4-hour performance in the last 2 years and ambulance handovers had also significantly improved.

The Committees-In-Common agreed limited assurance due to sustainability of improvements, however ongoing UEC improvements and the focus on the 65 week target were commended by the CIC.

Craig Hodgson joined at 11.30am.

4.4 Estates and Facilities – General Update

Craig Hodgson took the report as read. He highlighted the actions of the soft facilities services, where work was continuing to develop the parking policy.

He updated the Premises Assurance Model (PAM) SH18 action around safe and suitable non-HUTH properties and advised that a dual piece of work was being undertaken, including the drafting of a policy at HUTH to align with NLaG's. He added that they had used the NLaG compliance tracker model and a HUTH version had been created.

Craig Hodgson gave an update on catering. He explained this was on the Cabinet agenda to provide an updated strategy in November 2024. There was limited trading data available following the recent catering price increase but trading remained positive.

Craig Hodgson outlined some differences in the cleaning models across the 2 Trusts. There was a piece of work going forward to discuss recommendations and this will be brought to the Committees-In-Common at a future meeting. Craig Hodgson provided an update on the Community Diagnostic Centre (CDC) total facilities management contract, which went to the Board in August. The plan was to provide a report to the Board by October for assurance around the process and liability of the contract. Work progresses on cleaning model harmonisation, financial viability of catering provision and CDC total facilities management contract. Updates will be brought back as appropriate.

Helen Wright wondered if they were satisfied that the cost and investments were being incorporated into capital plans. Craig Hodgson explained that the capital plans are prioritised and linked to risks and that Simon Tighe would be providing a detailed update around risk register updates at the October meeting.

Helen Wright raised if there were any concerns around the capital underspend. Mark Brearley explained they were going through a process to identify and accelerate the spend for 2025 as a contingency.

4.5 Security / LSMS Annual Report and Work plan

Craig Hodgson took the report as read. He explained this was historically on the NLaG work plan for Board review.

Julie Beilby thanked Craig Hodgson for the report and found the Executive summary regarding partnership particularly helpful. She queried whether there were discussions around patients who are at risk of self-harming due to differences in the risks at HUTH and NLaG. Her final comment was regarding the lone working devices, where she noted there appeared to be a low take up or mismatch between the numbers of devices available.

Craig Hodgson explained that the units where available for lone working and they were provided to the areas and the issue was around low take up rather than units not being provided.

Craig Hodgson explained that the contract for the parking and security services at NLaG runs until the summer of 2026 and the HUTH contract expires earlier, but there was a potential to make those coterminous.

The incident reporting at NLaG would be realigned following the move from Datix to Ulysses.

Action: Craig Hodgson to ensure that lone working is included on the correct risk registers.

Gill Ponder raised a question around violence and aggression incidents between 2023-2024. The report showed around 25 occasions where staff had been violent to one another and she queried if that was correct. It was felt if this was accurate, then this would be referred to the Workforce, Education and Culture Committees In Common(WEC).

Action: Craig Hodgson to check the factual accuracy of the 25 occasions of violence and aggression between staff. If correct, a referral to WEC CiC would be made.

Jane Hawkard asked if racist behaviours were included in the Anti-Social Behaviour letters. Craig Hodgson believed it was all anti-social behaviour, but would clarify and bring this back to the CiC.

Action: Craig Hodgson to gain clarity on whether the anti-social behaviour letters included racist behaviours.

Craig Hodgson left the meeting at 11.55am.

The Committees-In-Common agreed that reasonable assurance had been given and approved the Security annual report.

*Helen Knowles joined the meeting at 11.57am***.**

4.6 Bank and Agency Demand Solutions (including Direct Engagement)

Helen Knowles took the report as read. She stated that she originally required approval, but stated that approval would not be required as they were now looking to extend current contracts.

Helen Knowles stated that she was working with procurement colleagues on the new extension and existing contacts, as there were opportunities with the contracts in place currently.

Mark Brearley offered to help Helen Knowles and her team from a finance perspective with the offers from companies and observed that it was good that the Group had more time to choose a new contract. Helen Knowles added that Rob Chidlow had also been supporting this work.

4.7 Contract Approvals

There were no contracts for approval.

4.8 Emerging Issues

No emerging issues were raised.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

The Committees-In-Common had nothing to raise in relation to the work plan.

5.2 Consolidated North Bank Site Report

The Committees-In-Common had nothing to raise from the consolidated North Bank Site Report.

5.3 Consolidated South Bank Site Report

The Committees-In-Common had nothing to raise from the consolidated South Bank Site Report.

5.4 Planned Care Board Meeting Minutes

The Committees-In-Common had nothing to raise from the Planned Care Board Minutes.

5.5 Unplanned Care Board Meeting Minutes

The Committees-In-Common had nothing to raise from the Unplanned Care Board Minutes.

6. ANY OTHER URGENT BUSINESS

David Sharif asked for feedback from the Committees-In-Common on the reports submitted for the meeting. Jane Hawkard pointed out that within the security report, HUTH did not have an action plan but NLaG did.

Helen Wright made a point that it would be helpful to remind attendees at future meetings to take reports as read.

Linda Jackson noted that the Winter Plan was on the work plan to come to PEF in September, but was not on the agenda. This was previously removed at the agenda set meeting, as it would not have been ready in time for the meeting. It was

acknowledged that changes in the team had led to a delay in Winter planning and that it should start earlier next year.
The Winter plan for 2024/25 would be brought to the CiCs in October.

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.

7.2 Matters for Escalation to the Trust Boards

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

Wednesday, 30 October 2024 at 09:00am in Suite 22, Education Centre, Castle Hill Hospital.

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		Y	Y	Y	Y			
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y	N	Y	Y			
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y	Y	Y				
Mark Brearley	Interim Group Chief Financial Officer									Y			
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N	Y	Y	Y			
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y	Y	Y	Y			
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y								
Paul Bytheway	Interim Group Chief Delivery Officer						Y	Y	Y	D			
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y	Y	D	N			
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D	D	D	D			
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N	N	N	N			
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y	Y	Y	Y			
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N								
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y	N	Y	N			
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N	N					
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y	Y	Y	D			

***KEY**: Y = attended* *N = did not attend* *D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 30th October 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:

Gill Ponder	Non-Executive Director (NLaG) - Chair
Mark Brearley	Interim Group Chief Financial Officer
Neil Rogers	Managing Director (North)
David Sharif	Group Director of Assurance
Ivan McConnell	Group Chief Strategy and Partnerships Officer
David Sulch	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer
Stuart Hall	Vice-Chair (HUTH)
Paul Bytheway	Interim Group Chief Operating Officer

In Attendance:

Jennifer Granger	Head of Compliance & Assurance (NLaG)
Leah Coneyworth	Head of Quality Compliance (HUTH)
Simon Tighe	Group Deputy Director of Estates and Compliance & Information Services
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (Minutes)
Phillipa Russell	Deputy Director of Finance
Jenny Hinchcliffe	Director of Nursing (South)
Nick Cross	Medical Director (South)

Observers

Mike Bateson	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 Helen Wright, Non-Executive Director (HUTH), deputised by David Sulch, Non-Executive Director (HUTH), Simon Parkes, Non-Executive Director (NLaG), Adam Creegan, Group Director of Performance and Jane Hawkard, Non-Executive Director (HUTH).

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 25th September 2024

The minutes of the meeting held on the 25 September 2024 were accepted as a true and accurate record.

1.4 Matters Arising

No items were raised.

1.5 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
4.3	Group IPR	Paul Bytheway agreed to review the cancer site report previously bought to the group and to bring back and update for the Cancer Deep Dive in September.	Can be closed. Deep dive for Cancer is a part of the agenda for this CiC.
3.1	BAF Report and Risk Register	David Sharif to arrange for the risk register to be updated to only show the short-term financial risk and the long-term financial risk be added to the BAF strategic risk register.	This will be in the revised BAF from November, carry forward to November.
3.3.1	Finance Strategy	Brian Shipley to include a finance strategy update within the finance report section at	Brian reported this was ongoing work. He would have something available for November's meeting and be

		future meetings, to update on current position, the challenges anticipated in the next five years and when a financial strategy will be available. within the NLaG CQC report is updated to correctly reflect the timescales for production of the clinical strategy and the financial strategy.	finalised by February.
3.3.1	CQC Action Report HUTH	Leah Coneyworth to forward TW4 detail and confirmation of the Ops lead for the CQC actions report to Paul Bytheway.	Complete can be closed. Update is in the report. Bigger update in main plan and meetings in place.
4.7	Procurement Report Including Scan 4 Safety	Edd James and Paul Bytheway to meet to discuss procurement audit process and reporting.	Complete. Edd James has been sent the structure and Is aware of escalations.
3.3.1	CQC Actions Report – Group	Adam Creegan to review the EOL CQC action and plan a meeting for those involved in this service to ensure this CQC action can be closed.	No update due to apologies. Carry forward to November and include Ivan McConnell as action lead officer.
4.5	Security / LSMS Annual Report and Work plan	Craig Hodgson to ensure that lone working is included on the correct risk registers.	Risk assessment had been complete and the correct registers was now being kept by the individual departments. Complete.
4.5	Security / LSMS Annual Report and Work plan	Craig Hodgson to check the factual accuracy of the 25 occasions of violence and aggression between staff. If correct a referral to WEC CiC would be made.	Simon reported this to be correct. The only thing it doesn't capture is follow-up actions for HR intervention. Agreed to refer this to WECC CiC.
4.5	Security / LSMS Annual Report and Work plan	Craig Hodgson to gain clarity on whether the anti-social behavior letters included racist	Simon Tighe updated that anti-social behaviour is a letter written, but racism is a

		behaviours.	criminal offence where police would be notified and take action. Action complete.

Action: Gill Ponder to refer issue to the Workforce, Education and Culture Committee (WEC CiC) regarding the number of 25 occasions of violence and aggression between staff.

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 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. He highlighted that there had been no change to the strategic risks or underlying scores.

He drew attention to a correction in the report. He and Mark Brearley had had a conversation regarding the Capital risk and they agreed this fits better with the Capital and Major Projects Committees-In-Common (C&MP CiC) as the risk was around capital investments and fits within the scope of that CIC's Terms of Reference. There were 11 high level risks detailed in this month's report and David Sharif expressed that future reports would be in a better position to provide more details on mitigations.

David Sharif noted that high levels risks would be coming quarterly to this Committee and there were plans in place to provide more detail around risk owners and the effect of the risks. Stuart Hall asked if there was any update on the new risk system being put into place. David Sharif stated this was being worked through with procurement.

Gill Ponder expressed doubts around the performance risk, as it spoke about change management and culture and this may be better aligned to the WEC CiC. Paul Bytheway challenged this stating performance and ways of working was a mindset change and if culture is also managed at this Committees-In-Common this would help in overall delivery. David Sharif informed the Committees-In-Common that they should expect in the future that strategic risks would be broken down into sub-risks and there would be very clear actions on improving performance.

3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s) as referred from the Audit, Risk & Governance Committee (ARG CiC)

There were no external or internal audit reports & recommendations to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances(s) as appropriate

There were no external reports, recommendations or assurances to note.

The agenda was taken out of order at this point.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Business Planning Timetable

Mark Brearley took the report as read. This report came to this CiC last month, and since then it had been developed into a single version across the Group.

Ivan McConnell stated that the teams were working on a draft two-year plan based on assumptions in advance of the receipt of national planning guidance. It was agreed to bring an update on the Business Plan to the CIC in December and to bring the plan for approval in February.

Action: Lauren Rowbottom to add the update and approval of the Business Plan to the CIC workplan in December and February respectively.

4.2.1 Costing and Benchmarking

Mark Brearley took the report as read. The costing submission had been completed against the national guidance and the report indicated where the group was at, but also included the costing assessment tool that gave a review on the quality of work.

Cost allocation scores appeared to be high and the usage element is not where they would want it to be, however Mark Brearley said that they were still in a good position regardless of this.

Jennifer Granger and Leah Coneyworth joined the meeting at 9.33am

Gill Ponder questioned if there was anything the Committee could to do help with improving usage scores or could Care Groups be asked for plans on how they will use their data to drive costs down. Mark Brearley stated a review of the Cost Improvement Plans (CIP) and business cases to help gauge the impact of cost to the Group was required, but unfortunately the maturity of the information was not yet at a level for use in Care Groups.

Stuart Hall voiced that historically both Trusts had been in a reasonably good position and the Group now appeared to also be performing well. He questioned what happens with the costing data. Mark Brearley replied that the data was used to help drive the ICB (Integrated Care Board) costs and compare income to

previous and current income. Paul Bytheway added that services needed to be transformed and staff should be the main focus if major changes to the Group were to be seen.

PA Consulting were working with the Group to increase the confidence level in delivery of the financial plan for the year. They would also be identifying opportunities to close any gaps identified and would then carry out further work to support delivery and suggest areas for further cost reductions next year. Mark Brearley informed the CiC that the financial strategy would not include all gaps, but a recovery plan up to 2027 would be received.

Gill Ponder wondered if we could expect the strategy before April 2025. Ivan McConnell stated that they would be receiving initial feedback from PA Consulting's work in 6 weeks and that he would bring a presentation on their work to the next meeting.

Action: Ivan McConnell to bring a presentation on PA Consulting's work with the Group to the November CIC meeting.

Gill Ponder raised a question regarding submitted data overstated on Cancer MDT and understated on direct access on Pathology activity and asked if anything was being done to correct this. Mark Brearley explained that previously there had been issues with the NHSE programme and corrections could be made.

The Committees-In-Common agreed limited assurance.

3.3.1 CQC Actions Report – Group

NLaG:
Jennifer Granger took the report as read. There were 5 open actions for this CiC and the ratings had not changed since the last meeting.

Leah Coneyworth updated on The EOL (End of Life) action from the action tracker; she had met with the QI (Quality Improvement) team last Friday and then had a further meeting with colleagues in the information team. The Team were now being provided with full access to all data and dashboards and progress was being made on this action. It was agreed to change the action owner to Ivan McConnell as the QI team falls under his management and he would chase this before next month's meeting.

Action: Lauren Rowbottom to update the EOL Action owner (3.3.1) to Ivan McConnell.

HUTH:
Leah Coneyworth took the report as read. There were 2 green and 1 amber action relating to this Committee and the ratings had not changed since last month.

The amber rating was related to Maternity triage. The positives since the last update were compliance had been achieved for the target of 80% of women triaged within 15 minutes of arrival at the department. There had been an investment of £1.2 million approved at Board to support triage and staffing. A further paper would be going back to the Board in February for further investment in Medical Staffing.

Stuart Hall questioned how the £1.2 million was going to be utilised. Leah Coneyworth replied that it would be utilised amongst Midwifery, Maternity Triage and specialised roles which would provide a safer service.

Jennifer Granger and Leah Coneyworth left the meeting at 9.50am

The Committees-In-Common agreed that they had received reasonable assurance with nothing for escalation to the Board.

4.2 Group Finance Report Month 6

Phillipa Russell took the report as read. The Group was currently on plan at the end of month 6 with a year-to-date deficit of £11.3m. Deficit funding had been received, with HUTH at £13.3m and NLaG at £14.9m. Funding received had almost covered all of the costs incurred due to industrial action.

Philippa noted a £1.4 million shortfall in elective recovery funding, with issues in cancer assessment unit coding and digestive diseases cancellations due to decontamination work for 4 months that had not been included in the plan. The coding issue had been corrected which would show an improvement moving into month 7.

The Year-to-date capital expenditure was £12.6m against a plan of £31.3m, with slippage in CDC and theatre programmes. Additional schemes were being brought forward from the 2025/26 plan to address the shortfall and create the budgetary headroom for the 2024/25 slipped schemes to be completed in 2025/26.

Philippa highlighted a tight cash position for HUTH, with £33.6m at month six across the Group, only £4.9m of which was HUTH. Revenue support funding may be needed if CIP delivery did not achieve the more challenging targets in the second half of the year.

Stuart Hall queried whether there was some provision in the CIP for annual leave costing to be built back in. Phillipa Russell responded that this was already built in. Mark Brearley added that work had been done with Jonathan Lofthouse, corporate teams and Care Groups to maximise Elective Recovery Funding (ERF).

Stuart Hall queried whether some funding could be recovered from Community Diagnostics. Ivan McConnell added that conversations were underway, but the capital would be spent in the next year.

Gill Ponder questioned whether the Group year-end forecast to break even is realistic based on the risks in the financial plan. Mark Brearley stated this was being reviewed and currently he was unsure about plan or achievement

expectations, but by month 7 he would have a clearer view on the unmitigated risks.

Gill Ponder further questioned what was happening around the grip and control of overspending at HUTH. Mark Brearley stated that overspending was an issue amongst all Care Groups and felt this fed more into a cultural piece of work to help them become accountable. Paul Bytheway voiced that he had met with all Operational Directors about their delivery plans.

David Sulch queried whether the finance risk on the BAF needed a rethink if it was expected to breakeven at month 8. Mark Brearley stated it was too early to make any adjustments but in 1 months' time he would be able to make an assessment.

The Committees-In-Common agreed to limited assurance and highlighting to the Board the risks to achieving the year end plan from the unidentified CIP gap, overspending and the greater challenges in the plan in the second half of the year. The Cash position at HUTH would also be highlighted. The CIC also acknowledged the work PA Consulting were carrying out to mitigate some of these risks.

4.3 Group Integrated Performance Report & Deep Dive - including Cancer Deep Dive

Elective

Neil Rogers highlighted the continued progress on 65 week waits. The report showed only 15 patients for HUTH and 11 for NLaG and this was in-line with trajectory. The Group expected to see further improvement in October. There was a national expectation of zero by September, this had moved forward to October and the new trajectory was for virtual elimination by December 2024. He added that waiting list teams had been made aware to ensure they were getting ahead when scheduling patients for surgeries to ensure they have enough notice.

There had been a national expectation of the region to have no more 7,000 patients waiting 65 weeks by December and the ICB were required to have no more than 16 by then. The teams were in discussion with York and Scarborough to see how the 16 could be apportioned across the ICB. The overall plan was to have zero patients waiting more than 65 weeks at HUTH and NLAG, as the Group was one of the best in the country in terms of 65-week delivery.

The performance for 52-week waits was in line with the operational plan for NLaG and was slightly above for HUTH. Work was on going to help decrease waiting list sizes. The NLaG Lorenzo go live problems had been resolved and the list size was back to where it was at the end of the previous financial year. HUTH had remained the same size and was a known issue. The on-going plan was to ensure all patients were seen at 40 weeks from referral.

Stuart Hall recognised the good work done to improve the 65-week performance.

HUTH was sat at 1.4% of operations cancelled on the day for non-clinical reasons against a tolerance of 0.65%. When the data was investigated, it showed 57 cancelled on the day operations where due to non-clinical reasons such as no beds available. Stuart Hall questioned why a serious treatment like interventional Radiology had 14 operations cancelled on the day. Neil Rogers explained this was due to two reasons; one being that Radiology was a resource that often prioritised more urgent cases compared to booked patients and the second reason being that this speciality had a lack of a defined bed base. To help with this ward 38 would be opened once the refurbishment work was completed and would act as a major trauma ward to free up beds on the 4th floor.

Neil Rogers reassured the CiC that the Plastic Surgery service was trying to fill the capacity gap created by current vacancies by working closely with vascular colleagues and trying to reduce any unnecessary waits. Dr Kate Wood queried if opportunities had been explored to use an alternative provider for the more complex patients. Neil Rogers replied that an alternative provider was already used but stated they charged a large amount of money.

Gill Ponder queried why there was a mismatch between the growth of the Patient Tracking List (PTL) of 10.7%, but referral growth was only at 6.7%. Neil Rogers explained that more patients were converting into needing treatment, but Advice and Guidance (A&G) were working at redirecting referrals for those patients who did not need to be seen.

Gill Ponder noticed that the continued growth in 52-week waits would have an impact on the March 2025 forecast position and she questioned what was being done about this. Neil Rogers stated there had been a lack of clarity around the 52-week standard by March and guidance stated it would not be affordable or possible across the NHS so all systems were asked to do their best to minimise 52 week waits by the end of 2024. Currently they were 200 patients away from that trajectory with ENT being the biggest problem area. The independent sector were being used to see long waiting ENT patients.

Gill Ponder noted that the ERF activity for NLaG appeared to be doing well in May and June but in July-September it had dropped down showing a reducing trend. Neil Rogers stated it would take approximately 6 weeks to show an improvement after addressing coding delays. Plans were also being developed to smooth the profile of annual leave over the summer months.

The Committees-In-Common agreed limited assurance for this item due to the patients waiting 65 weeks, the growing PTL and backlog follow up lists, with particular issues in some specialities such as plastic surgery.

Diagnostics

Neil Rogers reported that there had been a dip in performance for diagnostics in August due to leave. The metric for this was measured by how many patients were waiting by the end of the month that been waiting longer than 6 weeks. Improvements had been seen in in patients waiting more than 6 weeks since

August, with HUTH at 23.5% and NLaG at 16.9% in September, which put both Trusts back on the operational planning trajectory.

Focus was on those modalities which benchmarked worst and an independent sector provider had been sourced to get through the Echocardiograms which this had led to improvement**.**

Neil reported a number of data quality issues, for example long waits when investigated were waiting due to requiring further investigations. Further work was underway to resolve this issue. Audiology assessments on the North Bank for patients who were overdue for an assessment were being investigated to understand the reasons for the delays better.

Whilst the picture had improved in September, the Committees-In-Common agreed to limited assurance due to volume of patients waiting and the delays to the CDCs coming onstream.

Urgent Emergency Care (UEC)

Neil Rogers updated that the Group was still above target for this point in the year for the North Bank. Ward C20 had been closed in readiness for Winter. There had been a covid outbreak at Rossmore so this meant there had been no admissions there for a period of time, which then led on to increased number of patients with No Criteria to Reside (NCTR) and ED becoming congested due to lack of beds to move patients requiring admission into. This created a deterioration in ambulance handovers, a reduction in performance for non-admitted patients time spent in the department and in the time it took for patients to receive their first clinical assessment.

During September, the challenge on the South bank was not as high. The main issues there were delays in moving patients to a main hospital bed causing long waits in ED.

Paul Bytheway mentioned a trial for a 45-minute escalation of ambulance handovers, with plans to mitigate risks if the ambulance service had to transfer patients after 45 minutes.

The footprint on both sites had been updated and was reported to be working well, but the North still required more space. Neil Rogers reported that boarding had been enhanced and the Group was ensuring that wards had the right patients on them.

Length of Stay was increasing, and this was work in progress to get back on track. The team was trying to reinvigorate the SAFER process and Nick Cross was doing a piece of work on this focused on medical ward rounds.

Neil Rogers also highlighted the differences in the resource levels managing flow on the North and South bank, with 1-2 people and 8 people respectively. As a result, he was looking at the organisation of the site team on the North bank.

Nick Cross joined the meeting at 10.43am.

Stuart Hall queried what measures were being put into place to improve the time to see first clinician. Paul Bytheway stated that the time to see a clinician had been improved. Rotas had been revised and patients had been diverted to other areas such as the Urgent Treatment Centre. The challenge was space, therefore this led to patients waiting. Lessons were being learned across the North and South, for example North Bank Matrons had been across to the South to see how they controlled patient flow.

Gill Ponder brought attention to the overall performance at NLaG noting the deterioration in performance on time to see a first clinician, frailty waiting times, ambulance handovers over 60 minutes and time to initial assessment, despite reduced Type 1 attendances. Paul Bytheway asserted this was due to the number of people in the ED department and added that type 3 and type 1 reduction cannot be explained. He further added that the team had not been able to pick up any themes.

Jenny Hinchcliffe joined the meeting at 10.47am.

The Committees-In-Common agreed limited assurance due to the increase in patients with No Criteria to Reside and space restrictions, but noted the actions being taken and the improvements beginning to show in some areas.

Cancer deep dive

Paul Bytheway and Neil Rogers provided a summary of the data for the CICs' deep dive into cancer performance, discussing the challenges in meeting the 62-day standard, the impact of workforce issues and the need for cultural change. They emphasised the importance of the 28-day faster diagnosis standard. They further stated that the Group was continuing to see a significant increase in referrals, but that was not resulting in an increase in diagnosed cases of cancer.

The current Operations Director who co-ordinates cancer improvement was due to retire and an interim with a cancer improvement background was being brought in to replace her.

Neil Rogers stated that the number of activities had not increased so the backlog had increased. However, the performance from July saw an extra 200 people receiving an appointment resulting in clock stops, which in turn saw performance go down. He stated that the keys to delivering 62-day performance were increasing activity to reduce the size of the backlog and the 28-day faster diagnosis delivery (FDS). HUTH had historically delivered on 28-day FDS and NLAG were improving month by month and were expected to meet the target within a couple of months. Weekend working was in place to make better use of diagnostic equipment. Performance against the 62 day target had been impacted by 2 of the larger tumour sites that had historically met the target failing to do so over the Summer, which impacted overall performance. This had been due to workforce issues but Neil

Rogers reported that the performance at HUTH appeared to be back on track and sustainable. There was continued work on the backlog of patients.

Challenges in various tumour sites were also discussed, including urology, breast and dermatology. The Group were driving for pathology to be recognised and patients removed from the Cancer pathway earlier when their tests had confirmed that they did not have Cancer. That would benefit both the Group's performance against targets and patients, who would have the reassurance of a benign diagnosis sooner.

Nick Cross updated that he was working with GP colleagues to look at how they could support the dermatology service. The Care Group had been actively recruiting consultants to help provide extra capacity. A Consultant had been recruited for breast and Dermatology and there was an additional urology Consultant in the recruitment pipeline.

Stuart Hall questioned if there was anything more that could be done to help improve the 28-day FDS work. Neil Rogers stated it was all around timings, for example getting patients in the clinic within 28 days of referral and to get biopsies turned around in time for the clinician. He added that they were focusing on not getting patients back into the clinic just to tell them their results are fine as that would save appointment spaces. Those patients could be informed by telephone instead, which would reduce their anxiety whilst waiting for the results of their tests.

Gill Ponder turned attention to the non-recurrent funding and how this had not resulted in sustained improvement, yet the report showed that more funding would allow further improvement. She asked if the Group was in a danger of accepting the poor performance if further funding was not made available. Paul Bytheway stated that big improvements happened in March due to increased funding but levels have grown again. He stated that referrals were always growing regardless of funding.

Simon Tighe joined the meeting at 11.25am

The Committees-In-Common agreed they had limited assurance due to increased referrals without a corresponding increase in activity levels, leading to an increase in backlogs. The Group also remained in the Tiering system for Cancer performance and was not consistently meeting 62-day performance improvement trajectories.

4.4 Winter Plan

Paul Bytheway took the report as read. He remarked that the winter plan was not where he wanted it to be and unfortunately had got to a point of being 6 weeks behind. He emphasised the need to get back to the bed base from last year and to risk assess additional funding requests. The bed bridge would be refined over the next 3-4 weeks. Some quick wins were possible, such as Virtual Wards, but there were also some essential additions needed to manage risks, including an extra

paediatrician at the front door to deal with the expected increase in RSV cases in children.

Paul further stated that ward C20 at Castle Hill Hospital had closed from September to help get ready for Winter, however the ward ended up being used again to help with the increased number of No Criteria to Reside (NCTR) patients due to a Covid outbreak at Rossmore.

It was agreed that the final, risk assessed plan would be brought to November's PEF CiC, where a deep dive discussion would take place. To create the space for this on the agenda, it was agreed that all planned deep dives on the Workplan from November onwards would be moved back by 1 month.

Action: Lauren Rowbottom to:
- add the Winter Plan Deep Dive to the agenda for the complete plan to come back to November's CiC.
- send invitations to the meeting to Nick Cross, Jenny Hinchliffe and Amanda Stanford to attend for the Winter Plan Deep Dive
- add the Winter Plan Deep Dive to the Workplan in November and move all other planned Deep Dives back by 1 month on the Workplan

Jenny Hinchcliffe and Nick Cross left the meeting at 12.03pm.

The CIC agreed that they had received limited assurance due to the plan being incomplete and not yet risk assessed.

4.5 Estates and Facilities - General Update

Simon Tighe took the report as read. The North Bank held four high risks and the South Bank held nine.

Simon Tighe reported the lift A in the tower block at Hull Royal Infirmary had been completed however the upgrade on lift B had had to be put on hold until March 2025 due to mechanical failure on Lift C. Once Lift B was complete, C would be upgraded before moving onto D. By July 2025 this would put the tower block in a better position.

There were two new high risks on the North Bank. The first was the aging of critical ventilation in theatres, ITU and HDU. This was a Backlog Maintenance issue due to limited funding availability and access restrictions, which linked to the second risk (4348) of not having decant facilities across both the North and South Bank, resulting in insufficient routine maintenance for wards. This continued to be monitored and the team was working closely with the Infection, Prevention and Control (IPC) and Operational teams, as it also affected access requirements when deep cleans were necessary after infection outbreaks. This risk would be further refined once the Winter Plan had been agreed.

One risk on the South bank had been downgraded. The Oxygen system at Grimsby was updated, but the Scunthorpe oxygen management system was not. Due to changes in oxygen usage, demand for oxygen had reduced so the risk had been

downgraded in agreement with clinical and pharmacy members of the Medical Gas Committee. A number of the other high risks at Scunthorpe General Hospital would be closed as a result of the Public Sector Decarbonisation Scheme (PSDS) works taking place there over this year and next year.

Simon Tighe praised the good work that Alex Best and the Capital team were doing.

Phase 3 car parking at Castle Hill Hospital had opened and the team were now working on Phase 4, which was disabled parking.

Bids were being submitted for the next round of PSDS funding, where schemes with the highest CO2 reductions were likely to be most successful in receiving grants. The biggest Group opportunity for CO2 reduction was at Diana, Princess of Wales Hospital.

Simon Tighe went on to update that cleaning contracts across both organisations required reviewing. The OCS contract was due to expire in May next year and there was cabinet approval to extend it to November 2025 to enable a review of the best cleaning services model to adopt across the Group to take place.

The CDC contract had been agreed and was due to be signed by the Group Chair, Sean Lyons, on behalf of the Board.

Stuart Hall queried whether the critical ventilation piece of work could be deferred and was it the right time of year to be addressing this. Neil Rogers stated a ward had been made available to help get some of the essential work done.

Gill Ponder questioned whether the DPoW family catering services now being operated by the trust was cost efficient. Simon Tighe explained that a paper was taken to Cabinet that proved the trust could do it better and cheaper.

The Committees-In-Common agreed they had been reasonably assured due to the actions in place to mitigate the risks and the improvement works planned. They highlighted the risk around the lack of decant facilities and praised the positive work on the improvement of the lifts at HRI.

4.6 Contract Approvals - Sleep Therapy Service, Equipment and Consumables

Mark Brearley took the report as read. There were no concerns around the cost and the price for the contract was the best price that the Group could get. He further added if the contract was approved today, then it could start from the 1 of November with no additional costs incurred until then.

The Committees-In-Common approved the contract.

4.7 Emerging Issues

No emerging issues were raised.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

The Committees-In-Common had nothing additional to raise in relation to the work plan.

5.2 Consolidated North Bank Site Report

The Committees-In-Common had nothing to raise from the consolidated North Bank Site Report.

5.3 Consolidated South Bank Site Report

The Committees-In-Common had nothing to raise from the consolidated South Bank Site Report.

5.4 Planned Care Board Meeting Minutes

The Committees-In-Common had nothing to raise from the Planned Care Board Minutes.

5.5 Unplanned Care Board Meeting Minutes

The Committees-In-Common had nothing to raise from the Unplanned Care Board Minutes.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

David Sharif gave thanks to Paul Bytheway for his work and contribution to the Group and the Committees-In-Common added their thanks and wished him the best in his future role.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

Wednesday, 27 November, 9am – 12.30pm in The Nightingale Room, Education Centre, Scunthorpe General Hospital.

The meeting closed at 12.22pm.

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		Y	Y	Y	Y	Y		
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y	N	Y	Y	D		
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y	Y	Y				
Mark Brearley	Interim Group Chief Financial Officer									Y	Y		
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N	Y	Y	Y	N		
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y	Y	Y	Y	D		
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y								
Paul Bytheway	Interim Group Chief Delivery Officer						Y	Y	Y	D	Y		
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y	Y	D	N	Y		
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D	D	D	D	D		
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N	N	N	N	N		
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y	Y	Y	Y	Y		
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N								
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y	N	Y	N	N		
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N	N					
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y	Y	Y	D	D		

***KEY**: Y = attended* *N = did not attend* *D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)248

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12th December 2024
Director Lead	Tony Curry, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common & Julie Beilby Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-In-Common held on August & October 2024
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Workforce, Education and Culture Committees-In-Common held in September and November 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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 29th August 2024 at 13:30 to 17:00 at Nightingale Room, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) Chair
Sue Liburd	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Simon Nearney	Group Chief People Officer

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Georgina Birley	Personal Assistant (HUTH) (Minute Taker)
Jennifer Granger	Head of Compliance and Assurance (NLaG) (Item 3.3.1)
Sean Lyons	Group Chairman
Lucy Vere	Group Director of Learning and Organisational Development (Item 4.2, 4.3 and Item 4.5)
David Sharif	Group Director of Assurance
Dr Ashok Pathak	Associate Non-Executive Director
Mel Sharp	Deputy Chief Nurse
Julie Beilby	Associate Non-Executive Director (NLaG)
Dr Wajiha Arshad	Guardian of Safe Working (HUTH) (Item 4.4.1)
Dr Liz Evans	Guardian of Safe Working (NLaG) (Item 4.4.2)
Dr Andrew Gratrix	Associate Medical Director

Observers:

Ian Reekie	Lead Governor and Public Governor – North East Lincolnshire

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 by Kate Truscott, Non-Executive Director (NLaG), Dr Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse and Leah Coneyworth, Head of Quality Compliance and Patient Experience (HUTH).

1.2 **Declarations of Interest**

Dr Ashok Pathak stated his daughter was a defence lawyer and had dealt with employment dismissal cases involving the NHS and confirmed he would alert the CiC if there became a declaration of interest within the meeting.

1.3 **To approve the minutes of the meetings held on 25th July 2024**

The minutes of the meetings held on the 25th July were accepted as a true and accurate record with the below amendments:

Simon Nearney stated there were spelling mistakes and grammatical errors throughout the minutes. Also, that paragraph two, page six and paragraph four, page 11, needed rewriting. He would provide the correct wording to the minute taker to amend, this was agreed by the Chair.

Action: Simon Nearney to send amended paragraphs wordings to the minute taker to amend the July minutes.

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:

Simon Nearney reported that maternity support workers at Diana Princess of Wales Hospital (DPoW) were on their second strike for seven days. The Trust continued to have conversations with staff and Unison. Tony Curry asked if there had been an outcome from discussion. Simon Nearney confirmed that there had been discussions around the length of time of the strikes, a top up payment and there were further meetings planned. Dr Ashok Pathak asked what the impact on patients had been and if a resolution was in sight. Simon Nearney stated the impact had been managed with no compromise on patient care, but there had been some trouble covering the weekend shifts due to bank staff not wanting to cover for their colleagues, and compromises were needed from both staff and the Trust for a resolution. He commended the hard work of the management in the Family Services Care Group.

1.5 **Committees-in-Common Action Tracker**

There were no actions due for review in August. It was agreed later on in the meeting that actions with a date for review in September would be extended to October, when the next meeting would occur.

1.6 **Emerging Issues**

Simon Nearney reported that the consultant's additional hours and uplifting pay had been agreed, with Waiting List Initiative (WLI) at £125 per hour and Out of Hours rate (OOH) £175 per hour. He stated the rates were not in line with the BMA rate card but were on par with neighbouring Trusts including Leeds, Sheffield and York.

Sue Liburd reported that on 22nd August 2024 she and Linda Jackson, Vice Chair/Non-Executive Director, met with NLaG governors and there were concerns with the Community Diagnostic Centres (CDC) staffing proposals, it would have an impact on hospital clinicians and that staff could be poached from the Trust. Concerns were also raised about the emerging culture at NLaG and also that consultants were writing a letter to the Chief Executive stating the Care Group structure was no longer working. There was also a perception that "NLaG staff were leaving in droves". Sue Liburd asked if there was data to support the claim.

Simon Nearney stated CDCs were opening all over the country and that other Trusts would have similar staffing problems. Some new staff had already been appointed but the recommended staffing level would not be reached. The staffing model would rotate staff between hospital and CDC. Tony Curry questioned if the workforce model was sufficient to deliver services at the Trust and the CDC and if staff would deskill with this approach. Simon Nearney stated that the Trust and CDC would not be able to provide all services due to the staffing shortfall and the that the rotation model staff would preserve skills. Paul Bunyan was currently investigating the possibility of repatriating outsourced radiology reporting back within the Trust.

Dr Ashok Pathak stated there would be an impact but some of it would be positive due to the CDCs taking some of the Trust's referrals, but asked who would pay the CDC staff. Simon Nearney confirmed the Trusts would remain the employer and would pay staff. David Sharif stated that Gill Ponder, Non-Executive Director had raised this is the Capital and Major Projects CiC and was satisfied with the response.

Simon Nearney responded on the perception of a high number of staff leaving NLaG that turnover in April 2023 was 12%, had risen to 14% in January 2024 but was not at 10%. He acknowledged staff engagement was not good and was worse at NLaG than at HUTH. There were plans for culture improvements and the Executive Team had an away day, facilitated by Lucy Vere, to create a 10-point action plan. A point was raised about the new care group structure. He reminded the CiC that the care group structure had only been in place since April. Tony Curry asked if there were routes that consultants could raise concerns. Simon Nearney confirmed they can raise issues to their manager and through Local Negotiating Committees (LNCs).

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

There were no matters referred to the CIC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

David Sharif took the report as read. The two strategic risks, on culture risk and staffing, assigned to the CiC had not changed. The report included the high-level risks with a number past their date for review, but due to the deadline for submission of papers the report didn't reflect the work that had been carried out by the care groups since its submission.

David Sulch stated that risk 2550, that pharmacy was not able to maintain their level of service delivery to vacancies and maternity leave, was from 2019 and so was not a risk, but an issue and asked for the narrative to be dated so the CiC are aware that current controls were in place.

David Sharif acknowledged this as an issue and stated that this was the case for other risks too. He assured the CiC that a new system would deliver better tracking of the risks but would not be implemented until September 2024. Tony Curry stated there were no end dates on risks and wanted to know what the mitigating actions were for the risks.

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 Reports, Recommendations & Assurances as appropriate**

3.3.1 **NLaG and HUTH: CQC Actions Progress Report for August 2024**

NLaG:
Jennifer Granger gave an update on the NLaG report and the HUTH report in Leah Conneyworth's absence. She confirmed review meetings had taken place looking at all open and closed CQC actions which resulted in some changes to narrative, definitions of BRAG ratings and assurance levels for some actions. For NLaG there were 39 actions, 17 closed, one on paediatrics medical staffing moved from green to amber and five on training moved from amber to red. Review meetings had also happened for HUTH and some actions also had decreased in ratings.

Sue Liburd commended the work that had been done. Tony Curry also agreed the work carried out was good so it gave a better reflection, but stated there continued to be delays completing tasks and in particular training compliance. He confirmed he would be writing to Amanda Stanford, Group Chief Nurse, and query how to get actions to be closed or to a more managed position and sustained.

David Sulch asked if there were any themes that had arisen from the mandatory training action. Simon Nearney stated that core mandatory training at NLaG was around 90% but there were issues within certain subjects including resus and security. Lucy Vere added that there was sufficient capacity for training high Did Not Attend (DNA) rates were linked to last minute rescheduling of staff to address clinical shortages. She confirmed role specific training was being reviewed at both Trusts as mandatory training differed between them. Tony Curry asked if alternative ways of delivering training had been considered and Lucy Vere confirmed she had discussed this with Dr Kate Wood, Group Chief Medical Officer, specifically the difference in resus training across both Trusts. Sue Liburd stated leaders in those problem areas needed to be held to account for their staffs training and that the CiC needed to be reassured that there was an action plan in place to ensure improvement. David Sulch added it was the individual staff members responsibility to maintain training compliance to enable them to work.

Action: Tony Curry to write to Amanda Stanford addressing the issues of CQC actions reopening due to the training and compliance position not being sustained.

The CiC agreed on limited assurance.

COMMITTEE SPECIFIC BUSINESS ITEMS

4

Joint Business Items

4.1 **Workforce Race Equality Standard (WRES)**

Lucy Vere took the report as read. There had been general improvement at HUTH but the issue of bullying and harassment had not. NLaG had not seen an improvement and remained static. Dr Ashok Pathak stated it was encouraging to see an improvement but bullying concerns in the BAME community remained at both HUTH and NLaG. He asked what was being done to mitigate that and if there was a pattern in reports in certain care groups. Lucy stated the report showed last year's data and that information would come in next year's report. Work needed to be done with staff to ensure they felt comfortable reporting and that managers would progress.

Simon Nearney stated bullying and inappropriate behaviours at HUTH had reduced by 4% after the implementation of the Zero Tolerance QR code, but it was yet to be rolled out at NLaG. Development coaching, mentoring and focused resourcing was discussed for BAME staff. It was acknowledged that staff were commenting on the lack of BAME representation in leadership and executive level positions, and that managers should not be bias when recruiting to positions.

4.2 **Workforce Disability Equality Standard (WDES)**

Lucy Vere took the report as read. Reporting was low and there had not been much change at HUTH or NLaG. The report noted that the pressure felt by disabled staff to attend work was high, but more positive for reasonable adjustments at around 70-80% satisfaction. There was a running theme of bullying and staff being treated poorly, particularly at NLaG.

Dr Ashok Pathak asked what the breakdown of physical, mental, neurodiverse disability percentage of staff was but Lucy Vere stated that the Electronic Staff Record (ESR) system did provide this option, it was either yes or no to having a disability. Simon Nearney stated NLaG had done well with staff flexible working requests but there had been grievances against staff for working patterns.

David Sulch stated the report was difficult to understand and it didn't provide helpful narrative on what the Trusts were doing to help disabled staff.

4.3 **Groups response to the recent riots**

Lucy Vere gave a verbal update. Staff were divided by the Groups response to the riots but she was proud of colleagues that had taken people to and from work and helped each other. At a Network meeting staff were unhappy not being able to meet with the Chief Executive but they had met with him since. There had been positive listening events with Humberside Police and staff. The zero tolerance to racism tool was being brought forward with posters in patient facing areas.

Dr Ashok Pathak stated the overall response by the Trust didn't go down well with some and felt that executive level staff should have spoken to the BAME community sooner, but understood they were speaking with the police. Simon Nearney stated two staff had posted radical views on social media and that incidents would be dealt through formal disciplinaries. Tony Curry stated the comradery from teams was appeared positive in an unacceptable situation. David Sharif stated that during the riots the action for managers to check with teams and the cascade process did not happen. Tony Curry stated a formulated response would be useful if the situation occurred again.

4.4 **Guardian of Safe Working Hours – Annual Report**

4.4.1 **Guardian of Safe Working Hours – Annual Report (HUTH)**

Dr Wajiha Arshad presented the report. There had been a decrease in exception reports, the majority were from paediatrics surgery. There was a larger piece of working taking place looking at what could be done to improve the rotas, with the highest number of fines also in that area at £14k. 92% of rotas were now on E-roster. Dr Ashok Pathak asked what the fines were mostly for and for which teams. Dr Wajiha Arshad stated it was mostly for on call time breaches and in General Surgery for breaches in shift hours as a result of overrunning theatres and on-calls.

4.4.2 **Guardian of Safe Working Hours – Annual Report (NLaG)**

Dr Liz Evans presented the report. There had been a decrease in exception reports the last quarter, with the majority for medical specialities on calls. There were issues with staffing in medicine last quarter, due to strikes, as well as short notice sickness and consultants stepping down to cover rota gaps. Three work schedule reviews had been outstanding for more than six months and educational supervisors were not engaged in the process to make change, she had escalated to Dr Nick Cross, Medical Director – South who had emailed out to staff, but no difference had been seen yet.

Simon Nearney asked how the junior doctors morale and engagement was at NLaG and HUTH. Dr Liz Hardy stated it depended on which speciality the doctors were in and that some requested to come to the Trust but others were put here, and they were easily demotivated. Dr Wajiha Arshad stated the same for HUTH but the doctors were happy to speak them. Tony Curry asked if the overall management of working hours was good and if there were too many exceptions. Dr Wajiha Arshad stated the exceptions were a useful tool for them to step in and sort the issue. Rotas were being redesigned from junior doctor's requests. Dr Liz Hardy stated in NLaG that medicine didn't have good handovers and the complicated rotas caused issues. Dr Andrew Gratrix stated in a junior doctor meeting that morning that people were unaware on shift pattern requirements and handovers, but Dr Caroline Hibbert, Medical Director – North, had adjusted them to address the issue.

Lucy Vere explained that the tariff that comes to the Trust for the junior doctors and their education supervisors should go to the care groups but wasn't sure this was happening and unsure of the rate.

Action: Lucy Vere to contact NHS England (NHSE) to confirm the tariff rate for junior doctors.

The CiC agreed on an assurance rating of reasonable assurance for HUTH and NLaG.

4.5 **Learning and OD Progress Report**

Lucy Vere took the report as read and stated structures were in place in learning and OD but with some vacancies, and each manager in OD had a portfolio within the Group. A new induction for Agenda for Change (AfC) staff had been implemented with the first day being e-Learning and second day on site induction to the Group. A review of other staff's inductions would take place by February 2025. She thanked the hard work of the recruitment team. All care group directors had been proactive and had been carrying out timeouts and developing their teams. She would be carrying out a capacity and demand review for the OD team due to the amount of work that would be needed with the culture work starting soon.

The CiC agreed to rate as significant assurance.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The work plan was noted and there were no issues raised.

5.2 **Consultant Engagement**

The report was received as information and no questions were raised. A more detailed paper would come to the CiC at the meeting in October 2024.

6. ANY OTHER URGENT BUSINESS

Dr Ashok Pathak raised the increase in the number of disciplinary procedures in the last six months, and requested comparison data from previous years on how many disciplinaries had led to sanctions and in the increase in tribunal hearings, the outcomes and costs. Simon Nearney stated he could provide the data at the next meeting but that HR business partners manage the process well and formal investigations are only a last resort.

Action: Simon Nearney to provide data comparison on disciplinary procedures and tribunal hearings, the money associated and outcomes for this year and last year.

Action: Lauren Rowbottom to add the above to October's meeting agenda.

Tony Curry stated there were chronic recruitment issues with some roles including acute physicians, midwives and pharmacy staff and asked if there was a plan 'b' with a short to medium term solution and also if supply and demand had been looked at. Simon Nearney responded and stated that plan b's were used frequently to mitigate staffing issues and to ensure the service was safe. Dr Andrew Gratrix stated acute medicine consultant roles were difficult to recruit to and the Group were losing out to other Trusts. Simon Nearney stated that joining incentives had been used when recruiting to hard to recruit to consultant posts.

The CiC agreed that the Learning and OD report due in September would be circulated prior to the Time Out session in September and any queries would be discussed on the day, the other items on the workplan would be discussed in October's meeting.

David Sharif asked for feedback on the standard of the reports in the meeting. David Sulch stated the WDES report could be improved with better narrative to support the data. The CiC agreed the executive summaries could be improved with more concise information.

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 maternity support workers strike remained a challenge
- No changes to the BAF
- The review of the CQC actions and issues with mandatory training
- The Groups response and support to staff on the civil unrest and riots
- The CiC agreed on significant assurance on the Learning and OD Progress Report

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Workforce, Education and Culture CiC meeting:

The regular WEC meeting scheduled for Thursday 26th September had been revised as a Group Board Culture Development Session, actions due would be carried forward to October and any urgent items would be addressed via email.

The next regular WEC meeting will be held on Thursday, 24th October 2024, at 13:30, in the Main Boardroom, Diana, Princess of Wales Hospital.

The Committee chair closed the meeting at 16:32 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y							
Amanda Stanford	Group Chief Nurse	D	D	Y	D	D							
Kate Wood	Group Chief Medical Officer	Y	N	Y	D	D							
Tony Curry	Non-Executive Director (HUTH)	N	N	Y	Y	Y							
Kate Truscott	Non-Executive Director (NLaG)	Y	Y	Y	D	D							
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y							
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y	Y							
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y							

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 24th October 2024 at 13:30 to 17:00 at The Boardroom, Alderson House, HRI

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) Chair
Sue Liburd	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Simon Nearney	Group Chief People Officer
Dr Peter Sedman	Deputy Group Chief Medical Officer
Amanda Stanford	Group Chief Nurse
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (HUTH) (Minute Taker)
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement (Item 4.2 and 4.6)
Leah Coneyworth	Head of Quality Compliance and Patient Experience (HUTH) (item 3.3.1)
Lucy Vere	Group Director of Learning and Organisational Development
Helen Knowles	Group Director of People Services (Items 4.7 and 4.10)
David Sharif	Group Director of Assurance
Fran Moverley	HUTH Freedom to Speak up Guardian (Items 4.1.1)
Elizabeth Houchin	NLaG Freedom to Speak up Guardian (Item 4.1.2)
Lindsay Harding	Director of Workforce (Item 4.8)
Linda Jackson	Vice-Chair (NLaG)

Observers:

Robert Pickersgill	Deputy Lead Governor

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 Committees in Common Chair welcomed those present to the meeting.

Apologies were noted by Dr Kate Wood, Chief Medical Officer, Jennifer Granger, Head of Compliance and Assurance (NLaG) and Ashok Pathak, Associate Non-Executive Director (HUTH).

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 August 2024**

Julie Beilby enquired about the rollout of the zero tolerance QR code, which had been implemented in key areas and would be officially launched at the end of the month.

The minutes of the meeting held on the 29th August 2024 were accepted as a true and accurate record subject to the below amendments;

Sue Liburd expressed disappointment that the minutes from August's meeting did not reflect the robust discussion held regarding the additional challenges for ethnic minorities from a discriminatory point of view.

Simon Nearney brought attention to section 1.4 second paragraph, Maternity support 'works' needed to be changed to 'workers' and Item 1.6 emerging issues to be updated to show 'the consultant's additional hours and uplifting pay had been implemented; it was not agreed with both LNC's'.

Action: Simon Nearney to send amendment of minutes to Lauren Rowbottom.

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:

Simon Nearney gave an update on the Maternity Support Workers. Simon reported on the ongoing negotiations with maternity support workers, highlighting the issue regarding recognition and back pay for long-serving members. A meeting was held last Friday with Amanda Stanford and other colleagues, where a significantly increased offer was put forward. However, the offer was not accepted, and further strike action was a possibility. Further conversations were planned with Unison colleagues and the organiser to keep the dialogue going and see if a solution could be reached.

Simon updated on the recent civil unrest in Hull, noting that staff felt supported and the situation was handled well with proactive measures in place. Lessons had been learned following the last riots.

Simon mentioned the ongoing staff survey with a current response rate of 22%, and the Group was aiming for 60% by the end of November.

Simon reported on the flu vaccination efforts, including pop-up sessions from next week and peer vaccinators on the wards, and the aim was to reach a 50% vaccination rate. The current rate was 5%.

1.5 **Committees-in-Common Action Tracker**

The committee discussed the need to manage the action tracker more effectively, with a commitment to stick to set dates and avoid delays, and if actions are unable to meet the target date the chair must be made aware with a reason.

The following updates to the Action Tracker were noted:

Lucy Vere highlighted that internationally educated staff are facing safety concerns, including feeling unsafe in their neighbourhoods and at work. Efforts are being made to address these issues. Lucy mentioned that internationally educated staff feel they are being treated differently compared to white-presenting staff. This includes issues with inclusivity and support during placements. The team was working on a standard operating procedure for dealing with racist patients, which will include clear consequences and mutual aid between hospitals to address the issue. Lucy felt it would be beneficial for quarterly reports to be brought to this Committees-In-Common.

Lucy Vere provided an update on the Care Group support program, which included time-out sessions, bespoke support, and master classes to improve relationships and teamwork within Care Groups. Lucy noted that the program had seen good engagement from Care Groups, with positive feedback on the support provided. The focus had been on restorative work and keeping teams safe in a fast-paced environment. The next phase of the program included regular check-ins with Care Groups, additional support for nurse directors, and a four-day leadership program for direct teams starting in the new year.

1.6 **Emerging Issues**

Linda Jackson questioned when was the best time to schedule a time-out session. The Committees-In-Common felt it would be beneficial to have an extra-ordinary meeting in December.

Action: Lauren Rowbottom to co-ordinate an extra-ordinary meeting for December.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

There were no matters referred to the CIC.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

David Sharif took the report as read. He highlighted that on page 3 of the report, there was a table which contained three high level risks scoring 20 beyond their

review date. Overall, the BAF score had not changed. The work being done to refresh the BAF was in draft and it was going to be helpful in tracking actions against gaps in controls. The report at November's meeting would be the updated version.

David Sulch questioned whether the new BAF report would contain a report of when we believe target risks will be mitigated and how. David Sharif explained there was a process in place to review the risks, and how achievable they are.

Tony Curry wanted assurance that the three high level risks were being addressed. David Sharif explained that there was activity around all three risks, and a process was in place to escalate and deal with these.

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 Reports, Recommendations & Assurances as appropriate**

3.3.1 **NLaG and HUTH: CQC Actions Progress Report for September 2024**

Tony Curry updated the Committees-In-Common that following the Quality and Safety CiC timeout in September it was agreed that the CQC Actions Report would be reported on a quarterly basis rather than monthly to better reflect progress being made.

Leah Coneyworth gave a verbal update on the CQC Actions Progress of HUTH and NLaG. She highlighted that there had been no changes to the position reported previously, they were 22 actions open at NLaG that related to the Workforce, Education and Culture CiC 7 of which were red and 7 actions for HUTH 5 of which were red.

The main themes correlated across both sites which was mandatory training, particularly with medical staff, between 51-70% of compliance. Some themes being worked on was safeguarding at NLaG and resuscitation training at HUTH.

Leah updated that she had spoken with the head of security regarding the security resuscitation training and it had been confirmed that staff would be completing their resuscitation training and will not just be Emergency Department (ED) staff. The head of security was working with external agency to get dates in the diary.

Tony Curry recognised that historically the target dates for some actions were ambitious which was why a reset was required. Amanda Standford indicated that target dates were moved forward when they were not achieved to show as being on track when they were not.

The Committees-In-Common agreed that limited assurance was given due to actions not yet completed and embedded.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Freedom to Speak up (FTSU) Quarterly Reports

4.1.1 Freedom to Speak up Quarterly Report (HUTH)

Fran Moverley took the report as read. She highlighted that there had been 52 cases reported in Quarter 2 which had slighted reduced compared to Q1 but still higher than last year's reporting period. The main concerns were around people's roles, and a couple of themes relating to this were workload and working excessive hours, and this had resulted in some colleagues asking how they transfer out of roles. This was closely followed by inappropriate behaviours, with lots of comments around poor cultures that have been created as a result from these behaviours. Worker safety around people's physical environments typically at Hull Royal Infirmary was another concern reported and finally there were two concerns were around psychological safety and people feeling fearful in their teams.

Amanda Stanford referred to page 6 of the report where it looked to show corporate as being the department with the biggest number of concerns, she questioned if this was correct. Fran confirmed this was correct, 20 concerns were from HUTH. She added that the majority of concerns there had been consent to escalate them to deputy directors and senior management in their teams. Amanda questioned if there was any link between the concerns. Fran suggested to meet Amanda to look into the data, as there appeared to be spikes in certain teams but it may just be multiple reports from only 1-2 people.

4.1.2 Freedom to Speak up Quarterly Report (NLaG)

Elizabeth Houchin took the report as read. She highlighted that there had been 92 cases reported in Quarter 2, which was higher than the previous year but lower than Quarter 1. 8 concerns were raised via the anonymous staff app. The main themes were around inappropriate behaviours, HR processes, bullying and harassment.

National figures had been published and they showed that inappropriate behaviours accounted for almost 40% of concerns nationally. In quarter two for NLAG, inappropriate behaviours accounted for about 21%.

There had been a reduction in concerns where the impact of the group was mentioned and FTSU Champions had noticed that morale remained quite low regarding the impact of the implementation of changing systems and processes.

Sue Liburd queried whether any outstanding concerns that were discussed monthly and escalated, where they then closed or did they remain open for longer. Liz confirmed that they were open for longer due to being at a higher level of complexity, and stated she had some outstanding concerns that had been open for

several months. She expressed it was useful to meet with Simon Nearney and Jonathan Lofthouse monthly to talk through those and gain any support needed to moving forward with those concerns.

Linda Jackson noted that acute medicine had 15 concerns, digestive diseases had 13 and patient services had 14 and these stuck out compared to other Care Groups that reported zero and wondered if there were any trends in those area that were a concern. Liz observed that in digestive diseases 8 of the 13 concerns were involving a contract issues around fixed term contracts and a service review. In Acute and Emergency Medicine there had been some cultural issues and inappropriate behaviours reported there, but noted that work was being done in some areas and this was ongoing but this hadn't seen a reduction in concerns at that time. Lucy Vere added that the department were going through a programme of work and the OD team were working with the leadership team regarding the culture they're creating.

The Committees-In-Common agreed significant assurance due to the level of control and professionalism by the Guardians.

4.2 **IPR and Recruitment / Time to Hire KPI**

Paul Bunyan took the report as read. The vacancy position was decreasing and this was mainly due to the nursing position. The consultant vacancy position remained a concern and this continued to be more problematic at NLaG. Sickness was at the lowest point it has been since being recorded, but mental health such as stress was on the increase. Staff turnover was improving, however there was an increased number of people leaving within their first year of appointment. Paul updated that the exit interview process had been refined and this has since been released.

Agency position in comparison to last year was £7.7 million less and this was a result of the reduction in vacancy position, particularly the registered nursing position.

Linda Jackson praised the new format of the report. She further queried whether the data was triangulated across savings and the vacancy and recruitment plans. Paul explained that currently they do not and it was a further conversation to be had. Amanda further added that the safer staffing paper would be presented to the Board twice a year to compliment these reports.

Tony Curry understood the long-standing difficulties in the recruiting consultants and queried whether there was any prospect of this improving. Paul explained that the position was being looked at from an establishment point of view and also stated that some vacancies are harder to recruit than others.

The Committees-In-Common agreed to reasonable assurance due to the positive vacancy position but noted the challenges with the consultant vacancies.

4.3 **Job Planning**

Dr Peter Sedman gave a verbal update. He expressed there had been difficulty in aligning the North and South bank with their job plans and there was a large piece of work to get them aligned using a common job planning process for all sites.

The job planning policy had gone out to the Local Negotiating Committees (LNC) for discussion and approval. There is a plan to meet in December to finalise THIS with of starting job planning in January/February time. Following this panels working on a regular basis to moderate the process. Given the volume of work still to be done it would be approximately another 6 months before any real action and benefits would be seen.

Linda Jackson questioned whether job planning was per site. Peter informed it was per Trust and they had licences for NLaG and for HUTH and it was going to be developed towards the Care Group Structure.

Tony Curry questioned if there was confidence that the unified process would be adopted. Peter stated that job planning was always challenging and some people may not be easily persuaded, however felt there was no lack of confidence in getting to a positive position on it.

The Committees-In-Common agreed that limited assurance should be given as it was noted this was work in progress and was a very challenging piece of work.

4.4 **Medical Education Annual Report**

Dr Peter Sedman took the report as read and gave a brief overview of some highlights. There was hope that by 2025 there would be a single combined report. He expressed that there had been some really good work at both HUTH and NLaG but it was clear there was still some significant problems particularly in training of Junior Doctors on both sites. There had been good investment on the South Bank, and the teams had worked really hard on the North Bank.

There were challenges in terms of the workforce issues. Medical Schools were going to be increasing their number of Foundation Year 1 (FY1) Doctors, which would mean there would be a lot more Junior Doctors to accommodate in the next round of planning. 12 Junior Doctors had already been taken on this year.

Peter explained that there was a plan to change GP training so that they will no longer have to do the two years working in a hospital so it was hoped this would even out the increase in Junior Doctor position.

Linda Jackson stated that looking at the change in demand, they may have to look at what is needed to be able to service the increase. Peter agreed, adding it was difficult this year as the Junior Doctors came out with nowhere to go which imposed a risk of them being unemployed.

Linda Jackson queried if the Junior Doctors do not work for two years in the hospitals do they get to automatically go to work in a GP surgery without the experience they would have learned previously. Peter informed that without the hospital supervised training they are unable to invest in the next steps.

David Sulch recognised the risk around people taking on educational supervision commitments without having the time do them properly leading to trainings. He further asked a question regarding where they were at with the medical education funding and the financial savings of a 7% target. He added that the medical education funding was for trainees the Group get, and the money should no be used for other trust purposes. Simon Nearney declared he was meeting with the Chief Financial Officer and the Chief Executive the following day where he assured, he would have the conversation that the 7% couldn't be removed from medical education without having to reduce the amount of medical, training, expenses and salaries and he was optimistic on getting this resolved.

Lucy Vere added that the tariff rate received for medical education on the HUTH side was £16.5 million and for NLaG was £12.2 million.

The Committees-In-Common agreed reasonable assurance due to the positive work being carried out.

4.5

Guardian of Safe Working Hours – Annual Report

4.5.1

Guardian of Safe Working Hours – Annual Report (HUTH)

Dr Peter Sedman took the report as read and gave a brief overview of some highlights. This in the future will be combined as a single report for both HUTH and NLaG.

Between the 1st of April 2023 and the 31st of March there had been 570 exceptional reports and there was a significant number of fines incurred particularly in the first 6 months of that year. The total of deposits was £44,000 for areas such as plastic surgery and paediatrics where staff shortages were seen, this was not expected to look worse in the next report.

4.5.2

Guardian of Safe Working Hours – Annual Report (NLaG)

Dr Peter Sedman took the report as read and gave a brief overview of some highlights. The number of exceptional reports was lower on the South Bank. There were fewer trainees on the NLaG side compared to HUTH and then bill rates for Junior posts was reasonably high.

Tony Curry questioned if the overruns in Paediatrics and Plastics had been addressed dealt with. Peter stated this was particularly from the first 6 months of the year and related to a number of proactive Junior Doctors.

The Committees-In-Common agreed that reasonable assurance had been given for both the North and the South.

4.6

Well-Being Progress Report

Paul Bunyan took the report as read and gave a brief overview. Work commenced this year to develop a well-being framework, and this was going to help them assess what we do already and where improvements need to be made.

The Health and Wellbeing framework was brought in as a result of feedback from the National Staff Survey, Health and Wellbeing Champions and Strategic framework engagement across the Organisation.

There was 30 high level Health and Wellbeing actions. For Staff the main areas of concern where that they wanted to see improvement in nutrition, hydration and exercise. Staff were calling for better training line managers to deal with Health and Wellbeing and flexible working. Work on these key areas was ongoing to reassure staff that their concerns were being heard.

Since 2021 sickness as a result of psychological illness had increased by 50% and 25% of all sickness within the NHS was as a result of psychological illness. Paul reported that healthcare professionals were three to five times more likely to take their own life, with female registered nurses and female junior doctors being at the most risk and this was further exacerbated amongst members of the LGBTQI+ community and Black, Asian and Minority Ethnic (BAME) community.

There had been 271 interactions with CiC the Confidential Care Programme, with the main reasons being psychological illness and pressure being the main reason staff were struggling at work. The results of these were significant loss of sleep, anxiety, and depression.

Linda Jackson gave praise to the report and the data within the report to show and highlight the issues that affects staff well-being. Julie Beilby agreed, and highlighted the difficulties people face when discussing mental health issues. She added that it could be a benefit to have someone senior in the organisation if they have faced mental health issues to open up to staff and help champion discussions.

The Committees-In-Common agreed that due to the vast amount of work and commitment from the teams the item should receive significant assurance.

4.7 **Bank / Temporary Staffing & Spend**

Helen Knowles took the report as read and gave a brief overview. As per NHSE requirements there was now no opportunity for nursing staff to use agencies that were off framework. f. There was one exception being used at HUTH and this was for a haematologist which had also finished. Helen updated that the teams had done a lot of work working with agencies within nursing and midwifery regarding the preferred supplier lists. She further added that one of the things that the Group was measured against was the NHSE capped rates. As of 11th of October all nursing and midwifery agency shifts would be at the NHSE capped rates across the Group.

Comparing the overall agency spend from April 2023 - September 2023 to April 2024 - September 2024, HUTH showed an increase of £114,000 spend and NLaG showed a decrease of £6.7 million.

Tony Curry praised the positive outcomes and the sustainability of the processes in place.

4.8 The Committees-In-Common agreed that the progress made was very significant in reducing agency spend and acknowledged this has been done without impacting service delivery.

Employee Relations: MHPS & Other Capability & Conduct Cases

Lindsey Harding took the report as read and highlighted some points from the report which reported on the last 6 months of data so some trends may not be the reality across a whole year.

The larger table within the report talked about the number of cases of sickness and primarily that was dealt with within the advisory team.

The probation data within the report showed 12 cases representing 4% of the work. She updated that NLaG had only just introduced a probationary policy, so all the cases reported where from HUTH.

There were less cases in corporate closed within a 6-month period than expected within the head count, and there were more cases than what was expected in Estates and Facilities so further analysis would be undertaken. She explained this was a typical trend, and was related to behaviours and low-level misconduct issues. Within digestive diseases there were 7.8% of cases, however some cases were repeated due to issues within excel.

Lindsey reported that the average time to close cases was looking positive and overall, the group had an average of 50 days.

Disciplinary cases had some differences in approach. HUTH reported 98 cases in the reporting period in which 11 resulted in dismissals. NLaG reported 33 cases and 5 of those resulted in dismissal. Lindsey reassured the CIC that the teams where in the process of harmonising the policies to get a greater consistency in their approach.

The number of cases in HUTH on supporting and management attendance was far fewer than the number at NLaG and this was due to different approaches in the way cases where managed. Lyndsey updated that the sickness policy had recently been signed off by the policy sub group and would be ratified at the Joint Negotiating and Consulting Committee (JNCC) in November resulting in a harmonised policy across the Group.

Lindsey highlighted that BAME colleagues at HUTH where less likely to be involved in a disciplinary process compared to NLaG. She stated that colleagues in her team were reviewing this data and whether they should have been disciplinary cases. She further added there were 9 members of staff in a disciplinary process currently.

Julie Beilby thanked Lindsey for the report and expressed her support in aligning processes across the Group. She observed some language within the report that was negative towards NLaG and voiced that there was already tension in the harmonisation of the North and South so the language used in reports was important.

Linda Jackson expressed that the report was easy to read, but some jargon within the report was not explained and that would have been a lot more helpful. She questioned the difference in approaches in NLAG compared to HUTH. Lyndsey stated that each case was going to be assessed on the learning framework but the panel process was going to be taken away.

David Sulch voiced that it was important that the BAME number at NLaG needed to be more understood in detail. He asked if there was any bias in managing white staff over BAME staff when it comes to panel processes before getting to disciplinary stage. He expressed that seeing the figures with medical staff being taken out would be interesting to see.

4.9 The Committees-In-Common agreed that the next report being brought to this meeting would include a years' worth of data.

Medical Workforce Strategy

Dr Peter Sedman and gave a brief overview and stated this was a work in progress and hope to have this completed by Christmas 2024. He stated there would be draft strategy being sent to all stakeholders in the next few weeks and this would also be on Bridget to welcome opinions, this would then be presented in January 2025.

Action: Dr Kate Wood to present The Medical Workforce Strategy to the CiC in January 2025.

4.10

E-Rostering Progress Report

Helen Knowles took the report as read and gave background to the report. The resource centre which runs the rosters at NLaG now comes under People Services and Helen now managed this team. They had recently appointed a Group Medical Staffing Manager which would help harmonise processes at HUTH and NLaG.

Since the teams came together in February 2024 the rotation of doctors had been the focus due to the large rotations that happened in August, September and October.

The team had also spent time looking at the NLaG rosters and categorising them into red, blue, green and gold.

There were five rosters in 'red' which included Neonates, Plastic Surgery, ENT, Max Fax (OMFS) and the tiers they were at. The plan was to move Neonates to 'Green' by the 31st December and then 'gold' by the 31st March 2025, Plastic Surgery to move to 'blue' by 31st December and ENT and OMFS to be 'blue' by 31st December. The centralised medical staffing team had taken over the administration of more rosters which was helping move through some of the categories a lot quicker than when they were managed in the services.

There was piece of work underway by the medical staffing team and HR manager in getting GP trainees onto the roster.

Some challenges noted were that some of the rosters now come under 5 Care Groups due to the Care Group structure. Helen advised she was working with Andy Gratix to identify those rotas to then help get some ownership of those rotas where colleagues cover multiple care groups.

Linda Jackson questioned if the colour coding could be aligned to the CQC plan to make it easier for the audience. Helen committed to change the colour coding to be consistent. Linda further noted the positives of managing the Care Groups centrally but noted potential complexities of how do those co-ordinators co-ordinate across different specialities and Care Groups.

The Committees-In-Common agreed that a lot of progress had been made and reasonable assurance was given.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The work plan was noted and there were no issues raised.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

Amanda Stanford voiced that the funding for the domestic abuse co-ordinator runs out in February and from that point onwards the Group may not have no domestic abuse role and this was predominately for staff. She was working through a paper and was going to take this to cabinet. It was agreed that this should be to escalated to cabinet with a recommendation to commit funding.

Amanda Stanford also noted it would be beneficial for the sexual safety report to brought to the WEC CiC again in 2025 following the launch of a new policy and framework implementation.

Action: Amanda Stanford to bring a Sexual Safety report in 2025.

David Sharif explained to the Committees-In-Common that following the meeting members would receive a Committee Effectiveness Form for completion to gather views on how the Committee is working.

David Sharif further noted that during that week it was the annual conference with Disability Staff Network. Members of the Executive team where working with the network to help their long-term planning and help make adjustments for their processes and resources. He praised the events and expressed it was very positive.

Lucy Vere agreed to bring a paper to November's meeting of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) action plans and the harmonisation of the EDI team and portfolio.

Action: Lucy Vere to bring a paper to November's meeting of WRES and the WDES action plans and the harmonisation of the EDI team and portfolio.

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:

- HR update – Negotiations were ongoing regarding the NLAG maternity support workers, a further increased offer had been made but had been rejected. Further strike action was being considered.
- Group CQC Actions – There were no changes to the previous reported position. The CIC agreed that there was no assurance regarding the mandatory training compliance that was outstanding and requested a plan to be presented to the next meeting. Work with line-managers was ongoing to encourage protected time and to avoid DNAs (did not attends).
- The Freedom to Speak Up Guardians at HUTH/NLAG had been recognised by the National Team for their Group Partnership working. Significant assurance was given due to the confidence in the FTSU guardians and processes.
- The CIC were impressed by the work ongoing regarding staff wellbeing and took significant assurance from the report presented.
- Funding for the Domestic Abuse role for staff had ceased and this was now a risk to the organisation. The issue would be raised at Group Cabinet and the outcome reported to the CIC.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Workforce, Education and Culture CiC meeting:

Thursday 28th November, in the Nightingale Role, Education Centre, Scunthorpe General Hospital

The Committee chair closed the meeting at 16.45 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y		Y					

Amanda Stanford	Group Chief Nurse	D	D	Y	D	D		Y					
Kate Wood	Group Chief Medical Officer	Y	N	Y	D	D		D					
Tony Curry	Non-Executive Director (HUTH)	N	N	Y	Y	Y		Y					
Kate Truscott	Non-Executive Director (NLaG)	Y	Y	Y	D	D							
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y		Y					
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y	Y		Y					
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y		Y					

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)249

Name of the Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	12 December 2024
Director Lead	Dr Kate Wood, Group Chief Medical Director
Contact Officer/Author	Dr Elizabeth Evans, Guardian of Safe Working, NLaG Dr Wajiha Arshad, Guardian of Safe Working Hours, HUTH Joey Robson, Group Medical Staffing Manager, HUTH Rose Bundy, Guardian of Safe Working Hours Analyst, HUTH
Title of the Report	Guardian of Safe Working (GoSW) Hours - Annual Report for NLaG and HUTH
Executive Summary	**NLaG:** The report details patterns in exception reporting over the financial year and in comparison with previous years. The overwhelming majority of reports have been for excess hours, and there is a peak after rotation in both August and February which is in keeping with previous years. Immediate safety concerns remain minimal which is reassuring. Fill rates for doctors in training remain high, with minimal permanent gaps in rotas. The office of the Guardian is well established with high levels of engagement with the Doctors in Training. **HUTH**: Exception reports: 177 exception reports submitted over the quarter, with 111 submitted by F1 trainees. Fines: 10 fines issued over the quarter totaling £16,086.93. 6 fines issued to the Paediatric Surgery department; 1 to the Orthopaedic and Plastic Surgery department; 1 to Acute and Elective Surgery; 1 to the Plastic Surgery department; and 1 to the Oncology and Haematology department. eRoster Rollout: *Note: the format has been amended to align with other reports submitted to the Board.* Gold – Fully Operational (Fully on eRoster and eRoster main point of truth) Green – Fully Functional Blue – Partially Functional or Working Towards Implementation Red – Not Functional

	Red	Blue	Green	Gold
@ 1st April 2024	7 (11%)	16 (25%)	32 (50%)	9 (14%)
@ 30th September 2024	5 (8%)	16 (25%)	34 (53%)	9 (14%)

The five rosters in red as at 30th September 2024 include Neonates, Plastic Surgery and ENT and Maxillo-Facial Surgery (OMFS) at either Tier 1 (F1/F2 Resident Doctors) or Tier 2 (ST/CT3+ Resident Doctors) or a combination of both. For Neonates, the plan is to move them to Green by 31st December 2024 and Gold by 31st March 2025. For Plastic Surgery, the plan is to move them to Blue by 31st December 2024. For ENT and OMFS the Medical Staffing Team are working with the Care Groups to develop a compliant rota pattern to be implemented on the system at Blue by 31st December 2024.

Trainee Doctor Fill Rate:
Over the quarter, 94.1% of trainee doctor posts were filled, an increase from 89.8% last quarter.
Immunology and Stroke Medicine have fill rates of 0% due to their establishment consisting of 1 doctor which NHE were unable to recruit to.
Neuro-rehab has a 40% fill rate due to an NHSE vacancy and a 0.8 less than full time trainee.
Emergency Medicine is the department with the highest bank and agency usage over the quarter, with a fill rate of 91.1%.

Background Information and/or Supporting Document(s) (if applicable)	**NLaG:** 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 **HUTH:** N/A
Prior Approval Process	Workforce, Education and Culture Committees-in-Common Meeting on 24 October 2024
Financial implication(s) (if applicable)	**NLaG:** N/A **HUTH:** 10 fines issued over the quarter totaling £16,086.93. The Guardian of Safe Working Hours Funds stands at £68,169.20 at the time of the report being written.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Annual Report

Dr Liz Evans
Guardian of Safe Working
April 2024

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Executive summary

The Annual Report of the Guardian of Safe Working Hours shows the exception report information for the annual period of April 2023 to March 2024. Quarterly reports continue to be generated and shared at TMB, JLNC, the Junior Doctor's Forum (JDF) and with colleagues at NHS England (previously Health Education England).

There are no trainees within the Dentistry service at NLaG and so the Annual Report applies only to doctors in training.

We are now in the eighth year of the 2016 national contract for doctors in training which aimed to encourage stronger safeguards to prevent doctors working excessive hours. Exception reporting (ER) of extra hours, missed breaks and missed educational opportunities is well established in Northern Lincolnshire and Goole NHS Foundation Trust and we continue to positively promote exception reporting through induction, training, drop ins and the monthly Junior Doctors' Forum.

The 2016 contract was subject to review in 2019 and although largely unchanged there were some notable differences which the Trust has implemented.

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 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 terms and conditions of service (TCS) and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

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.

High level data – as of March 2024

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

Source: Recruitment via establishment spreadsheets and vacancy spreadsheets.

Exception report analysis

The table below, from the Allocate software, provides a breakdown by speciality 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**	**-**	**-**

These data show the areas that generate the highest number of exception reports. This enables specific focus to be given to these areas in order to support the specialty in reducing exception reporting and providing a good learning environment for the doctors in training. Note - the number of trainees in this comparison is not the same as the number stated in the data above as it does not include doctors who were on rotational GP placements. These areas did not produce any exception reports so have not been included. 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.

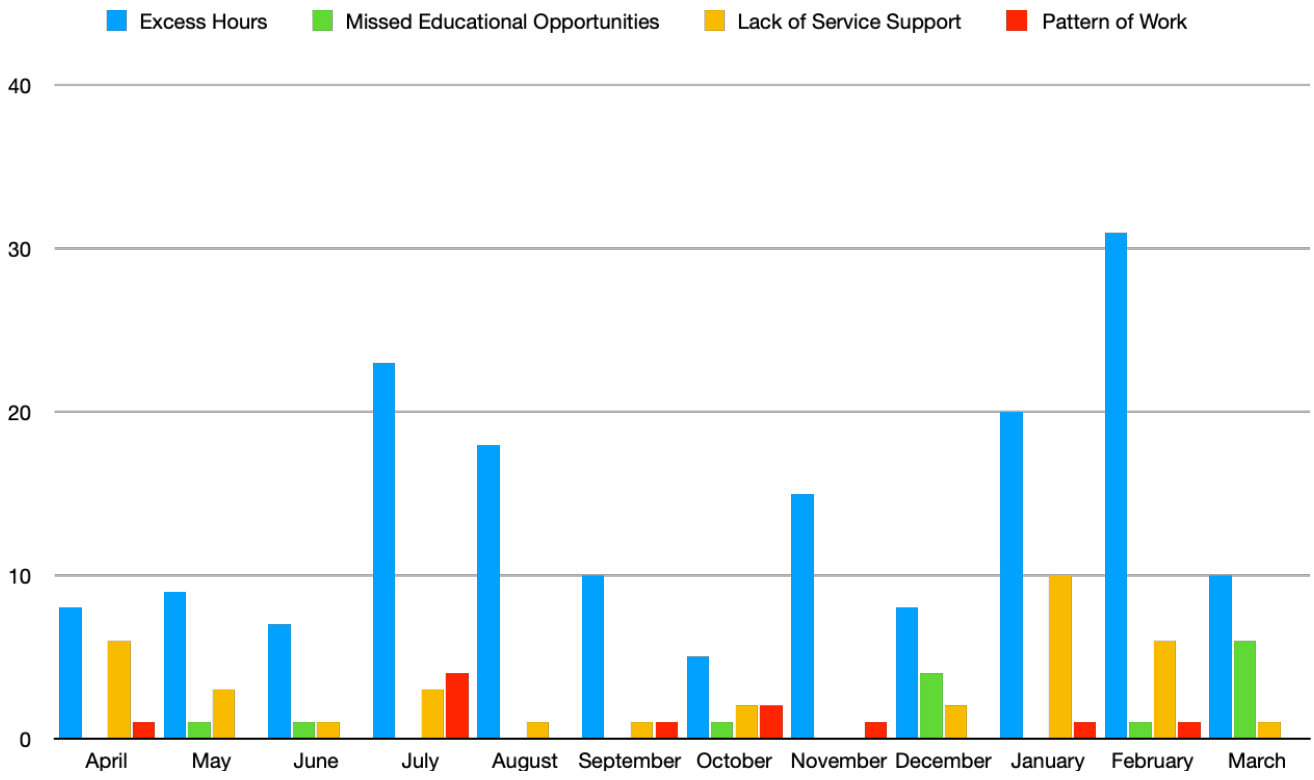


Figure 1: Reasons for exception reporting by month.

The above table (figure 1) shows the number of exception reports submitted from all departments by month, broken down to show the reasons reports were submitted. As is usual the vast 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.

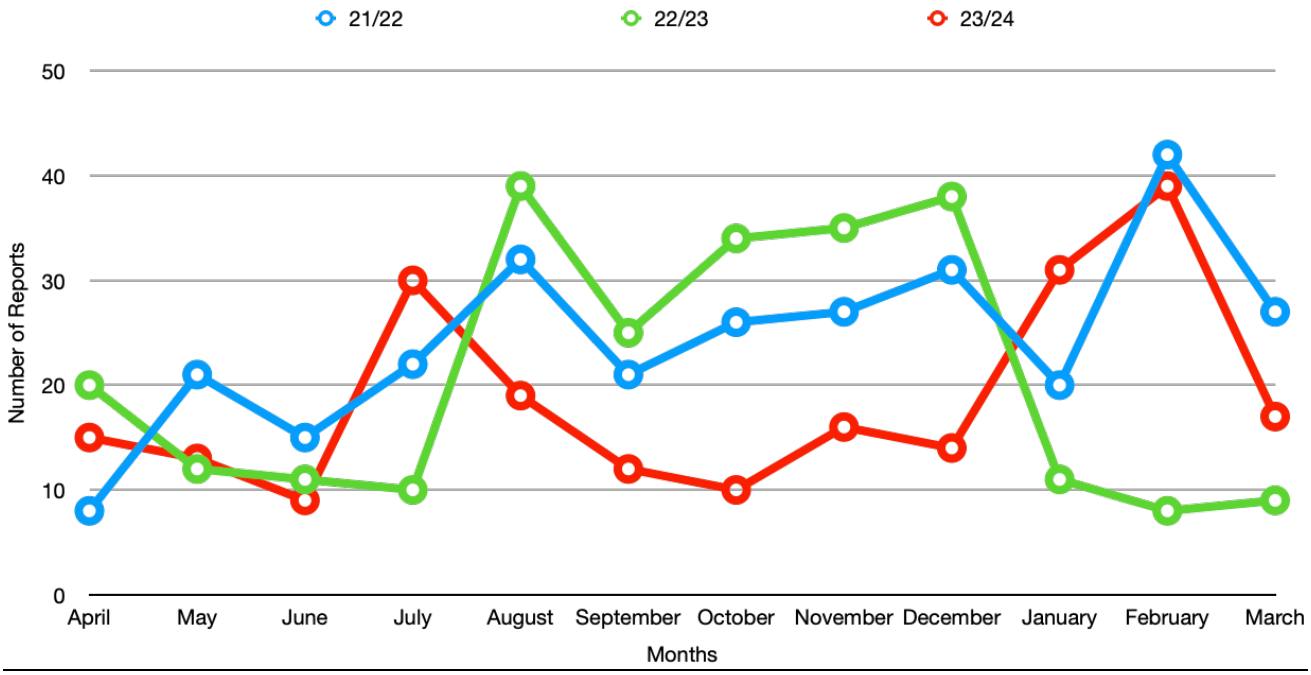
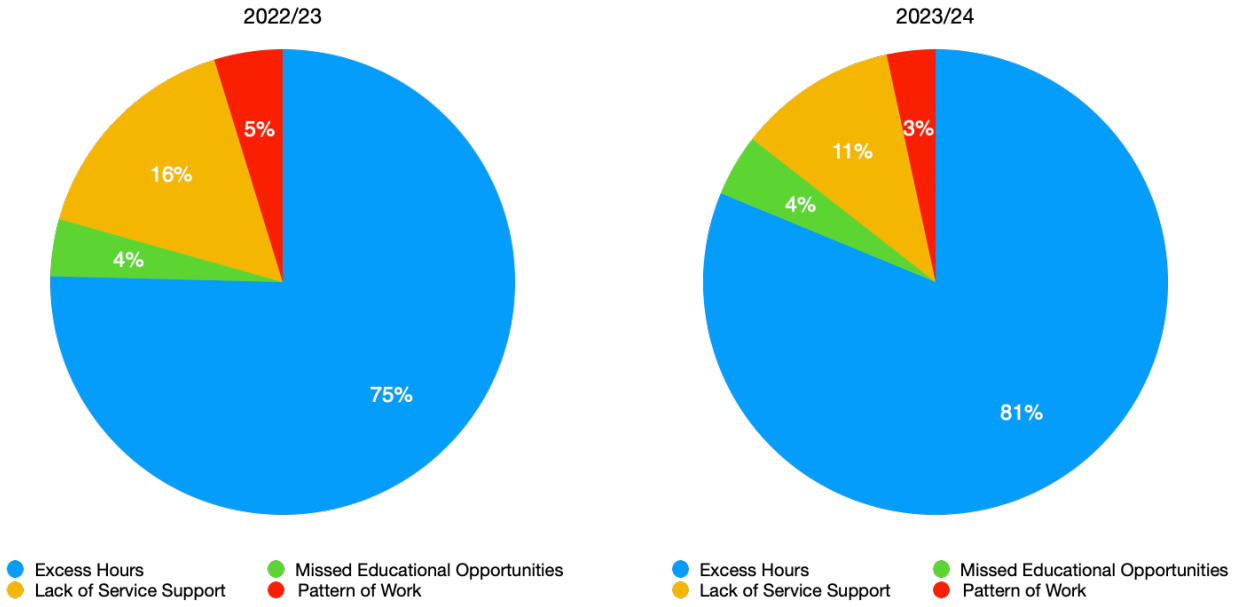


Figure 2: Exception reports by month

As figure 2 shows the rate of exception reporting follows roughly the same pattern as previous years. There is a peak in reporting in the winter months, which has been seen before. The reason for the low level of reporting last winter remains unclear. The peak in the summer which is due to the new doctors rotating into the trust reflects the decrease in efficiency by new doctors rotating and is an expected finding.

Figure 3: Reasons for Exception Reporting by Year



As shown in figure 3, the reasons for exception reporting show some consistency comparing this year with the last. By far the most common reason for exception reporting remains excess hours, and this is a pattern we would expect to see continue moving forward. This is because excess hours is the most easily quantifiable type of breech, which makes the doctors much more likely to report it. A higher proportion of the reports this year concerned issues with service support. It is encouraging that the doctors in training felt that they were able to escalate their concerns in this way, and that positive change could be made in response.

Case study

During the second quarter of the year an issue was raised via exception reporting and at the JDF about planned changes to a rota for doctors in training. This change had been decided upon after an extremely short consultation period, which meant that many of the doctors in training did not have a chance to consider the offer and make their feelings known. This issue was compounded by strikes, and the time scales involved were so short as to constitute a contractual breech as the work schedule was not published with sufficient notice. We worked together with representatives from human resources, the BMA and the department involved to consult with the doctors and make changes to the rota which were to the satisfaction of all involved, and achieved this within the short timescale required. This helped the doctors in training to feel as though they had some control over their working conditions, while helping the department to fill rota gaps and rationalise their use of staff.

Summary

1. 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.

2. 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.

3. 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, after discussion at the JDF.

4. 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.

5. The GoSW holds Junior Doctor Forums every month and these are a valuable opportunity for our Doctors representatives to meet with the Guardian, MD office, Director of Medical Education (DME) office, BMA and LNC in one place. We have regular attendance from the freedom to speak up guardian, and the trusts Chief Medical Information Officer, Dr Alastair Pickering. This enables the Doctors in Training to engage in the improvements to the digital infrastructure, and gives them the opportunity to shape their working environment.

6. Issues addressed at the JDF over the past year have included:

    - Rota concerns
    - Working conditions
    - Locum pay
    - Mandatory training requirements

7. 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.

8. The GoSW has regular meet ups with the Freedom to Speak Up Guardian and the representatives of PGME to identify common themes. These have been very successful at identifying areas of difficulty, enabling us to provide more holistic support to the Doctors in Training.

9. Work to improve the knowledge and engagement of the educational supervisors is ongoing.

10. The impact of the strikes on the Junior Doctors contract compliance appears to have been minimal, which is a reassuring finding.

11. 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.

Recommendations

1. To continue to support and encourage the work of the Guardian and the DME in engaging Educational Supervisors and Consultants in the exception reporting system.

2. To ensure a positive regard for the education of trainee doctors, recognising the importance of the medical workforce and safeguarding the balance of service provision and education.

3. To support initiatives to improve the experience of doctors in training at NLaG, and to celebrate examples of good practice. This will strengthen the Trust's reputation and attractiveness as a training provider/employer.

4. To promote the engagement of the Junior Doctors in the exception reporting process, and to promote the system as an agent for positive change and patient safety within the trust.

Dr Liz Evans - Guardian of Safe Working

Date: April 2024

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Annual Report on Safe Working Hours
Doctors and Dentists in Training
Annual Board Report GOSW 1st April 2023 – 31st March 2024

1. Executive Summary

This paper provides an annual summary of gaps, exception reports, and fines department for each quarter from April 2023 – March 2024.

Dr Wajiha Arshad began her role as Guardian of Safe Working from September 2023 and is responsible for monitoring the safe working of junior doctors within the Trust. This relates to their working hours, service support available and education/training opportunities.

From April 2023 – March 2024 exception reports have been submitted for a wide range of themes, such as industrial action, missed educational opportunities, lack of service support, and isolated instances requiring trainees to work additional hours to maintain patient safety.

The majority of fines issued were to both Plastic Surgery and Paediatric Surgery and were in relation to non-resident on call shifts where doctors have not received adequate rest, and have breached 13 hour maximum shift length.

All quarterly Guardian of Safe Working reports are available on Bridget.

2. Introduction

This report provides an overview of rota gaps, vacancies, exception reports and fines for the period 1st April 2023 – 31st March 2024.

3. High Level Data

Average number of doctors / dentists in training (total):	614.25 / 690.75
Annual fill rate among this staff group (%):	87.53%

Information on exception reporting is detailed within the junior doctor's contract (pages 37-39) found on NHS Employers website.

4. Exception Report Summary

There were a total of 574 exception reports (574 episodes) reported by doctors in training and locally employed doctors for the period 1st April 2023 – 31st March 2024.

Out of 574 exception reports submitted, 39 were flagged as immediate safety concerns.

Reason:	**Number of exception reports submitted:**
Hours	403
Pattern	65
Educational	57
Service Support	49

Rota & Department:	Number of exception reports submitted:
Rota 25, Acute/Elective F1	58
Rota 14, Frailty Medicine	40
Rota 4, Medicine F1 Frailty Medicine	35
Rota 23, Surgery F1	30
Rota 8, Oncology and Haematology	28
Rota 18, Medicine F1 Oncology	28
Rota 4, Medicine F1 Gastro	23
Rota 66, Paediatric Surgery	22
Rota 12, Medical Oncology SpR	21
Rota 121, CT Surgery & Cardiology	18

Of the 574 exception reports submitted over the annum, 236 were closed within 30 days, and 126 were closed within the 7 day contractual time frame.

Grade:	Number of exception reports submitted:
F1	278
F2	83
CT1/ST1	110
CT2/ST2	16
ST3/CT3+	87

5. Summary of Fines issued 1st April 2023 – 31st March 2024

58 fines were issued over the period, totalling £44,905.84.

Out of 58 fines issued, 32 were issued to the Plastic Surgery department (£25,842.50), and 21 were issued to the Paediatric Surgery department (£16,884.58).

The majority of fines issued to both Plastic Surgery and Paediatric Surgery are in relation to non-resident on call shifts where doctors have not received adequate rest, and have breached 13 hour maximum shift length.

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.

6. Annual Data Summary

The following table shows the NHSE establishment rate in comparison to how many trainees are in post from 1st April 2023 – 31st March 2024. This does not show any locally employed doctors recruited to backfill any NHSE vacancies.

	Quarter 1 April - June 2023		Quarter 2 July - September 2023		Quarter 3 October - December 2023		Quarter 4 January - March 2024		Average fill rate
Department	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	percentage
Academic, GP, Psych & Community	164	142.3	148	135	148	135.4	143	134.3	90.71%
Acute Medicine	26	21.6	29	23.2	29	26.2	29	25.3	85.22%
Anaesthetics	58	51.6	64	59.9	64	59.1	64	62.3	93.16%
Breast Surgery	5	1	5	2	5	3	5	4	50.00%
Cardiology	17	15	19	17	19	18	18	18	93.15%
Cardiothroacic Surgery	7	6	7	5	7	6	7	6	82.14%
Chemical Pathology	1	1	1	1	1	1	1	1	100.00%
Colorectal Surgery	11	9	13	12	13	13	13	13	94.00%
Dermatology	2	2	2	2	2	2	2	2	100.00%
Elderly Medicine	27	23.4	27	27.4	27	26.2	27	26.2	95.56%
Emergency Medicine	46	44.9	48	40.7	48	40.2	48	36.6	85.47%
Endocrinology	9	8	10	8.8	9	8.8	9	8.8	92.97%
ENT	11	9.6	11	10.6	12	10.6	13	11.6	90.21%
Gastroenterology	11	10.6	11	10.2	11	10.2	10	9.5	94.19%
General Surgery	1	1	1	1	1	0	1	0	50.00%
Haematology	9	9.2	10	9.2	10	9.2	10	8	91.28%
Histopathology	4	4	7	7	7	7	7	6.6	98.40%
Immunology	1	0	1	1	1	1	1	1	75.00%
Infectious Diseases/Neuro-Rehab	13	10.3	14	14.3	14	14.3	14	14.3	96.73%
Neurology	13	12	15	11.5	15	12.5	15	12.5	83.62%
Neurosurgery	8	8	8	6	8	6	8	7	84.38%
Obstetrics & Gynaecology	24	23.8	27	23.1	27	23.6	28	27	91.98%
Oncology	15	14.6	21	19	21	18	21	19	90.51%
Ophthalmology	8	7	8	6.8	8	7.8	8	7.8	91.88%
Oral & Maxillofacial Surgery	12	7	11	3	11	3	11	3	35.56%
Paediatric Neonatal Medicine	14	14.1	14	12.3	14	12.3	16	14.2	91.21%
Paediatric Surgery	2	0	2	1.8	2	1.8	2	2	70.00%
Palliative Care	2	1.8	2	2.4	2	2.4	2	2	107.50%
Plastic Surgery	9	8.8	9	8.8	9	8	9	8	93.33%
Paediatrics	21	15.9	23	18.7	23	17.7	24	21.6	81.21%
Radiology	29	29.4	38	36.8	38	35.8	38	31.4	93.29%
Renal Medicine	12	11	11	9	11	8	11	8	80.00%
Respiratory Medicine	20	17	20	18.9	20	19.3	20	19.3	93.13%
Rheumatology	6	6	6	5.6	6	5.6	6	5.8	95.83%
Stroke Medicine	1	2	1	1	1	1	1	1	125.00%
Trauma & Orthopaedics	17	13	18	13	18	17	18	17	84.51%
Upper GI	14	12	15	13	15	13	15	14	88.14%
Urology	9	8.2	9	9.2	9	9	9	9	98.33%
Vascular Surgery	10	6	12	8.8	13	11	13	10.8	76.25%
Total	**669**	**588.1**	**698**	**616**	**699**	**624**	**697**	**628.9**	**87.53%**

7. Issues Arising and Actions taken to resolve issues

403 of 574 exception reports were submitted due to excess hours worked. The Guardian of Safe Working encourages appropriate exception reporting to enable doctors to be appropriately compensated for their time via TOIL or payment. Clinical supervisors are continuing to meet with trainees within the days and weeks following the exception reports being submitted to ensure they are supported and compensated.

The Guardian of Safe Working team have undertaken a piece of work to chase and close off exception reports which have been open for significant amounts of time without action. They continue to send out reminders to supervisors and trainees every 7 days, and are working with trainees to ensure they are able to close off exception reports and receive compensation where appropriate.

- Rota 25 (Acute/Elective F1) and Rota 14 (Frailty Medicine) received the highest number of exception reports out of all of the rotas within the Trust.
- Rota 25's exception reports were all from F1 trainees, and the majority of reports were due to trainees working overtime in an attempt to maintain patient safety due to acutely unwell patients.
- Rota 25 was amended this year to incorporate a later ward round to alleviate pressures faced by doctors on the day shift. Overall, supervisors and trainees working on rota 25 continue to meet within the 7 day deadline to have initial review meetings, ensuring that doctors are appropriately supported.

- Rota 14's (Frailty Medicine) exception reports were submitted by a range of F2, CT1 and ST1 trainees, and the majority of exception reports related to overtime. Rota 14 has been discussed at length this year at the JDF with doctors reporting that their handover often results in them staying late. As a result of these concerns being raised at the JDF, the Medical Staffing Team and The Guardian of Safe Working are currently working with Dr Hibbert, North Bank Medical Director to amend the medicine tower block rotas to alleviate handover pressures and make the rotas more accessible for annual leave to be taken. Rota 14 also received a small number of educational exception reports due to missed SDT; the Medical Staffing Team have now taken over the rota coordination of Rota 14 to assist with facilitating SDT.

The vast majority of exception reports over the annum have been submitted by foundation grade doctors, appropriately reporting instances where they have worked beyond their rostered finish times, or felt as though they did not receive the support or educational opportunities required.

The Guardian of Safe Working continues to encourage all junior doctors to exception report where appropriate at the JDF. The Medical Staffing Team have also encouraged exception reporting at trust induction.

The majority of fines issued to both Plastic Surgery (Rota 40) and Paediatric Surgery (Rota 66) are in relation to non-resident on call shifts where doctors have not received adequate rest, and have breached 13 hour maximum shift length. Both Plastic Surgery and Paediatric Surgery are areas that commonly have overnight referrals interrupting rest and maximum shift length.

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. Questions for consideration

The Workforce, Education and Culture meeting has requested to receive this report and decide if the report provides sufficient information and assurance and decide if any further information / actions are required.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)260

Name of the Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	12 December 2024
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Dr Liz Evans, Guardian of Safe Working Hours, NLaG Helen Fitzpatrick, Revalidation & Appraisal Coordinator / Admin for Guardian of Safe Working, NLaG Dr Wajiha Arshad, Guardian of Safe Working Hours, HUTH Joey Robson, Group Medical Staffing Manager, HUTH Rose Bundy, Guardian of Safe Working Hours Analyst, HUTH
Title of the Report	Guardian of Safe Working (GoSW) Hours Quarter 2 Report for NLaG and HUTH – 01 July 2024 to 30 September 2024
Executive Summary	**NLaG:** Exception Reports This quarter saw an increase in the number of exception reports which is to be expected at this time of year. The majority of these reports were for excess hours at foundation level. There has been a slight increase in the number of immediate safety concerns submitted, however the ratio of immediate safety concerns to reports submitted remains low which is reassuring. Fines No fines have been issued over this quarter. E-roster rollout The progress of e-Roster use across the Group has been categorized as follows: Gold – Fully Operational (Fully on eRoster and e-Roster main point of truth) Green – Fully Functional Blue – Partially Functional or working towards implementation Red – Not Functional Current position of e-Roster for NLaG is shown below: @30th September 2024: Red 0 (0%); Blue 0 (0%); Green/Platinum 14 (29%); Gold/Platinum 35 (71%) The project to roll out use of e-Roster at NLaG has been in place for some time and this is reflected above. Next steps is to continue engagement with system use in those areas that are already using the system functionality. In addition, GP Trainees are partially rostered, however, in the absence of clearly identified funding from NHSE (formerly HEE/Deanery) work cannot

progress to transfer all GP Trainee rosters onto the system. The team continue to work with NLaG finance colleagues to identify this funding and ensure it is transferred into the Medical Staffing Team.

Trainee Doctor Fill Rate
The fill rate for Doctors in Training over this Quarter was 89.9%. This is the first time that this has been reported in this report so there isn't a comparison at this time with the previous Quarter. This will evolve with subsequent reports.

HUTH:

Exception reports:
177 exception reports submitted over the quarter, with 111 submitted by F1 trainees.

Fines:
10 fines issued over the quarter totaling £16,086.93.
6 fines issued to the Paediatric Surgery department; 1 to the Orthopaedic and Plastic Surgery department; 1 to Acute and Elective Surgery; 1 to the Plastic Surgery department; and 1 to the Oncology and Haematology department.

eRoster Rollout:
Note: the format has been amended to align with other reports submitted to the Board.

Gold	Fully Operational (Fully on eRoster and eRoster main point of truth)
Green	Fully Functional
Blue	Partially Functional or Working Towards Implementation
Red	Not Functional

	Red	Blue	Green	Gold
@ 1st April 2024	7 (11%)	16 (25%)	32 (50%)	9 (14%)
@ 30th September 2024	5 (8%)	16 (25%)	34 (53%)	9 (14%)

The five rosters in red as at 30th September 2024 include Neonates, Plastic Surgery and ENT and Maxillo-Facial Surgery (OMFS) at either Tier 1 (F1/F2 Resident Doctors) or Tier 2 (ST/CT3+ Resident Doctors) or a combination of both. For Neonates, the plan is to move them to Green by 31st December 2024 and Gold by 31st March 2025. For Plastic Surgery, the plan is to move them to Blue by 31st December 2024. For ENT and OMFS the Medical Staffing Team are working with the Care Groups to develop a compliant rota pattern to be implemented

	on the system at Blue by 31st December 2024. <u>Trainee Doctor Fill Rate:</u> Over the quarter, 94.1% of trainee doctor posts were filled, an increase from 89.8% last quarter. Immunology and Stroke Medicine have fill rates of 0% due to their establishment consisting of 1 doctor which NHE were unable to recruit to. Neuro-rehab has a 40% fill rate due to an NHSE vacancy and a 0.8 less than full time trainee. Emergency Medicine is the department with the highest bank and agency usage over the quarter, with a fill rate of 91.1%.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Workforce, Education and Culture Committees-in-Common Meeting on 28 November 2024
Financial implication(s) (if applicable)	**<u>NLaG:</u>** No fines were issued over the quarter covered by this report. The Guardian of Safe Working Hours funds stands at £0.00. **<u>HUTH:</u>** 10 fines issued over the quarter totaling £16,086.93. The Guardian of Safe Working Hours Funds stands at £68,169.20 at the time of the report being written.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust
Quarterly Report on Safe Working Hours (Doctors and Dentists in Training)
1st July 2024 – 30th September 2024

1. Purpose of this Report

Under the Doctors and Dentists in Training Terms and Conditions (England) 2016, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from 1st July 2024 - 30th September 2024.

- Exception reports and monitoring
- Locum usage
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	217.05
(establishment)	241.44
Amount of time available in job plan for guardian to do the role:	2 PA (8 hours per week)
Admin support provided to the guardian (if any):	8 hours per week
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between health groups)

Information on exception reporting is detailed within the Doctors and Dentists in Training Terms and Conditions (England) 2016 (pages 37-39) which can be found on the NHS Employers website.

3. Immediate Safety Concerns

There have been five exception reports submitted this quarter with an immediate safety concern highlighted. 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 escalated appropriately. This quarter the immediate safety concerns were from a range of specialties across both sites. The theme of three of the concerns was Foundation Doctors being unable to access supervision while caring for unwell patients, and the other two concerned the work intensity being too high so doctors were unable to take breaks for the duration of their shifts. These issues were escalated where appropriate.

4. Exception Reports

There were a total of 107 exception reports reported by Resident Doctors for this quarter. This represents an increase from the 59 reports received in the preceding quarter, which is a normal finding for this time of year. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

Exception reports (episodes) by department

Accident and emergency and General medicine had the highest number of exception reports submitted over the quarter.

Table A:

Specialty (Where exception occurred)	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
General medicine	8	40	44	7
Accident and emergency	2	33	29	4
Obstetrics and gynaecology	4	8	12	0
Cardiology	0	3	3	0
General surgery	2	2	3	0
Paediatrics	0	2	2	0
Acute Medicine	0	1	1	0
Diabetes & endocrinology	0	1	1	0
Gastroenterology	0	1	1	0
Geriatric medicine	0	1	1	0
Paediatric - accident and emergency	0	1	1	0
Respiratory Medicine	0	1	1	0
Total	**16**	**94**	**99**	**11**

Exception reports (episodes) by grade

Table B:

Grade	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
FY1	11	33	41	3
FY2	0	21	19	7
CT1	0	11	12	4
ST5	0	5	5	0
ST4	0	4	4	0
ST2	0	2	2	0
CT2	0	0	0	0
ST1	0	0	0	0
ST3	0	0	0	0
Total	**11**	**76**	**83**	**14**

Exception reports (episodes) by rota

Table C:

Rota	**No. exceptions raised (episodes)**	**No. exceptions closed**	**No exceptions outstanding**
DPOW Medicine FY1 FY2 August 24	22	20	2
DPOW A&E FY1 August 24	20	20	0
DPOW A&E F1 April 24	19	19	0
SGH A&E FY1 Aug 24	18	18	0
SGH Gen Med FY1 F2 Aug 24	11	11	0
DPOW Gen Surg Resident Aug 24	9	9	0
SGH Gen Med FY1 F2 Dec 23	7	7	0
SGH Gen Med Dr Majeed Aug 23	6	6	0
DPOW Medicine CT/ST1-2 1 in 14 April 24	5	5	0
DPOW Gen Surg Resident April 24	4	4	0
DPoW A&E FY2 ST1/2 1 in 14 August 24	3	3	3
DPOW O&G FY1 Aug 24	3	3	0
FINAL SGH Gen Med ST3+ SAS updated Oct 23	3	3	0
SGH Med Rota IMT Aug 24	3	3	0
SGH Gen Surg FY1 Dec 23	2	2	0
SGH Med Rota 1 in 10 June 23	2	2	0
SGH O&G FY1 December 2023	2	2	0
SGH Paediatrics Resident December 23	2	2	0
DPOW O&G RESIDENT Aug 24 V2	1	1	0
DPOW O&G St3+ SAS Aug 24	1	1	0
Dr Draper St5 December 23	1	1	0
SGH Gen Surg Resident April 24	1	1	0
Total	**145**	**143**	**5**

Exception reports (episodes) - response time

The Doctors and Dentists in Training Terms and Conditions (England) 2016 require that the Supervisor meets with the Resident Doctor to discuss an exception report within seven days.

It has continually been identified that meeting within seven days is often difficult for Resident Doctors and Supervisors. Guardian of Safe Working Hours continues to educate both Resident Doctors and Supervisors on the importance of exception reporting and meeting in a timely manner.

Table D:

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	Outstanding
CT1	2	2	7	0
CT2	0	0	0	0
FY1	45	26	37	0
FY2	2	3	4	0
ST1	0	0	0	0
ST2	0	0	2	0
ST3	0	0	0	0
ST4	2	1	2	0
ST5	2	6	2	0
Total	**53**	**38**	**54**	**0**

5. Work Schedule Reviews

The following rotas were under review during quarter 2; all relevant care groups are aware.

- Accident and emergency - DPOW A&E FY1 August 24
- General Medicine - DPOW A&E FY1 August 24
- General Medicine - DPOW Medicine CT/ST1-2 1 in 14 April 24

All work schedule reviews have now been closed. In Accident and Emergency there was a change to the foundation year one rota to allow time for handover, which should help to reduce the reporting of excess hours. The two work schedule reviews in medicine were closed- they had been open for a very long time and the submitting doctors rotated to another trust. This has been escalated to the medical director and the reports closed.

6. Locum bookings 1st July 2024 – 30th September 2024

This section details the use of Bank and Agency doctors to backfill vacant shifts. This is broken down into Bank (not including additional hours) and Agency bookings. This is also presented via department, grade and reason for booking.

Bank 1st July 2024 – 30th September 2024

Bank usage shown below does not include additional hours worked by substantive Resident Doctors. NLaG utilise the Care 1 Bank to cover Bank shifts and this is detailed below:

Table D:

Locum Bookings (Bank) by department		
Specialty	**Number of shifts worked**	**Number of hours worked**
Acute Medicine	73	490.5
Care of the Elderly	29	208
Emergency Medicine	510	2866.11
Endocrinology and Diabetes	2	23
ENT	70	512.5
General Medicine	124	719.5
Obstetrics and Gynaecology	5	57.5
Orthopaedic and Trauma Surgery	176	1147
Paediatrics and Neonates	1	11.5
Respiratory Medicine	30	229
Urology	9	71.5
Total	**1029**	**6336.11**

Table E:

Locum Bookings (Bank) by reason		
Reason	**Number of shifts worked**	**Number of hours worked**
Annual Leave	30	165.5
Extra Cover	3	28.5
Extra Theatre Lists	1	9.5
Induction	12	71.5
Less Than FT Trainee Gap	8	49
Maternity/Pregnancy leave	8	46
Sick	8	45
Study Leave	6	34.5
Unpaid Leave	4	30
Vacancy	949	5856.61
Total	**1029**	**6336.11**

Agency 1st July 2024 – 30th September 2024

Use of Agency staff to backfill vacancies is a last resort once all other avenues (ie. Additional Hours, Bank, Alternate Staff roles) have been exhausted. Clear Agency approval processes are in place across all Care Groups and all agency bookings are managed by the Rota Co-Ordinators.

Table F:

Locum Bookings (agency) by department		
Specialty	**Number of shifts worked**	**Number of hours worked**
Emergency Medicine	156	896.07
Trauma & Orthopaedics	51	343.5
General Medicine	40	226.25
Respiratory Medicine	21	161.5
ENT	18	137
Elderly Medicine	16	110.5
Acute Medicine	9	53.5
Obs & Gynae	2	21.5
Anaesthetics	0	0
Breast Surgery	0	0
Cardiology	0	0
Chest Medicine	0	0
Clinical Oncology	0	0
Colorectal Surgery	0	0
CT Surgery	0	0
Endocrinology	0	0
Gastroenterology	0	0
General Surgery	0	0
Haematology	0	0
Infectious Diseases	0	0
NCTR/Winter Wards	0	0
Neonatology	0	0
Neurology	0	0
Neurosurgery	0	0
Oncology	0	0
Oral and Maxillofacial Surgery	0	0
Paediatric Surgery	0	0
Plastic Surgery	0	0
Radiology	0	0
Renal Medicine	0	0
Rheumatology	0	0
Stroke	0	0
Upper GI Surgery	0	0
Urology	0	0
Vascular Surgery	0	0
Total	**313**	**1949.82**

Table G:

Locum Bookings (agency) by Reason		
Reason	**Number of shifts worked**	**Number of hours worked**
Vacancy	300	1875.32
Annual leave	12	65
Additional Resource	1	9.5
Compassionate Leave and Special Leave	0	0
Sickness	0	0
Maternity/Paternity Leave	0	0
Study Leave	0	0
Crem Fees	0	0
Total	**313**	**1949.82**

Locum work carried out by doctors in training

This data is collected to help assess where individual doctors in training are working the most additional hours so that any breaches of the Working Time Directive (WTD) and the 2016 Terms and Conditions can be explored.

The table represents the top 10 doctors in training that have worked the most extra hours.

Table H:

Base Specialty	**Grade**	**Number of hours worked**	**Number of hours rostered per week**
Acute Medicine	Core Trainee/ST1&2 (formerly SHO)	7.5	40:00
Acute Medicine	Core Trainee/ST1&2 (formerly SHO)	46	40:00
Care of the Elderly	CT	110.5	40:00
Emergency Medicine	Core Trainee/ST1&2 (formerly SHO)	115.51	40:00
Emergency Medicine	Core Trainee/ST1&2 (formerly SHO)	100	40:00
Emergency Medicine	Core Trainee/ST1&2 (formerly SHO)	94.25	40:00
Emergency Medicine	Specialist Registrar	169.56	40:00
Emergency Medicine	Specialist Registrar	168.75	40:00
Emergency Medicine	Specialist Registrar	168.5	40:00
Emergency Medicine	Specialist Registrar	79.5	40:00
ENT	Trust Grade (Junior)	137	40:00
General Medicine	Specialist Registrar	226.25	40:00
Obstetrics and Gynaecology	StR (ST3-8)	21.5	40:00

Orthopaedic and Trauma Surgery	Trust Grade (Junior)	178.5	40:00
Respiratory Medicine	Core Trainee/ST1&2 (formerly SHO)	165	40:00

7. Vacancies:

Doctors and Dentists in training establishment and current doctors in training in post as appointed by NHS England (formerly Health Education England).

Table I:

Row Labels	Sum of Sum of WTE Bud	Sum of Vacancies WTE	Sum of Sum of WTE Cont
Ct 1-2	**41**	**-2.41**	**43.41**
OTHER-TRAINING GRADE	**41**	**-2.41**	**43.41**
Acute And Emergency Medicine	7	-0.89	7.89
Cardiovascular	3	0.09	2.91
Community, Frailty & Therapy	4	-3.48	7.48
Digestive Diseases	5	2	3
Medical Education	5	0.4	4.6
Neuroscience	1	-1	2
Specialist Cancer And Support Services	0	0	0
Specialist Medicine	6	0	6
Specialist Surgery	2	1	1
Theatres, Anaesthetics And Critical Care	8	-0.53	8.53
Ct 3-7	**5**	**5**	**0**
OTHER-TRAINING GRADE	**5**	**5**	**0**
Community, Frailty & Therapy	5	5	0
Fh01 Found Programme Doctors	**52**	**1.49**	**50.51**
OTHER-TRAINING GRADE	**52**	**1.49**	**50.51**
Acute And Emergency Medicine	7	2	5
Cardiovascular	1	0	1
Community, Frailty & Therapy	5	1	4
Digestive Diseases	16	2	14
Family Services	5	0	5
Head & Neck	1	0	1
Neuroscience	1	0	1
Specialist Medicine	13	-0.51	13.51
Specialist Surgery	3	-2	5
Theatres, Anaesthetics And Critical Care	0	-1	1
Fh02 Found Programme Doctors	**33**	**-5.23**	**38.23**
OTHER-TRAINING GRADE	**33**	**-5.23**	**38.23**
Acute And Emergency Medicine	5	-0.6	5.6
Row Labels	**Sum of Sum of WTE Bud**	**Sum of Vacancies**	**Sum of Sum of WTE Cont**

		WTE	
Community, Frailty & Therapy	0	-1	1
Digestive Diseases	5	-2	7
Family Services	9	-2.63	11.63
Head & Neck	4	1	3
Major Trauma Network	1	0	1
Neuroscience	1	1	0
Specialist Medicine	5	2	3
Specialist Surgery	3	2	1
Theatres, Anaesthetics And Critical Care	0	-5	5
St 1 Lower	**15.94**	**5.91**	**10.03**
OTHER-TRAINING GRADE	**15.94**	**5.91**	**10.03**
Family Services	15	7.57	7.43
Head & Neck	0.94	0.34	0.6
Theatres, Anaesthetics And Critical Care	0	-2	2
St 2 / Upper	**64**	**10.99**	**53.01**
OTHER-TRAINING GRADE	**64**	**10.99**	**53.01**
Acute And Emergency Medicine	9	2.44	6.56
Cardiovascular	4	0	4
Community, Frailty & Therapy	1	1	0
Digestive Diseases	9	5	4
Family Services	19	-2.59	21.59
Head & Neck	2	0	2
Neuroscience	1	-0.92	1.92
Specialist Medicine	7	4	3
Specialist Surgery	6	2	4
Theatres, Anaesthetics And Critical Care	6	0.06	5.94
Vts Vocational Training Scheme	**30.5**	**8.64**	**21.86**
OTHER-TRAINING GRADE	**30.5**	**8.64**	**21.86**
Acute And Emergency Medicine	15	6.32	8.68
Community, Frailty & Therapy	2	0	2
Digestive Diseases	1	0	1
Family Services	8	0.32	7.68
Head & Neck	0	-0.5	0.5
Major Trauma Network	0	-1	1
Neuroscience	1	1	0
Specialist Medicine	2.45	2.45	0
Specialist Surgery	1.05	0.05	1
Grand Total	**241.44**	**24.39**	**217.05**

8. Fines

The Doctors and Dentists in Training Terms and Conditions (England) 2016 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

No fines have been issued this quarter.

9. GOSW Funds Expenditure

As per previous Quarterly Reports, the GOSWH funds previously available have been spent with the agreement of NLaG Resident Doctors' Forum so there are no outstanding funds.

Officer to Contact
Dr Liz Evans, Guardian of Safe Working Hours NLaG
Helen Fitzpatrick, Revalidation & Appraisal Coordinator and Admin for Guardian of Safe Working
Joey Robson, Group Medical Staffing Manager

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st July 2024 – 30th September 2024

1. Purpose of this Report

Under the Doctors and Dentists in Training Terms and Conditions (England) 2016 the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from July - September 2024.

- Exception reports and monitoring
- Locum usage
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	674.6
(establishment)	717
Amount of time available in job plan for Guardian of Safe Working Hours 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:	0.25 PAs per trainee (max; varies between care groups)

Information on exception reporting is detailed within the Doctors and Dentists in Training Terms and Conditions (England) 2016 (pages 37-39) which can be found on the NHS Employers website.

3. Immediate Safety Concerns

Resident doctors are able to escalate exception reports as immediate safety concern where they feel appropriate. Over the quarter, there has been 5 exception reports escalated as an immediate safety concern. Of the 5 immediate safety concerns, 4 related to concerns around minimum staffing levels, and 1 related to a scenario where a doctor was concerned about a patient and how long it took for the initiation of a management plan.

4. Exception Reports

There has been a total of 177 exception reports (177 episodes) reported by resident doctors this quarter highlighting a wide range of themes further detailed in this report.

Exception reports (episodes) by department 1st July – 30th September 2024
General Medicine, Medical Oncology, and Vascular Surgery have had the highest number of exception reports submitted over the quarter.

Within General Medicine, out of the 89 exception reports submitted, 79 were due to hours (overtime), 6 were due to educational reasons, 3 for pattern, and 1 for service support.

Medical Oncology and Vascular Surgery had significantly less exception reports submitted compared to General Medicine.
Out of the 29 exception reports submitted within Medical Oncology, 24 were for hours (overtime), 3 were for service support, and 1 related to pattern.

Out of the 17 exception reports submitted for Vascular Surgery, 16 were for hours (overtime) and only 1 related to service support.

Table A:

Specialty (Where exception occurred)	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
General Medicine	2	89	49	40
Medical Oncology	0	29	19	10
Vascular Surgery	0	17	4	13
General Surgery	11	14	12	2
Paediatric Surgery	0	9	9	0
Surgical Specialties	3	6	2	4
Anaesthetics	0	3	0	3
Clinical Oncology	0	2	2	0
Cardiology	0	1	1	0
Cardio-thoracic Surgery	1	1	1	0
Geriatric Medicine	0	1	1	0
Haematology	0	1	0	1
Neurology	0	1	1	0
Paediatrics	0	1	1	0
Plastic Surgery	1	1	1	0
Psychiatry	0	1	1	0
Total	**18**	**177**	**104**	**73**

Exception reports (episodes) by grade 1st July – 30th September 2024

The highest number of exception reports were submitted by FY1 trainees.
111 exception reports were submitted by FY1 trainees in the quarter, and of those, 97 were submitted in relation to hours (overtime), 7 were for educational reasons, 4 for pattern, and 3 for service support.

Table B:

Grade	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
FY1	5	111	56	55
FY2	6	31	20	11
ST3/CT3+	2	18	17	1
ST1/CT1	5	16	11	5
ST2/CT2	0	1	0	1
Total	**18**	**177**	**104**	**73**

Exception reports (episodes) by rota 1st July – 30th September 2024
Rota 18 (Oncology F1), Rota 8 (Oncology and Haematology F2/CT) and Rota 18B (Endocrinology F1) were the rotas with the highest number of exception reports over the quarter.

Rota 18 (Oncology F1) had 32 exception reports submitted in total, with 30 relating to hours (overtime), 1 for service support and 1 for educational reasons.

Rota 8 had 25 exception reports submitted, 20 relating to hours (overtime), 3 for service support, and 2 for pattern.

Rota 18B had 16 exception reports submitted, 15 for hours (overtime) and 1 for pattern.

Table C:

Rota	**No. exceptions raised (episodes)**	**No. exceptions closed**	**No. exceptions outstanding**
Rota 18 - Oncology	32	7	25
Rota 8 - Oncology & Haematology	25	15	10
Rota 18B - Endocrinology	16	14	2
Rota 23 - Surgery	11	3	8
Rota 4B - Medicine	10	5	5
Rota 25 - Acute/Elective	9	8	1
Rota 66 - Paediatric Surgery	9	9	0
Rota 23 - Surgery	8	3	5
Rota 4 - Gastroenterology	6	6	0
Rota 14 - Frailty	5	5	0
Rota 14 - Frailty	5	3	2
Rota 130 - NCTR & Gen Medicine	5	4	1
Rota 12 - Medical Oncology	4	4	0
Rota 124a - General Surgery Acute	3	0	3
Rota 76 - Critical Care	3	0	3
Rota 4 - Acute Medicine	3	1	2
Rota 4 - Frailty	3	1	2
Rota 4 - Neurology	3	2	1
Rota 27 - Acute & Elective Surgery	3	2	1
Rota 9 - Chest/Renal	2	2	0
Rota 131 - NCTR & Gen Medicine	2	2	0
Rota 121 - Cardiology & CT Surgery	1	1	0
Rota 40 - Plastic Surgery SpR	1	1	0
Rota 124b - ENT	1	0	1
Rota 124a - General Surgery Elective	1	1	0
Rota 18B - Critical Care	1	0	1
Rota 29 - Vascular Surgery	1	1	0
Rota 60 - Paediatric	1	1	0
Rota 18B - Psychiatry	1	1	0
Rota 20 - Cardiology	1	1	0
Rota 6 - RMO 1, 3, 4	1	1	0
Total	**177**	**104**	**73**

Exception reports (episodes) - response time 1st July – 30th September 2024

The Doctors and Dentists in Training Terms and Conditions (England) 2016 require that the supervisor meets with the resident doctor to discuss an exception report within seven days.

It has continually been identified that meeting within seven days is often difficult for resident doctors and supervisors. The Guardian of Safe Working Hours continues to educate both resident doctors and supervisors on the importance of exception reporting and meeting in a timely manner.

Table D:

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	No. outstanding
FY1	5	10	41	55
FY2	5	3	12	11
ST1/CT1	0	3	8	5
ST2/CT2	0	0	0	1
ST3/CT3+	8	1	8	1
Total	**18**	**17**	**69**	**73**

5. Work Schedule Reviews

The following rotas were under review between 1st July – 30th September 2024; all relevant care groups are aware.

- Oral & Maxillofacial Surgery – Rota 38
- ENT – Rota 34

6. Locum bookings 1st July – 30th September 2024

This section details the use of bank and agency doctors to backfill vacant shifts, this is broken down into bank (not including additional hours) and agency bookings. This is also presented by department, grade and reason for booking.

Bank 1st July – 30th September 2024

Bank usage shown below does not include additional hours worked by substantive resident doctors. HUTH utilises the Remarkable Bank to cover bank shifts and this is detailed below.

Table E:

Locum Bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F2	2111	861	20965.09	8678.5
CT/GPSTR/ST1-2	1968	62	16394.77	596.75
ST3+	1350	314	10567.25	2715.67
F1	202	28	1330.3	261.5
Total	**5631**	**1265**	**49257.41**	**12252.42**

Table F:

Locum Bookings (Bank) by Department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Emergency Department	1213	343	12065	3447.5
Acute Medicine	606	200	5284.56	1989.51
Anaesthetics	536	0	5300.75	0
Elderly Medicine	428	127	3495.3	1117.33
Trauma & Orthopaedics	317	74	2581	804.08
Paediatrics	235	14	2148	147
General Surgery	187	102	1962.5	989.5
Colorectal	170	0	1092.5	0
Neurosurgery	170	29	1282.5	321
Obstetrics and Gynaecology	165	41	1501	367
Ophthalmology	159	0	1460	0
ENT	143	46	840.5	500.42
Infectious Diseases	136	28	717	308
Oral and Maxillofacial Surgery	132	94	1095.5	722
Stroke	109	53	880.5	429.5
Oncology	108	27	883	328.75
Rheumatology	101	13	818.75	111.5
Cardiology	94	11	682.25	125
CT Surgery	93	0	714	0
Haematology	88	0	704	0
Urology	88	4	760.5	50
Neurology	74	30	599	241
Vascular Surgery	48	0	388.75	0
Upper GI	38	0	178	0
Respiratory	36	3	291.5	12.75
Gastroenterology	30	2	238.5	16.33
Paediatric Surgery	30	1	397.5	8
General Medicine	28	20	276.5	186.75
Chest Medicine	20	0	269.3	0
Plastic Surgery	11	1	21	13
Dermatology	10	0	80	0
Endocrinology	7	1	61.5	12.5
Radiology	7	0	35	
Renal	7	1	77.75	4
Neonatal	6	0	65	0
Rehabilitation	1	0	9	0
Total	**5631**	**1265**	**49257.41**	**12252.42**

Table G:

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Vacancy/Strike Action	4109	997	39287	9684
Additional Resource	654	101	3096.8	1030
Sickness	567	108	4506.4	1012
Annual leave	144	44	1283.8	441
Maternity/Paternity Leave	124	2	897.75	17.25
Compassionate Leave and Special Leave	19	8	140	47
Study Leave	10	1	38	12.5
Crem Fees	4	4	8	8
Total	**5631**	**1265**	**49257**	**12252**

Agency 1st July – 30th September 2024

Use of Agency staff to backfill vacancies is a last resort once all other avenues (ie. Additional Hours, Bank, Alternate Staff roles) have been exhausted. Clear Agency approval processes are in place across all Care Groups and all agency bookings are managed by the central Medical Staffing Team.

Table H:

Locum Bookings (Agency) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F2	2111	274	20965.09	2682.09
CT/GPSTR/ST1-2	1968	1025	16394.77	9467.58
ST3+	1350	60	10567.25	624.44
F1	202	0	1330.3	0
Total	**5631**	**1359**	**49257.41**	**12774.1**

Table I:

Locum Bookings (Agency) by Department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Emergency Department	1213	256	12065	2468.59
Acute Medicine	606	157	5284.56	1325.3
Anaesthetics	536	347	5300.75	3591.25
Elderly Medicine	428	121	3495.3	921
Trauma & Orthopaedics	317	0	2581	0
Paediatrics	235	119	2148	1198.94
General Surgery	187	12	1962.5	129
Colorectal	170	0	1092.5	0
Neurosurgery	170	0	1282.5	0
Obstetrics and Gynaecology	165	4	1501	47.5
Ophthalmology	159	132	1460	1089.03
ENT	143	2	840.5	20
Infectious Diseases	136	24	717	198
Oral and Maxillofacial Surgery	132	0	1095.5	0
Stroke	109	31	880.5	266
Oncology	108	15	883	166.25
Rheumatology	101	33	818.75	246
Cardiology	94	34	682.25	297.5
CT Surgery	93	0	714	0
Haematology	88	46	704	466
Urology	88	0	760.5	0
Neurology	74	0	599	0
Vascular Surgery	48	0	388.75	0
Upper GI	38	0	178	0
Respiratory	36	8	291.5	62.5
Gastroenterology	30	5	238.5	37.5
Paediatric Surgery	30	11	397.5	221
General Medicine	28	1	276.5	11.5
Chest Medicine	20	0	269.3	0
Plastic Surgery	11	0	21	0
Dermatology	10	0	80	0
Endocrinology	7	0	61.5	0
Radiology	7	0	35	0
Renal	7	1	77.75	11.25
Neonatal	6	0	65	0
Rehabilitation	1	0	9	0
Total	**5631**	**1359**	**49257.41**	**12774.11**

Table J:

Locum Bookings (Agency) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Vacancy/Strike Action	4109	1143	39286.81	10704.07
Additional Resource	654	74	3096.75	681.29
Sickness	567	80	4506.35	844.25
Annual leave	144	55	1283.75	469
Maternity/Paternity Leave	124	7	897.75	75.5
Compassionate Leave and Special Leave	19	0	140	0
Study Leave	10	0	38	0
Crem Fees	4	0	8	0
Total	**5631**	**1359**	**49257.41**	**12774.11**

Locum work carried out by doctors in training 1st July – 30th September 2024

This data is collected to help assess where individual doctors in training are working the most additional hours so that any breaches of the Working Time Directive (WTD) and the 2016 Terms and Conditions can be explored.

The table represents the top 10 doctors in training that have worked the most extra hours.

Table K:

Base Specialty	Grade	Number of hours worked	Number of hours rostered per week
Otolaryngology	ST5	238	44:30
General Practice	ST3	156	40:00
General Practice	ST2	155.5	40:00
Vascular Surgery	ST4	150	46:45
General Practice	ST3	134	32:00
Trauma and Orthopaedic Surgery	ST4	126.5	47:15
Cardiothoracic Surgery	ST6	126	47:00
General Practice	ST3	118	40:00
General Surgery	ST5	98	47:15
Neurosurgery	ST6	83.5	46:45

7. **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).

Hull University Teaching Hospitals NHS Trust - Resident Doctor Trainee Establishment July to September 2024

	Trainee Establishment						Trainee In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Filled September 2024**	% Filled June 2024
Academic, GP, Psych & Community	9	32	0	109	0	150	9.6	32	0	95.1	0	136.7	**91.1%**	93.3%
Acute Medicine	5	7	8	0	7	27	4	7	7.7	0	4.8	23.5	**87.0%**	87.2%
Anaesthetics	5	4	23	0	31	63	5	7	21.7	0	32.5	66.2	**105.1%**	97.7%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	**80.0%**	80.0%
Cardiology	3	2	3	1	8	17	3	2	3.6	1	9.6	19.2	**112.9%**	100.0%
Cardiothroacic Surgery	0	3	0	0	4	7	0	3	0	0	3	6	**85.7%**	71.4%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Colorectal Surgery	9	0	2	0	3	14	9	0	1	0	2	12	**85.7%**	85.7%
Dermatology	1	0	0	1	0	2	1	0	0	0	0	1	**50.0%**	100.0%
Elderly Medicine	7	3	5	7	6	28	7.8	3	5	6.6	5.2	27.6	**98.6%**	92.6%
Emergency Medicine	0	14	17	6	18	55	0	14.1	16.7	6.4	12.9	50.1	**91.1%**	74.4%
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	**100.0%**	88.9%
ENT	2	2	2	3	5	14	2	2	2	3	3.6	12.6	**90.0%**	89.2%
Gastroenterology	3	1	2	0	7	13	3	1	2	0	6.8	12.8	**98.5%**	85.0%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	**100.0%**	100.0%
Haematology	2	2	2	0	5	11	2	2.8	2	0	5.6	12.4	**112.7%**	90.0%
Histopathology	0	0	0	0	7	7	0	0	0	0	5.8	5.8	**82.9%**	94.3%
Immunology	0	0	0	0	1	1	0	0	0	0	0	0	**0.0%**	100.0%
Infectious Diseases	2	1	1	2	6	12	2	1	1	1	6.6	11.6	**96.7%**	102.1%
Neuro-Rehab	0	0	0	2	0	2	0	0	0	0.8	0	0.8	**40.0%**	100.0%
Neurology	5	3	3	0	5	16	3	3.8	3	0	3	12.8	**80.0%**	88.7%
Neurosurgery	1	1	2	0	4	8	1	1	2	0	4	8	**100.0%**	100.0%
Obstetrics & Gynaecology	0	4	6	4	13	27	0	4	5	5	12.6	26.6	**98.5%**	92.9%
Oncology	3	0	2	4	12	21	3	0	2	3	10.6	18.6	**88.6%**	99.0%
Ophthalmology	1	1	0	0	6	8	0	1.6	0	0	6.8	8.4	**105.0%**	85.0%
Oral & Maxillofacial Surgery	0	0	10	0	2	12	0	0	4	0	2	6	**50.0%**	27.3%
Paediatric Neonatal Medicine	0	0	9	0	5	14	0	0	8.4	0	6	14.4	**102.9%**	88.8%
Paediatric Surgery	0	1	2	0	0	3	0	1	1	0	0	2	**66.7%**	100.0%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**	100.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	6	9	**100.0%**	100.0%
Paediatrics	3	4	4	2	9	22	3	5	4.6	2	10.1	24.7	**112.3%**	94.2%
Radiology	0	1	0	0	39	40	0	1	0	0	38.4	39.4	**98.5%**	85.3%
Renal Medicine	2	1	2	0	6	11	2	1	2	0	5.6	10.6	**96.4%**	90.9%
Respiratory Medicine	6	2	2	2	8	20	5	2	2	2	7.6	18.6	**93.0%**	101.5%
Rheumatology	3	1	1	2	3	10	2	1	2	2	3.6	10.6	**106.0%**	96.7%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	**0.0%**	100.0%
Trauma & Orthopaedics	0	5	3	1	9	18	0	5	3	1	8	17	**94.4%**	77.8%
Upper GI	9	0	2	0	4	15	9.8	0	1	0	4	14.8	**98.7%**	86.7%
Urology	1	3	2	0	3	9	1	3	1	0	3	8	**88.9%**	100.0%
Vascular Surgery	6	0	1	0	5	12	6.8	0	1	0	2	9.8	**81.7%**	71.7%
TOTAL	**93**	**99**	**122**	**148**	**255**	**717**	**90**	**105.3**	**110.7**	**130.9**	**237.7**	**674.6**	**94.1%**	89.8%

8. Fines

The Doctors and Dentists in Training Terms and Conditions (England) 2016 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 Doctors and Dentists in Training Terms and Conditions.

Summary of fines issued 1st July – 30th September 2024

10 fines issued over the quarter totaling £16,086.93. 6 to the Paediatric Surgery department; 1 to the Orthopaedic and Plastic Surgery department; 1 to Acute and Elective Surgery; 1 to the Plastic Surgery department; and 1 to the Oncology and Haematology department.

9 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 fines issued to Paediatric Surgery, Plastic Surgery, Acute and Elective Surgery, and Orthopaedic and Plastic Surgery were all in relation to non-resident on call shifts where the resident doctors remained on site breaching 13 hour maximum shift length, and returned to site for a variety of call outs throughout the night, breaching the minimum rest required.

The fine issued to Oncology and Haematology was in relation to a day shift where a resident doctor was on site for 13 hours and 15 minutes, breaching the 13 hour maximum shift length, incurring a fine.

<u>Steps taken to resolve issues:</u>

The circumstances resulting in these fines are deemed to be exceptional circumstances due to external factors, Industrial Action 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.

9. GOSW Funds Expenditure

The Guardian of Safe Working Hours Funds stands at £68,169.20 at the time of the report being written. Over the quarter there have been several purchases made to benefit the Resident Doctor cohort using Guardian of Safe Working Hours funds, totalling £6,178.

The Guardian of Safe Working Hours funds have been used to provide refreshments at a wide range of resident doctor teaching events over the quarter.

The Guardian of Safe Working Hours has plans to run a series of Vascular Access Courses using the funds to purchase necessary equipment.

All expenditure from the GOSW Funds is agreed at the Resident Doctors' Forum.

Officer to contact:
Dr Wajiha Arshad, Guardian of Safe Working Hours
Rose Bundy, Medical Staffing Analyst
November 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)252

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	12 December 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 attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2025 and December 2025. The report also includes the schedule for January - December 2026.
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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE -2025 - V9

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays -9.00 am - 5.00 pm)		13.02.25 **Boardroom, HRI**		10.04.25 **Boardroom, DPOW**		12.06.25 **Boardroom, HRI**		14.08.25 **Boardroom, DPOW**	**HUTH Annual General Meeting - Date TBC**	09.10.25 **Boardroom, HRI**		11.12.25 **Boardroom, DPOW**
Board Development (Thursdays -9.00 am - 5.00 pm)			13.03.25 **Boardroom, DPOW**		08.05.25 **Boardroom, HRI**		10.07.25 **Boardroom, DPOW**		11.09.2025 **Boardroom, HRI**		13.11.25 **Boardroom, DPOW**	
Committees in Common												
Performance, Estates & Finance (Tuesdays -9.00 am - 12.30 pm)	Meeting falls in December 2024 due to previous reporting cycle	04.02.25 **Boardroom, DPOW**	04.03.25 **Boardroom, HRI**	01.04.25 **Nightingale, SGH**	06.05.25 **Boardroom, HRI**	03.06.25 **TBC, CHH**	01.07.25 **Boardroom, DPOW**	05.08.25 **Nightingale, SGH**	02.09.25 **Boardroom, HRI**	30.09.25 **(please note falls in September) TBC, CHH**	04.11.25 **Boardroom, DPOW**	02.12.2025 **Nightingale, SGH**
Capital & Major Projects (9.00 am - 12.00 pm)	30.01.25 **Boardroom, DPOW**			22.04.25 **Boardroom, HRI**		18.06.25 **Boardroom, DPOW**		20.08.25 **Nightingale, SGH**		22.10.25 **Boardroom, HRI**		16.12.25 **Boardroom, HRI**
Quality & Safety (Thursdays -9.00 am -12.30 pm with exceptions as stated)		27.02.25 **Nightingale, SGH**	27.03.25 **Boardroom, DPOW**	29.04.25 **Boardroom, HRI** (Tuesday)	29.05.25 **TBC, CHH**	26.06.25 **Nightingale, SGH**	24.07.25 **Boardroom, HRI**	28.08.25 **Boardroom, DPOW**	25.09.25 **TBC, CHH**	30.10.25 **Nightingale, SGH**	27.11.25 **Boardroom, HRI**	18.12.25 **Boardroom, DPOW**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		05.02.25			27.05.25			06.08.25			20.11.25	
Workforce, Education & Culture (Wednesdays -9.00 am - 12.30 pm)	29.01.25 **Boardroom, DPOW**	26.02.25 **Boardroom, HRI**	26.03.25 **Nightingale, SGH**	30.04.25 **TBC, CHH**	28.05.25 **Boardroom, DPOW**	25.06.25 **Boardroom, HRI**	23.07.25 **Nightingale, SGH**	27.08.25 **TBC, CHH**	24.09.25 **Boardroom, DPOW**	29.10.25 **Boardroom, HRI**	26.11.25 **Nightingale, SGH**	17.12.25 **TBC, CHH**
Audit, Risk & Governance Committee (Thursdays -9.00 am -12.30 pm with exceptions as stated)	23.01.25 **Boardroom, HRI**			24.04.25 **Boardrom, HRI**		20.06.25 HUTH & NLaG **Annual Accounts** Friday - 9.00 am - 12.00 pm **Boardroom, HRI**	31.07.25 **Boardroom, DPOW**				12.11.25 **Boardroom, DPOW**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	22.01.25			02.04.25			09.07.25		23.09.25			
HUTH (9.00 am - 12.00 pm)		06.02.25			07.05.25			07.08.25			06.11.25	
Executive Team Meetings												
Group Cabinet Meeting (Tuesdays -2.00 pm - 5.00 pm)	07.01.25 14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25	01.04.25 08.04.25 15.04.25 22.04.25 29.04.25	13.05.25 20.05.25 27.05.25	03.06.25 10.06.25 17.06.25 24.06.25	08.07.25 15.07.25 22.07.25 29.07.25	05.08.25 12.08.25 19.08.25 26.08.25	09.09.25 16.09.25 23.09.25 30.09.25	07.10.25 14.10.25 21.10.25 28.10.25	11.11.25 18.11.25 25.11.25	02.12.25 09.12.25 16.12.25 23.12.25
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	09.01.25	25.02.25 (9.00 am - 10.30 am) **NED & Governor only Meeting**		16.04.25			17.07.25		04.09.25 (1.30 pm - 5.00 pm) **AMM & Highlight Reports**		05.11.25	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays -5.30 pm - 7.00 pm)			11.03.25			03.06.25				07.10.25		02.12.25
Appointments & Remuneration Committee (Thursdays -3.00 pm - 4.30 pm)		20.02.25			29.05.25				25.09.25			
NED & CEO Meetings												
NED & CEO Meetings (Tuesdays -10.00 am - 12.00 pm)	14.01.25	18.02.25	18.03.25	15.04.25	13.05.25	17.06.25	15.07.25	19.08.25	16.09.25	14.10.25	18.11.25	09.12.25
Union Meetings												
JNCC - NLAG (Mondays -2.30 pm - 4.30 pm)	20.01.25	17.02.25	17.03.25	21.04.25	19.05.25	16.06.25	21.07.25	18.08.25	15.09.25	20.10.25	17.11.25	15.12.25
JNCC - HUTH (Thursdays -10.45 am - 12.45 pm)	02.01.25		06.03.25		01.05.25		03.07.25		04.09.25		06.11.25	
Consultant Meetings												
JLNC - NLAG (Tuesdays -12.30 pm - 2.00 pm)	21.01.25	18.02.25	18.03.25	15.04.25	20.05.25	17.06.25	15.07.25	19.08.25	16.09.25	21.10.25	18.11.25	16.12.25
LNC - HUTH (Wednesdays -10.00 am - 1.00 pm)	15.01.25		19.03.25		21.05.25		16.07.25		17.09.25		19.11.25	

MEETING SCHEDULE -2026 - V3

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays -9.00 am - 5.00 pm)		12.02.26		09.04.26		11.06.26		13.08.26	**HUTH Annual General Meeting - Date TBC**	08.10.26		10.12.26
Board Development (Thursdays -9.00 am - 5.00 pm)			12.03.26		14.05.26		09.07.26		10.09.26		12.11.26	
Committees in Common												
Performance, Estates & Finance (Tuesdays -9.00 am - 12.30 pm)	06.01.26	03.02.26	03.03.26	07.04.26	05.05.26	02.06.26	07.07.26	04.08.26	01.09.26	29.09.26 **(please note falls in September)**	03.11.26	01.12.26
Capital & Major Projects (9.00 am - 12.00 pm)		18.02.26		21.04.26		17.06.26		19.08.26		21.10.26		15.12.26
Quality & Safety (Thursdays -9.00 am -12.30 pm with exceptions as stated)	29.01.26	26.02.26	26.03.26	30.04.26	28.05.26	25.06.26	23.07.26	27.08.26	24.09.26	29.10.26	26.11.26	17.12.26
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		04.02.26			26.05.26			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays -9.00 am - 12.30 pm)	28.01.26	25.02.26	25.03.26	29.04.26	27.05.26	24.06.26	22.07.26	26.08.26	23.09.26	28.10.26	25.11.26	16.12.26
Audit, Risk & Governance Committee (Thursdays -9.00 am -12.30 pm with exceptions as stated)	22.01.26			23.04.26		19.06.26 HUTH & NLaG **Annual Accounts** Friday - 9.00 am - 12.00 pm **Boardroom, HRI**	30.07.26				11.11.26 (Wednesday)	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	21.01.26			01.04.26			08.07.26			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			10.11.26	
Executive Team Meetings												
Group Cabinet Meeting (Tuesdays -2.00 pm - 5.00 pm)	06.01.26 13.01.26 20.01.26 27.01.26	03.02.26 10.02.26 17.02.26 24.02.26	03.03.26 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 14.04.26 21.04.26 28.04.26	05.05.26 12.05.26 19.05.26 26.05.26	02.06.26 09.06.26 16.06.26 23.06.26 30.06.26	07.07.26 14.07.26 21.07.26 28.07.26	04.08.26 11.08.26 18.08.26 25.08.26	01.09.26 08.09.26 15.09.26 22.09.26 29.09.26	06.10.26 13.10.26 20.10.26 27.10.26	03.11.26 10.11.26 17.11.26 24.11.26	01.12.26 08.12.26 15.12.26 22.12.26
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	08.01.26	24.02.26 (9.00 am - 11.00 am) **NED & Governor only Meeting**		15.04.26			16.07.26		03.09.26 (1.30 pm - 5.00 pm) **AMM & Highlight Reports**		04.11.26	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays -5.30 pm - 7.00 pm)			10.03.26			02.06.26				06.10.26		01.12.26
Appointments & Remuneration Committee (Thursdays -3.00 pm - 4.30 pm)		19.02.26			28.05.26				24.09.26			
NED & CEO Meetings												
NED & CEO Meetings (Tuesdays -10.00 am - 12.00 pm)	13.01.26	17.02.26	17.03.26	14.04.26	12.05.26	16.06.26	14.07.26	18.08.26	15.09.26	13.10.26	17.11.26	08.12.26
Union Meetings												
JNCC - NLAG (Mondays -2.30 pm - 4.30 pm)	19.01.26	16.02.26	16.03.26	20.04.26	18.05.26	15.06.26	20.07.26	17.08.26	14.09.26	19.10.26	16.11.26	14.12.26
JNCC - HUTH (Thursdays -10.45 am - 12.45 pm)	08.01.26		05.03.26		07.05.26		02.07.26		03.09.26		05.11.26	
Consultant Meetings												
JLNC - NLAG (Tuesdays -12.30 pm - 2.00 pm)	20.01.26	17.02.26	17.03.26	21.04.26	19.05.26	16.06.26	21.07.26	18.08.26	15.09.26	20.10.26	17.11.26	15.12.26
LNC - HUTH (Wednesdays -10.00 am - 1.00 pm)	14.01.26		18.03.26		20.05.26		15.07.26		16.09.26		18.11.26	

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)250

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 December 2024**
Director Lead	**Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs**
Contact Officer / Author	**Rebecca Thompson, Deputy Director of Assurance**
Title of Report	**Capital & Major Projects Committees-in-Common**
Executive Summary	**Minutes taken at June, August and October 2024 Capital & Major Projects Committees-in-Common**
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	**Capital & Major Projects Committees-in-Common**
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on 25 June 2024
9.00am to 12.00noon via Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director, NLaG (Chair)
Julie Beilby	Associate Non-Executive Director, NLaG
Lee Bond	Group Chief Financial Officer
Tony Curry	Non-Executive Director, HUTH
Simon Parkes	Non-Executive Director, NLaG
Helen Wright	Non-Executive Director, HUTH

In Attendance:

Alex Best	Interim Group Deputy Director of Capital Services
Paul Bytheway	Group Chief Delivery Officer
Linsay Cunningham	Deputy Director of Strategy
Any Hayward	Group Chief Digital Officer
Jonathan Lofthouse	Group Chief Executive
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Rebecca Thompson	Deputy Director of Governance
David Sharif	Group Director of Assurance
Lynn Arefi	Personal Assistant (Minutes)

Observer(s):

Stuart Hall	Non-Executive Director, HUTH
Ian Reekie	Governor Observer (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

Gill Ponder welcomed those present to the meeting as the Committee Chair. Apologies were noted from Jane Hawkard.

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 23 April 2024**

The minutes of the meeting held on 23 April 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

Gill Ponder invited Committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.5 **Committees-in-Common Action Tracker**

The Action Tracker was reviewed, and all outstanding actions were noted as completed and therefore closed.

1.6 **Terms of Reference – Final**

The Committees received, the Terms of Reference (ToR) and noted that the following still required amending: Page 5 Group Chief Clinical Design Officer needed to be removed from the ToR. Subject to this amendment the Committee agreed the ToR as the final version.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

Gill Ponder reported that no matters had been referred by the Trust Board for consideration by the Committees.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

3.1a It was noted that the HUTH BAF would be referred to in item 10.1 – Complete Board
3.1b Assurance Framework later in the agenda. David Sharif added that in future that the reports for NLaG and HUTH would be taken as one item on the agenda. David Sharif went on to note that since the last meeting there had been no change in the risk scoring adding that the IT and Cyber risk remained above the target risk rating of 10.

It was noted that the NLaG BAF was also be referred to in item 10.1.

Julie Beilby queried the level of compliance on training for Cyber Security. Andy Hayward confirmed that that an audit of the data security and protection toolkit which would be brought back to the Committee. It was noted that the training was reported through the Workforce Committee and is currently around 88%.

Helen Wright asked David Sharif what the confidence levels were of reaching the target scores that had been set. David Sharif added that this very much depended upon the risks and noted that these targets were set before he joined the Trust and therefore would look to colleagues to support this answer. Lee Bond referred to the

risk around securing sufficient capital for the coming decades and added that with the state of public finances currently and the impending new Government he confirmed he was not confident. Helen Wright suggested that it may be worth refreshing on what the target risk is; i.e. "what is within our gift to achieve" to ensure we were moving in the right direction. David Sharif added that a strategy refresh is currently underway and as part of this there is a series of plans to do this.

Simon Parkes noted that there was quite a lot we were doing to mitigate a "cyber-attack" and added he would like to understand why we seemed unable to change the impact score on this. Andy Hayward advised that this would be discussed in more detail at the Trust Board Development session next week. Andy Hayward suggested that the risk score was left as is until these further discussions had taken place. Simon Parkes re-iterated that this was a significant issue that the Trust Board needed to understand fully.

Gill Ponder acknowledged the Committee's concerns and suggested it would be helpful if Andy Hayward brought back the output from the Trust Board development session to the next meeting to inform further discussions.

ACTION: Andy Hayward to provide a report on the output from the Trust Board Development Session.

3.2 **Risk Register Report**

David Sharif advised the Committee that currently he was not in a position to present the risk register at this meeting but assured Committee members that a full report would be brought to the next meeting in August.

ACTION: David Sharif - Risk Register to be presented to the August meeting.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports or recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendations & Assurances**

There were no external reports, recommendations, or assurances to note.

REVIEW: Assurance rating, escalate or additional information requested.

- Cyber Security – the Committees-in Common agreed limited assurance

4. COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 **Group Capital Funding Update**
4.2 **Group Capital Plan Delivery – Expenditure Against Plan**

Lee Bond spoke to both items 4.1 and 4.2 - the report provided the capital spend for the two months to May 2024, for both Trusts. It was noted that both Trusts had

received additional Integrated Care Services (ICS) Capital Departmental Expenditure Limit (CDEL); HUTH £2.8m and NLAG £2.9m relating to achievement of 2023/24 revenue plan and revenue surplus. Total spend to date was HUTH £0.4m, NLAG £0.6m. Lee Bond went on to note that capital plans had been amended to align to actual spend at month 2 and then went on to refer to capital funding noting that the capital plan had been set but already changes were starting to be seen to the capital funding including Reinforced Autoclaved Aerated Concrete (RAAC) both at SGH £700k and HUTH £1.8mil. A grant of £20.6mil was received for SGH de-carbonisation fund, this would be discussed further on the agenda.

Lee Bond noted that it had been recognised that the full funding for Electronic Patient Record was unlikely to be spent and therefore £4mil had been deferred to next year across both HUTH and NLaG. It was also noted that a grant from ROCHE had been received at HUTH for £975k to assist with the provision of service of the CDC in Beverley. Lee Bond added that this was a "moving feast" but he would ensure that the Committee received regular reconciliations and detailed movements. Moving on to the delivery of the capital programme Lee Bond added that the capital plan had been re-phased at month 2 and therefore it looked like only £1mil had been spent across the group within the first 2 months. Lee Bond advised that discussions had been held at the Group Capital meeting to ensure the Trust had plans in place so there are no major problems during Quarter 4. Concerns were ensuring that all the capital accruals at the end of the previous year had been utilised and discharged in a proper manner.

Lee Bond went on to note that the only issues were unallocated reserves in NLaG which related to HASR, the Decision-Making Business Case would require to be completed and strategic choices would need making before the monies were committed. Lee Bond noted that the other risk highlighted was breakdown of equipment and associated high cost of repairs and replacements.

Lee Bond went on to add that he was relatively "calm" in respect of the capital programme at this point in time.

Gill Ponder thanked Lee Bond for the update and opened for comments and questions.

Helen Wright asked if Lee Bond envisaged a refresh once the Strategic Plan was confirmed. Lee Bond confirmed that there was a possibility of £5mil been available. He went on to add that he did not believe that the capital allocation would be reduced as a result of any external factors or plans from either a regional or national perspective.

Gill Ponder went on to add that, had the Trust not had the NHSE reset then it probably would have been behind plan, and it was important that we needed to ensure all monies were spent within year.

4.3 **Review & Evaluation of New Business Cases, Investments & Dis-investments within Delegated Limits and/or Endorsement for Trust Board Approval**

4.3.1 **Update on New Build - Hull Royal Infirmary (HRI) HUTH**

Lee Bond advised the Committee that at the last meeting a Short Form Business Case was circulated for information, it was noted at the time that this had not yet

secured Group Cabinet approval. Following discussion at Group Cabinet Jonathan Lofthouse had rightly challenged the business case and had asked if key issues and the original plan could be re-visited, especially around the re-provision of paediatric day services. Lee Bond added that there was still a lot of work to do in understanding the clinical challenge and moving services. It was work in progress to ensure we had the best solution to move forward. Currently the business case was "off the table". Jonathan Lofthouse asked for clarity around the allocated £4.2mil and would this then be additional monies. Lee Bond confirmed this would. Helen Wright referred to the due diligence and added that she was slightly surprised it had reached the Chief Executive without getting the appropriate level of challenge and scrutiny and asked if the rust were comfortable with the due diligence process or did this need to be reviewed. Lee Bond confirmed he was happy with the processes that were currently in place.

4.3.2 **Public Sector Decarbonisation Scheme (PSDS) - NLaG**

Lee Bond introduced the agenda item giving context for the Committee. Lee Bond advised that the scheme was £20.6mil over two years with the Trust contributing £6.5mil which would be included in next year's plan. The scheme would deliver a fully decarbonised site at SGH. The team believe that this could be delivered for a revenue "cost neutral". Lee Bond added that he felt confident that the full £27mil would be spent over the 2 years.

Alex Best presented the circulated report which provided a progress update on the Northern Lincolnshire and Goole Public Sector Decarbonisation Scheme (PSDS) programme of works at Scunthorpe General Hospital. The Trust was awarded grant funding in May 2024, to the value of £20,638,791 with a total applicant contribution of £6,485,718. This funding would be spread over the two financial years giving a total project cost of £27,124,509.

Alex Best went on to note that the report set out the intended strategy for both financial years. The programme of works was ambitious but achievable. The group project management team have direct experience of such schemes namely PSDS1 at Hull University Trust in 2021/22 which covered the field of dreams, LED lighting, roof upgrades amongst other schemes.

Upon completion of the scheme the Scunthorpe site would be in a unique position of being one, if not the first large scale acute hospital that would be fully decarbonised from an energy perspective. Alex Best noted that the added gains were also the reduction in major Estates, Facilities and Development risks, significant reduction in backlog maintenance works and a significant improvement to the Scunthorpe Estate.

Tony Curry asked Alex Best how confident he was on realising the revenue as described. Alex Best confirmed that there was a number of schemes which would generate significant savings including looking to maximise the roof space and other areas for solar panels and heat storage and therefore there was a reasonable level of confidence. Helen Wright asked if local solar suppliers were being used. Alex Best confirmed that at HUTH they had used a number of different contractors and noted that there was "plenty of appetite" for solar contractors to deliver these schemes. Helen Wright then went on to ask how far along this plan would take the Trust with regards to the net zero target. Ivan McConnell added that this would

need to be framed within the wider estate context. Ivan McConnell and Alex Best would bring back to the October meeting further assurance on how the de-carbonisation programme impacted on the Net Zero strategy.

ACTION: further assurance on how the de-carbonisation programme impacted on the Net Zero strategy to be present to the October Committee-in-Common – Ivan McConnell and Alex Best.

Tony Curry then went on to ask would there be noticeable interruptions as this work is carried out. Alex Best noted that the biggest disruption would be replacement of glazing and we would possibly have to look at decant options. Alex Best added that the number of contractors onsite would also be an issue and would look at the possibility of a "central area" for all contractors.

Gill Ponder referred to the revenue impact and how would the worst-case scenario be managed. Alex Best confirmed that this remained a risk as unfortunately with Net Zero the electrical generation of heat is significantly more expensive than burning gas. Gill Ponder as we had no direct control of District Network Operator how would the risk of slippage to the critical enabler be managed. Alex Best noted that a substation had already been installed so in terms of the overall works a significant amount of work had already been completed. Gill Ponder then went on to refer to the section within the report about re-covering the roofs at SGH, as these are in a poor state of repair already was this not a risk around this and was there contingency. Alex Best confirmed that all roofs would have a detailed survey carried out prior to any commencement of work and added that a significant amount of contingency had been built into the scheme. Gill Ponder asked if there was any opportunity to make use of some of the work that had already taken place on SGH with the Bore Holes to optimise the availability of cheaper power. Alex Best confirmed that every opportunity would be looked at to optimise wherever possible.

Gill Ponder thanked Alex Best for the update.

4.3.3 **Electronic Patient record (EPR) – Draft Business Case**

This item to be addressed under item 6.1.

4.3.4 **Urgent Care Building Works - HRI**

Lee Bond went on to note that a bid had been placed by the Trust for £990k, this work is essentially within the acute medical unit within HRI to change into a same Day Emergency Care Unit. A further option was currently being developed with the team working through options if we were to receive the funding. Lee Bond would update the Committee on any progress.

4.4 **Review & Evaluation of Existing Business Cases**

There were none for the Committees-in-Common to note.

4.5 **Post Capital Project Evaluation**

There were none for the Committees-in-Common to note. Helen Wright suggested it would be helpful to receive a schedule of the timing of the Post Capital Project Evaluation reviews. Lee Bond would get a schedule together.

ACTION: A schedule of Post Project Evaluations to be created. Lee Bond.

4.6 **Capital Contract Approvals**

There were none for the Committees-in-Common to note.

REVIEW: Assurance rating, escalate or additional information requested.

- Capital Plan delivery – the Committees-in-Common agreed they were reasonably assured
- PSDS – the Committees-in-Common agreed they were reasonably assured and was well managed.

5. Major Service Change / Transformation

5.1 **Humber Acute Services Review (HASR)**

Ivan McConnell gave a brief overview and passed on to Linsay Cunningham who shared the presentation and went on to note that the Humber Acute Services Programme was now in the final stages of decision making and had developed a Decision-Making Business Case (DMBC) following the closure of the statutory consultation on the options presented in the Pre-Consultation Business Case.

Linsay Cunningham noted that the Decision-Making Business Case had been presented to the Private Humber and North Yorkshire Integrated Care Board in June and would now go to the Public Trust Board in July 2024 for a decision and final approval.

The Decision-Making Business Case made some recommendations to change the proposal based on feedback gathered during consultation and detailed planning with clinical and managerial teams within the Group. These were highlighted within the report.

The proposed changes had also been discussed with the Integrated Care Board Chief Executive and the Executive Team in advance of the meeting in June.

Linsay Cunningham added the Decision-Making Business Case had also been submitted to NHSE for a final Gateway Assurance Review prior to Integrated Care Board decision making in July.

Linsay Cunningham advised that key issues around travel and access would be picked up and considered with the ICB. The key feedback was around the future of SGH Hospital and concerns that one change may lead to others.

Benefits would be driven through the programme around the consolidation of specialist skills which will enable better more “joined up” services reducing some of

the duplication. Linsay Cunningham added that we would still need to retain two emergency departments and we would obviously need to retain a number of skills and expertise on both sites. It would also provide a platform for changes to planned care.

Helen Wright thanked Linsay Cunningham for the comprehensive summary and asked if there were any areas that had to be compromised and were not happy with. Ivan McConnell noted that probably Paediatrics but there was a plan in place as we looked forward. It was noted that Urology consolidation of temporary service change had been in place for 4 years and were now in a position that allowed us to put in a foundation for future service change. Julie Beilby acknowledged that the decision was with the ICB and asked if the Trust were working on their own comms strategy. Linsay Cunningham confirmed that work with ICB and the Trust was ongoing especially around the handling of a single message with staff informed in a timely manner around the decision.

The Committee were asked to note:

- The completion of the Consultation and Engagement on the Humber Acute Services proposal for change
- The recommendations set out within the Decision-Making Business Case to the Integrated Care Board
- The timeline for ICB decision making

5.2 **Community Diagnostic Centre (CDC) Programme**

Ivan McConnell summarised the report noting that the Community Diagnostic Centre Programme was making significant progress with the Grimsby Spoke and Scunthorpe Hub scheduled to open in October 2024, and the Hull Hub opening was scheduled for March 2025.

Ivan McConnell noted that the recruitment process was making noteworthy progress on the South Bank and plans were in place for the North Bank. Key issues to highlight on workforce were:

- Radiologists – multiple recruitment approaches have been investigated – it is likely that the service will be outsourced within the first year of operation
- NOUS and echo staff have also proved difficult to recruit to Although work was currently being undertaken to review the potential to extend several outsourcing contracts with existing suppliers

The workforce profile had been aligned to the planned activity schedule and agreed with NHSE.

Moving on to revenue Ivan McConnell noted that the current revenue position key themes included there being a deficit for 2024/2025, but the ICB overall would make a planned revenue surplus meaning that all provider costs would be covered. There would also be a surplus for 2025/2026. The financial position was under constant review as NHSE continued to revise activity assumptions on a regular basis. Lee Bond clarified that the risks are been managed as a system programme and there are risks emerging within York and Scarborough which is not without challenges.

Helen Wright noted the overall surplus for 2025/26 which she had noted comprised a fair significant deficit at Grimsby and what was driving this. Ivan McConnell noted that this was tariff driven and the plan was to move Ophthalmology into the site. If this happened there would be a commitment from Ophthalmology to improve productivity. Helen Wright asked if there was a plan beyond this to make the CDC at Grimsby more viable. Ivan McConnell added that on current assumptions and tariff then it would be financially viable 2025/26.

Gill Ponder referred to slide 7 and outsourcing of radiology reporting and how would this impact on the business case and the Trust's financial position. Ivan McConnell confirmed that a recent recruitment drive had been unsuccessful and therefore we did have an issue but would need to ensure we have value for money as we moved forward. Non obstetric ultrasound was always in the plan as an outsource.

REVIEW: Assurance rating, escalate or additional information requested

HASR – the Committees-in-Common agreed on limited assurance due to the risks *(Ivan McConnell did query the "limited assurance" and asked for a caveat to be added on the basis it had substantial assurance from everyone else in the system)*

CDD – the Committees-in-Common agreed on limited assurance

Break 10.45am – 15mins

6. Digital

6.1 Digital Plan Delivery – Bi Monthly Update
Electronic Patient Record (EPR) Draft

The Committee noted that item 4.3.3 Electronic Patient Record (EPR) draft business case would be discussed within this agenda item. Andy Hayward introduced Alison Drury to the meeting and noted that as she had been working on the financials of the business case, she was present to answer any queries associated with the numbers.

Andy Hayward advised that the Outline Business Case represented a ten-year investment of £55.9mil Capital, £98mil Revenue to upgrade 32 of our clinical systems to a single, modern platform across both banks of the Humber. The investment was supported by the NHS England Frontline Digitisation Programme with a central investment of £18.5mil of Capital and £3.3mil of Revenue. It was noted however, at this stage in the programme there was a £14.5mil Capital challenge if the Group wished to admit a competitive number of suppliers to its procurement process. A funding gap was not uncommon at Outline Business Case (OBC) stage and there were plans to engage with NHS England regional and central teams around potential resolutions once the case was submitted.

Andy Hayward went on to add that once approved by the Board of the Humber Health Partnership (HHP), the OBC would be reviewed by the Integrated Care Board and then progress to central review. It was noted that this could take around 3 months. It was anticipated that final approval of the case at the NHSE EPR Investment Board (EPRIB) would be sought in late September early October 2024.

HHP retains the right to make approved amendments to the case until this date. Any residual challenges will be noted as part of a conditional approval by NHSE to be resolved through submission of the full business case, which would be submitted in Quarter one of the next financial year (2025/26).

Andy Hayward drew the Committee's attention to the Executive Summary at the beginning of the main document, which contained a summary of all the key information within the 5 cases of the OBC.

It was noted that there were 16 Appendices to the OBC, which contained all relevant supporting information. Andy Hayward advised the Committee that for the purposes of brevity, the following had been included for immediate review within the pack if required.

- Comprehensive Investment Appraisal (CIA) model
- Draft Outline Business Specification (OBS)
- Draft call off contract Terms and Conditions
- Clinical Safety Management System
- User Centred Design workshop outputs

Andy Hayward advised that the financial implications were included within the Executive Summary, Economic and Financial Cases of the OBC, with further detailed information available in the Comprehensive Investment Appraisal (CIA) model, which was included as an Appendix of the business case.

Lee Bond posed the question that if capital affordability was not an option would we have gone with another supplier. Clinical choice is extremely important and had it been swayed by affordability. And Hayward confirmed that the requirements had been developed agnostically of affordability. If the level of capital availability was increased, then there would be access to more suppliers to bid and therefore a greater choice.

Andy Hayward went on to advise that the management case would be getting to a further stage middle of next calendar year followed by contract negotiation and delivery. The programme team would be recruited, and specialist support would be brought in to look at data migration preparation and review clinical and operational process to ensure we were ready for the new software – this work would also have benefit throughout the Ops teams. Andy Hayward advised that he had a significant role within this scheme along with Paul Bytheway, Kate Wood and Amanda Sanford.

Previous versions of this case had been reviewed by the Executive Cabinet and Trust Board since October 2023. It was advised that Version 7 was approved by the Digital Leadership Group on 5 June 2024.

It was noted that if this Committees-in-Common were happy to approve this Business Case to be presented to the Trust Board it would be presented to the Group Executive immediately following this meeting. It was then due to be discussed at the Trust Board Development on 2 July then onto the ICB on 16 July which would then allow it to move to the National Approval Process.

Gill Ponder thanked Andy Hayward and Alison Drury for the helpful summary and opened for questions. Helen Wright asked if there were any trusts nationally that we could understand their benefit realisation. Andy Hayward said there were no

trusts that were “that far down the line” but he added that conversations had been held with the National Benefits Team and some benchmarking would be available, but we would need to ensure we have a robust plan. Lee Bond suggested it may be worth holding a separate and independent session on benefits including cash releasing benefits, maybe a confirm and challenge session.

Julie Beilby went on to agree that this was an important scheme for the organisation to do for improvement for both staff and patients, but she noted her concern for organisational capacity as everyone who is working on it, at whatever level, to buy into it. Staff engagement at every level would be absolutely pivotal. Andy Hayward agreed with Julie Beilby’s concern and added that this would be a risk which would need to be tracked. Visible clinical leadership was key along with the “buy in” from staff and we would need to ensure we are ready for deployment in all respects. Julie Beilby asked where did the “absolute accountability” sit. Andy Hayward confirmed that the CEO had ultimate accountability for the contract but there are other links within the region. Andy Hayward confirmed that this required to be looked at in more detail.

Lee Bond asked at what point did Andy Hayward expect the capital shortfall to be resolved and how. Andy Hayward advised that he had discussions booked with the Centre and would hope it would be sorted by NHSE by FBC.

Gill Ponder noted that there were a number of things shown as optional within the case and asked how these were determined eg.data reporting, and infection control and coding. Andy Hayward confirmed that this was done within the stakeholder engagement panel and user experience, essentially, we would not want the provider to cover everything as this would be done within our own data warehouse.

REVIEW: Assurance rating, escalate or additional information requested

The Committee agreed there was nothing to escalate to the Trust Board but from an assurance rating there were clearly a lot of risks, but a structured programme was emerging and therefore reasonable assurance was given subject to an independent review around benefits.

7. Highlight Reports from Sub-Groups

7.1 Capital

The minutes taken at the Capital Allocation Committee in May 2024 were received and noted.

8. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 Matters to be Referred to other Board Committees

There were no matter to be referred to other Board Committees.

9.2 **Matters for Escalation to the Trust Boards**

There were no matters to be escalated to the Trust Boards.

10. Items for Information

10.1 **Complete Board Assurance Framework (BAF) – for Reference (HUTH & NLaG)**

The Committee received and noted the BAF.

11. DATE AND TIME OF THE NEXT MEETING

11.1 **Date and Time of the next CiC meeting:**

Tuesday, 27 August 9.00am, Boardroom, Hull Royal Infirmary.

The Committee Chair closed the meeting at 12.00 noon.

Cumulative Record of Attendance at the Capital & Major Projects Committees-in-Common 2024/2025

		2024				
Name	**Title**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**
CORE MEMBERS						
Gill Ponder	Chair / Non-Executive Director (NED - NLaG)	Y	Y			
Mike Robson	Chair / NED (HUTH)	Y	x			
Helen Wright	NED (HUTH)	-	Y			
Lee Bond	Group Chief Financial Officer	Y	Y			
Tony Curry	NED (HUTH)	Y	Y			
Simon Parkes	NED (NLaG)	Y	Y			
Shaun Stacey	Group Chief Delivery Officer	Y	x			
Quoracy: *three of five core members (inc.one of two Trust NEDs, two Group Executive Directors or appointed deputies)*						
REQUIRED ATTENDEES						
VACANT	Group Director of Estates	D	D			
VACANT	Group Director of Transformation	V	D			
Andy Hayward	Group Chief Digital Information Officer	D	Y			
Alistair Pickering	Chief Medical Information Officer	Y	-			
Alison Drury	Deputy Director of Finance (HUTH)	Y	Y			
Ivan McConnell	Group Chief of Strategy & Partnerships	Y	Y			
Ian Reekie	Governor Observer (NLaG)	Y	X			
David Sharif	Group Director of Assurance or deputy	Y	Y			

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on 27 August 2024
9.00am to 12.00noon Boardroom, Hull Royal Infirmary
(**notes produced from a recording**)

For the purpose of transacting the business set out below:

Present:

Core Members:

Helen Wright	Non-Executive Director, HUTH (Chair)
Gill Ponder	Non-Executive Director, NLaG
Lee Bond	Group Chief Financial Officer
Tony Curry	Non-Executive Director, HUTH
Simon Parkes	Non-Executive Director, NLaG

In Attendance:

Paul Bytheway	Group Chief Delivery Officer
Alastair Pickering	Group Chief Information Officer
Jonathan Lofthouse	Group Chief Executive
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Rebecca Thompson	Deputy Director of Assurance
David Sharif	Group Director of Assurance

Observer(s):

Stuart Hall	Non-Executive Director, HUTH
Ian Reekie	Governor Observer (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

Helen Wright welcomed those present to the meeting as the Committee Chair. Apologies were noted from Andy Hayward and Julie Beilby.

Helen Wright advised that Stuart Hall was an observer at this meeting looking at the quality of Board papers within Committees-in-Committee.

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 25 June 2024**

The minutes of the meeting held on 25 June 2024 were reviewed with the following amendments requested.

Page 6 item 4.3.3 should have read “we had no direct control of the district network operator…”. Subject to the change the minutes were accepted as a true and accurate record. Lee Bond referred to page 5 should read “Paediatric Day Surgery” and not “services”.

1.4 **Matters Arising**

Helen Wright invited Committee members to raise any matters requiring discussion not captured on the agenda. Lee Bond referred to the Cash Releasing Benefits within the last minutes in relation to Electronic Patient Record (EPR) and advised there had been a session held with members of the digital and finance teams. Lee Bond added that discussions were booked with the Centre with hopes of capital funding being progressed through NHSE by the time the Full Business Case (FBC) for EPR was completed. It was noted that there was still a risk at Outline Business Case (OBC) level, of which the committee should be aware.

1.5 **Committees-in-Common Action Tracker**

The Action Tracker was reviewed with the following comments noted:

- 3.2 - would be covered in November
- 4.3.2 – this should sit within Estates
- 4.5 – on August agenda
- 6.1 – session to be held with Helen Wright and Jane Hawkard to be part of the session. Lee Bond would send feedback on benefits realisation prior to his departure.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

Helen Wright reported that no matters had been referred by the Trust Board for consideration by the Committees.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**
3.2 **Risk Register Report**

David Sharif noted that the attached report detailed the Quarter 2 Board Assurance Framework (BAF) and Risk Register report, relevant to the Committees-in-Common (CiC) into one report. David Sharif took the report as read and went on to note that there were still 3 strategic risks pertinent to this agenda with no movement in scores. All of the risks from Datix and Ulysses were now being received and reported. David Sharif added that this still came with a “slight warning” around the

categorisation of risks to the CiC but added that he was assured these were complete in totality and would be reviewed monthly going forward. David Sharif added that he had tried to provide an overview of the risks facing the entire trust before then focusing on the ones specific to the CaMP CiC. Helen Wright opened up for questions. Tony Curry asked in terms of the expectation of the reduced risks specifically Information Technology (IT) did we have a greater sense that there was enough mitigation coming through as we were citing “limited assurance” in a couple of the areas. David Sharif added that a Digital Board would need to be in place and once this was up and running there would then be a greater sense of the impact and mitigations that we could take forward, this would most likely be in October.

ACTION: Revisit the digital risks in context with the October Digital Board – David Sharif.

Simon Parkes noted that he had a concern with the IT failure and a direct risk to life there was no real sense of when, if ever we would meet the target risk. It would be helpful to understand at the Board session in October if we had sufficient mitigation in place to get us to the target score and whether this score is good enough when looking after patients.

Gill Ponder queried why Cyber Security was being discussed at this meeting as she thought it had been agreed that this would be reviewed by ARG. David Sharif confirmed that it was being covered here due to the next ARG committee not being held until October. This would prevent a gap in governance.

Gill Ponder then went on to ask what the timescale was for the transition to one risk management system. Jonathan Lofthouse advised that this was currently in the procurement stage with migration expected during Q3 and Q4.

Gill Ponder then referred to page 4 and asked why were there 3 high risks which were 2 years past their review dates and 2 that were 1 year over.

It was noted that meetings with care groups had taken place and cleansing of all risks was ongoing.

Gill Ponder then went on to refer to 3329 and 3330 and where it mentioned that there had been no acute reporting since February due to Lorenzo. The Committee had been told that there would be no loss of data or reports and as such this was concerning.

Helen Wright noted that the Committee felt uncomfortable about where we were currently around risks, although satisfactory progress was being made with regards capturing the risks and noted the work taking place around cleansing of risks. Helen Wright added that she felt on behalf of the Committee, they were less comfortable around the mitigation actions, the review date and ownership of risks and asked when this review would be completed and brought back to the Committees-in-Common. David Sharif advised that the reviews of all care groups was due to finish by the September Group Risk and Assurance Committee in order there was assurance that all constituent risks across the group would have been reviewed by a lead executive and the care groups which would include a full longitudinal review including effective mitigations. Helen Wright asked if committees would be seeing the pre-mitigation and post-mitigation scores. David Sharif noted that it was not always as straightforward as he would like but he added that he was comfortable

that the risk owners and the risk managers are clear on a day-to-day basis. Helen Wright suggested that this would be revisited post September following the cleansing exercise to fully understand the pre mitigation and post mitigation to ensure we were content as a committee with the level of risk. Progress would be reported to the CiC in October.

Jonathan Lofthouse referred to item 2308 within the report, fire alarm compliance and he requested an update given it had been on the risk register for 8 years. It was noted that this would be discussed at August Performance, Estates and Finance Committee and this would confirm the situation surrounding the fire alarm risks at Goole.

The Committees-in-Common received and noted the Board Assurance Framework and the Risk Register report.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports or recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendations & Assurances**

There were no external reports, recommendations, or assurances to note.

REVIEW: The Committee agreed they had reasonable assurance that the risks were now being appropriately reviewed and the work around cleansing was being undertaken. The Committee agreed that they had limited assurance around the mitigation and activities and how sufficiently these mitigated the risks but acknowledged that a range of assurances were under development. Progress would be reported to the CiC in October.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Group Capital Plan Funding & Delivery (including Day Surgery Building Control Approval)**

Lee Bond took the papers as read and went on to outline the key themes contained within the Capital Plan report. Lee Bond noted that the report provided the updated Integrated Care Services (ICS) Capital Control Totals, along with the updated Trust Capital Programme for 2024/25. Lee Bond noted the following key points:

- the additional PDC funding agreed since the June plan totalling £2.8m
- Spend to 31 July 2024 was behind plan by £8.0m, with £6.3m of this being due to slippage on the Community Diagnostic Centre (CDC) at NLaG
- the Executive Cabinet are recommending an allocation of £6.6m against the existing identified priorities, this would leave circa £5m of uncommitted resources in the plan against which a small number of strategic schemes were being considered.
- Risks associated with the cladding of the new day surgery unit at Castle Hill. . There had been difficulties securing building control sign off due to changes to guidelines that are NHS specific, but not mandatory from a building control standards perspective. Work was ongoing with East Riding Council to reach

a resolution to this issue. At this time the risk is considered minimal with no further investment being recommended.

Lee Bond recommended the Committee note the changes being made to the overall capital programme and also note the slow progress being made with regards to the delivery of the programme year to date. The Committee were asked to endorse the recommendation from Group Cabinet to utilise £6.6m in line with the table on page 4 of the report – this was approved.

Finally, the Committee were asked to note the planning work that was underway with regards to the circa £5m of capital resource that was still to be committed this financial year.

Jonathan Lofthouse suggested a piece of work on financial risk on the CDC potential income loss relating to the nuance of the contract. Ivan McConnell agreed to pick this up.

Action: Ivan McConnell to produce a report on the potential CDC financial risks arising from loss of income due to building delays.

Tony Curry made an observation that there was more than £1m in relation to the overruns on existing capital projects and queried if all of the contingencies had been used. Lee Bond noted that there had been issues along with a transitional period within the Estates and Facilities department, the situation had not been ideal and Lee Bond added that he hoped it would soon settle down.

Gill Ponder queried how we were at risk for not getting certification for Phase 2 due to access. Lee Bond confirmed that the cladding from the whole of building may have to be removed which may cause problems with the access. Lee Bond went on to note that there were a number of issues that would need to be resolved before certification was given, the existing cladding complied with building regulations but did not comply with the latest Health Technical Memorandum.

Gill Ponder then went on to ask if we had considered allocating further monies to increase our resilience either to prevent a cyber-attack or to mitigate the effects if there was an attack. Lee Bond confirmed that this had not been raised as a risk which suggested that the digital team are comfortable.

Simon Parkes went on to refer to the capital delays and slippage and noted his concerns over the operational consequence these may cause. He queried whether it would be more difficult to hit the challenging financial targets for the year. Lee Bond acknowledged that there would be some financial implications on certain schemes including the CDCs and endoscopy, which would be quantified.

Helen Wright asked that, when the £6.6m was prioritized had staff issues that had been flagged with estates been considered in the process and were we content that enough credence had been given to these issues within the plan. Lee Bond confirmed that there would be 2 items that would have the biggest impact on staff, the extra car parking and the £500k relating to the CEO for several small level investments for staff concerns.

Review & Evaluation of New Business Cases, Investments & Dis-investments

4.2

within Delegated Limits and/or Endorsement for Trust Board Approval

4.3 **Post Project Evaluation Schedule**

Lee Bond took the report as read and noted it described the process of post project evaluations and provided an update as to the major capital schemes that required post project evaluations and when these were due. Lee Bond asked the Committee to agree the following:

- PPE's should be completed for all significant capital schemes (not just schemes funded by Loans or PDC).
- Agree that all schemes received a 6-month review (post go-live) but to decide on which schemes required a review at 24 months.
- Review the capital programme and assess whether any further additions were required to the list included in the table contained within the report on page 2

Lee Bond added that the templates would be populated, and a work plan would be put together every 6 months.

The CiC received and noted the Post Project Evaluation Schedule.

4.4 **Capital Contract Approvals**

None to note.

REVIEW: The Committees-in-Common agreed reasonable assurance for capital and the capital plan overall and were happy to approve the £6.6m and the proposal relating to Post Project Evaluation.

5. Major Service Change / Transformation

5.1 **Humber Acute Services Review (HASR) Update including Key Risks**

Helen Wright invited Ivan McConnell to update the CiC on HASR. Ivan McConnell took the paper as read which provided the CiC with an update on the current status of the Humber Acute Services Programme and identified the key risks and mitigations. Ivan McConnell noted that the Decision-Making Business Case (DMBC) had been considered by the Integrated Care Board (ICB) Board in July 2024 with a revised recommendation then approved. The Implementation Planning phase had commenced which was noted as Group responsibility. An Implementation Group had been established to take this forward. Ivan McConnell went on to add that Challenge to outcome and request for local resolution had been lodged by North Lincolnshire Health and Wellbeing Board/North Lincolnshire Council (NLC). It was noted that NLC had raised the issue of transport.

Ivan McConnell went on to add that a local resolution process had been agreed of 8 weeks which would consist of 4 meetings with a review point of effectiveness. A draft Terms of Reference had been agreed.

Lincolnshire County Council (LCC) had also made a referral to the Secretary of State on the process and the potential impact on their local population but had not requested local resolution.

Work would continue on the implementation planning and Ivan McConnell added that the team would seek to bring that forward as quickly as possible.

Ivan McConnell noted the key risks:

• Delay to implementation caused by challenge.
- mitigation – supporting ICB colleagues to respond to challenge and actively managing the resolution process.

The CiC received and noted the report on the update position of HASR.

5.2 **Community Diagnostic Centre (CDC) Programme – Update**

Ivan McConnell took the report as read which provided an update on the current status of the Community Diagnostic Centre (CDC) Programme and identified the key risks and mitigations. A comprehensive governance approach was in place for the CDC Programme which included:

• ICB Diagnostics Board
• NHSE Regional monthly Assurance Board
• NHSE National Bimonthly Assurance Review – National CDC Programme Director led
• Place Based Diagnostic Board- Northern Lincolnshire and East Riding of Yorkshire Programme Status.

Moving on to the programme status Ivan McConnell highlighted that good progress was being made with 2 of the centres scheduled to open by the end of October 2024. Currently they were forecasting up to a four-week delay across our major schemes. The East Riding Community scheme was currently experiencing a delay due to planning consent following an ecology survey which had found great crested newts. Ivan McConnell advised that at present there was no definitive time period for a resolution. It was highlighted that these delays could result in a potential loss of activity and consequently revenue. Currently work was ongoing on reprofiling activity and revenue impacts and agreeing approach with NHSE Regional and National teams in line with the revised CDC assumptions issued on 15 August 2024.

Ivan McConnell added that the Programme Team were seeking to ensure that we could mitigate any potential delays through weekend working, but are constrained by delays in the delivery of equipment, planning consent and supplier capability, particularly for power connections.

Ivan McConnell advised that the following work would continue:

• Provide assurance to the National, Regional, ICB and Place based assurance groups on programme delivery and issues and risk management

• Ensure continued engagement with contractors to ensure we claw back as much time as possible caused by build delays

• Evaluate the potential to deliver activity from alternative sites in the short term – notably ultrasound and pathology tests thereby minimising any potential activity and income loss

• Reprofile the activity forecasts in line with the revised NHSE activity assumptions issued on 15 August 2024

• Escalate issues internally through Cabinet, Board and Committees as appropriate.

Gill Ponder went on to ask the following questions which came out of a recent Council of Governors meeting, the first was around the workforce plan and the impact on existing staff of removing work from the hospital site. Ivan McConnell responded by saying the CDC activity is "new" activity additional to that activity which would be put through the hospital site; it would have direct access from GPs – direct access service. Recruitment to the CDC was separate and all clinical staff would be on a rotational contract. Gill Ponder added that she thought the original question was more related to Ophthalmology, Ivan McConnell confirmed that this would be a "lift and shift" process with ultimately a much-improved working environment for both staff and patients. Gill Ponder then moved on to a question that was raised by a councillor who asked if the Trust were satisfied, they had received a good commercial deal for the units within Freshney Place, Grimsby. Ivan McConnell confirmed that he thought that the Trust had "got the best deal they could get" and we were still in discussions to reduce the rent further.

REVIEW: The Committees-in-Common agreed that they had reasonable assurance that HASR and CDC were being well managed although noting there are still increased risks relating to timings and quality.

10:35 Break 10 minutes

6. Digital

6.1 Digital Plan Delivery – Bi Monthly Update

Alastair Pickering took the paper as read and went on to outline the key themes from the report starting with the Electronic Patient Record Programme. The Outline Business Case (OBC) continued to progress through the national Frontline Digitisation Programme (FDP) governance with the Trust's team addressing any queries on our OBC directly when approached. Work with procurement to recruit a dedicated EPR programme team that will support the systems' evaluations and into delivery had commenced. This would include clinical staff in the procurement evaluation and decision-making prior to the implementation support.

Moving on to the Maternity System, Alastair Pickering advised that the go live date for the South site was currently 24 September 2024.

Alastair Pickering then noted that work on the patient portal was progressing well. Work was also ongoing within technical services and system upgrades.
Alastair Pickering drew the CiC attention to recent issues including;

- Crowdstrike - No direct local system impact but connections to national services affected that impacted on some systems. Minimal impact on patients and care identified e.g. delays to available results
- ePMA (North) - an update was being presented to the Quality & Safety CIC by the Chief Medical Officer as there was outstanding work to be delivered by the supplier to fix a known system problem that was mitigated locally.

Gill Ponder went on to query that, as part of the Windows 11 upgrade, the Trust had a high level of old systems not under control of the digital team and not capable of being upgraded to Windows 10 let alone Windows 11. This seemed like a huge vulnerability for the Trust both in terms of our resilience from a system perspective but also cyber security and would there be plans to address this issue as part of the Windows 11 upgrade. Alastair Pickering acknowledged these issues and confirmed that Group wide applications were under review with the IT team identifying those vulnerabilities. The Digital team were aware of the risks of not upgrading and this was constant work in progress. Helen Wright asked when we would understand the spend associated with the Windows 11 upgrade. Alastair Pickering noted that at the moment the costs of not upgrading were understood but did not have timescales, he agreed to get an update for the next meeting.

ACTION: Alastair Pickering to provide an update on the cost and timescales for Windows 11 Upgrade – Oct 24

REVIEW: In terms of assurance the Committees-in-Common agreed they had reasonable assurance with the major projects' updates and agreed the programmes were well planned and managed. In relation to the overall digital plan, resilience and Cyber, the Committees-in-Common agreed that they did not have sufficient information available to them to determine a level of assurance and noted that the assurance for Cyber would sit with the Audit, Risk and Governance CiC.

Highlight Reports from Sub-Groups

7. Group Capital Committee Meeting Minutes

7.1 The minutes taken at the Group Capital Committee in June and July 2024 were circulated for information. Helen Wright asked if a refreshed strategic plan for capital spend was being pulled together. Lee Bond confirmed that as part of the annual planning process, a 3-year assessment plan would be put together.

Any Other Urgent Business

8. Any Other Urgent Business

8.1 Jonathan Lofthouse advised that the Trust had the opportunity to rent rooms within the ERGO building in Hull which were relatively cheap. If a decision is made at Group Cabinet to take on these rooms, Jonathan Lofthouse agreed to report back. Jonathan Lofthouse then suggested that the CiC may want to hold the next meeting in the newly refurbished boardroom at Castle Hill which would also give CiC members an opportunity to look around the new Endoscopy centre and education centre.

Action: Joanne Palmer to move the location of the next meeting to the new Boardroom at Castle Hill hospital and arrange for Committee members to have a tour of the new Endoscopy centre and education centre.

Helen Wright asked Committee members if they had any observations or feedback for improvement on the quality of papers for this committee. Overall, the Committee agreed that the papers were concise but going forward would want to focus on what had changed since the last meeting with more updates on progress. Reflection of assurance ratings and steps taken to provide the CiC with more assurance should be noted by presenters. It was agreed that it would be useful if the agenda could indicate if approval was required from the CiC for a certain item etc.

Matters to be referred by the Committee

9.

Matters to be referred to other Board Committees

9.1

- Risks – risks around Cyber and business continuity would move to Audit, Risk and Governance.

Matters to be escalated to the Trust Boards including any proposed changes

9.2 **to the BAFs**

- Building Certification issue and potential risk of re-cladding £0.3m
- Capital spend behind plan and as a consequence agreed additional project spend of £6.6mil
- Mindful of local challenges around HASR
- CDC Delays
- EPR Benefit Realisation – concern
- Risk mitigation – revised ratings post mitigation
- Review of Strategic Risks
- The requirement for awareness of 5-year plans for digital upgrades and equipment replacements

11. DATE AND TIME OF THE NEXT MEETING

11.1 **Date and Time of the next CiC meeting:**

Tuesday 29 October 9.00am, Boardroom, Hull Royal Infirmary.

The Committee Chair closed the meeting at 12.00 noon.

Cumulative Record of Attendance at the
Capital & Major Projects Committees-in-Common 2024/2025

		2024				
Name	**Title**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**
CORE MEMBERS						
Gill Ponder	Chair / Non-Executive Director (NED - NLaG)	Y	Y	Y		
Mike Robson	Chair / NED (HUTH)	Y	x	X		
Helen Wright	Chair / NED (HUTH)	-	Y	Y		
Lee Bond	Group Chief Financial Officer	Y	Y	Y		
Tony Curry	NED (HUTH)	Y	Y	Y		
Simon Parkes	NED (NLaG)	Y	Y	Y		
Shaun Stacey	Group Chief Delivery Officer	Y	x	X		
Jonathan Lofthouse	Group CEO			Y		
Quoracy: *three of five core members (inc.one of two Trust NEDs, two Group Executive Directors or appointed deputies)*						
REQUIRED ATTENDEES						
VACANT	Group Director of Estates	D	D			
VACANT	Group Director of Transformation	V	D			
Andy Hayward	Group Chief Digital Information Officer	D	Y	X		
Alistair Pickering	Chief Medical Information Officer	Y	-	Y		
Alison Drury	Deputy Director of Finance (HUTH)	Y	Y	X		
Ivan McConnell	Group Chief of Strategy & Partnerships	Y	Y	Y		
Ian Reekie	Governor Observer (NLaG)	Y	X	X		
David Sharif	Group Director of Assurance or deputy	Y	Y	Y		

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 29 October 2024 at 9.00am to 12.00pm at Boardroom HRI

For the purpose of transacting the business set out below:

Present:

Core Members:

Mark Brearley	Group Chief Financial Officer
Gill Ponder	Non-Executive Director NLAG (Chair)
Tony Curry	Non-Executive Director (HUTH)
Paul Bytheway	Interim Group Chief Delivery Officer

In Attendance:

David Sharif	Group Director of Assurance
Sean Lyons	Trust Chair
Jonthan Lofthouse	Group Chief Executive
Ivan McConnell	Group Chief Strategy and Partnerships Officer
Jo Palmer	PA to the Committees in Common (Minute taker)
Neil Proudlove	Deputy Chief Information Officer
Ian Reekie	Chair of Governors (observing via Microsoft Teams)
Rebecca Thompson	Deputy Director of Assurance

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 for absence were noted from Helen Wright, Non-Executive Director, Simon Parkes, Non-Executive Director, Andy Haywood, Group Chief Digital Officer, Stuart Hall, Non-Executive Director, Alastair Pickering, Group Chief Information Officer and Alex Best, Group Deputy Director of Capital Services.

1.2 Declarations of Interest

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

1.3 To approve the minutes of the meeting held on 27 August 2024

The minutes of the meeting held on the 27 August 2024 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. No items were raised.

1.5 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

June 2024 3.2 Risk Register – On agenda, so item to be closed
June 2024 6.1 EPR - to be carried forward to November. Mark Brearley and Andy Haywood to liaise with Helen Wright and Jane Hawkard
August 3.2 BAF – On agenda, so item to be closed
August 4.1 Capital Plan Funding – Update included in the paper for item 5.2 on the agenda, so item to be closed
August 6.1 Digital Plan Delivery – Update on costs included in the paper for item 6.1 on the agenda and timescales confirmed as completion planned by October 2025. Item to be closed
August 8.1 AOB – item to be moved to February as the room was not yet available to book

1.6 **Review of Effectiveness – Process overview**

David Sharif advised that a form would be circulated after the meeting to seek attendees' views on the effectiveness of the Committee as part of the annual governance review. A fast turnaround for responses was preferable in order for the summarised responses to be presented at the next Committee meeting for discussion and agreement on any actions required as a result.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

There were none to discuss.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF) including high level risks – NLAG/HUTH Quarter 2 2024**

This item was taken in conjunction with item 3.2 below.

David Sharif took the report as read and advised that it was the last update in its legacy state. There were 195 risks in total, 11 were high level, one of which was overdue.

The question was raised on how switchboard could be supported and Mark Brearley believed the software needed to be updated. Jonathan Lofthouse asked for an update for the next Committee in Common meeting.

ACTION: Neil Proudlove to investigate and update at the next Committee meeting

Tony Curry questioned the overdue risks and how they were managed or mitigated to determine the score currently. Gill Ponder felt the report needed to show the mitigating actions, to which David Sharif agreed. It was noted that ideally it should be an automated process and Procurement were currently looking into potential suppliers. Tony Curry felt there was no sense of when there is a change and Gill Ponder posed the option of approaching the risk owners and asking them for concise updates on the high level risks only. David Sharif felt these were good suggestions and agreed to take forward.

ACTION: David Sharif to discuss further with risk and compliance

Assurance was noted as reasonable but it was felt that more detail was needed on the latest status and actions taken to mitigate risks, especially for those with a high risk score.

3.2 **Risk Register Report – update to focus on mitigations planned and actioned**

This was covered in Item 3.1.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Capital Planning & Delivery

4.1 **Group Capital Plan Funding & Delivery**

Mark Brearley took the paper as read. There were currently a range of schemes being considered to ensure capital was fully utilised. The management of slippage/uncommitted funds had been discussed through Cabinet. The Ward 10 refurbishment was now not proceeding, but others would now move forward. A spend of £1million on the hybrid theatre equipment would hopefully progress this year. A first draft of the new capital programme for 2025/26 would be updated at the November Committee in Common.

Tony Curry felt that the monies did not add up and Ivan McConnell felt that was fair challenge. Mark Brearley advised that there was slippage due to delays with the Community Diagnostic Centres (CDCs) at NLAG and with HASR, EPR and digital diagnostics but plans for spend in 2025/26 would be brought forward for use in the current period.

Gill Ponder questioned whether it was a lack of planning, phasing or delays with procurement. Equipment renewal remained a big issue on the risk registers.

Sean Lyons noted some good effort with underspend in some areas but questioned whether there was a potential risk if the CDCs do not open when expected and whether productivity gains were made elsewhere. Ivan McConnell responded that the manpower had been recruited.

ACTION: 2025/26 draft capital programme to be presented at the next Committee meeting

4.2 **Review & Evaluation of New Business Cases, Investments & Dis-investments within Delegated Limits and/or Endorsement for Trust Board approval**

There were none to discuss.

4.3 **Post Capital Project Evaluation**

Sean Lyons asked whether there was now an agreed process in place. Mark Brearley responded that there was a standard process in place, a key point of which was having clear timescales in place for completing schemes. A timetable of reviews had been brought to a previous meeting of the Committees in Common by the Chief Finance Officer.

4.4 **Capital Contract Approvals**

There were none to discuss.

Assurance was noted as reasonable in that a good process was in place. It was felt that the underspend needed to be noted in the Highlight report but the Committees were assured that plans were in place for expenditure in 2025/26 to be brought forward to create the financial headroom in 2025/26 to complete the schemes originally due for completion in 2024/25. Tony Curry asked for reassurance that the full resource would be spent and Mark Brearley confirmed that 2025/26 schemes would be actioned for spend in 2023/24 to ensure that the Capital budget was not underspent.

Highlight Report: The Committees agreed that the year to date underspend on 2024/25 and plans in place for 2025/26 expenditure to be brought forward should be highlighted to the Board.

5. Major Service Change/Transformation

5.1 **Humber Acute Services Review – Update including Key Risks**

Ivan McConnell advised the Committee that approval for the revised recommendation had been received from the ICB Board and implementation planning had commenced. An Implementation Group had been established to take this forward and engagement meetings were ongoing, but challenge had been received from North Lincolnshire Council/North Lincolnshire Health and Wellbeing Board. Local resolution meetings were taking place in accordance with the process. The issues raised were sustainability, health inequalities and transport. There had also been a direct referral to the Secretary of State by Lincolnshire County Council which had bypassed the local resolution process. It questioned the impact on the local population and the process but there were no further details as the Council had not formally advised the Group of the challenge.

Jonathan Lofthouse referred to a recent discussion with MP Sir Nic Dakin and that he had raised concerns over the implementation, particularly around transport and advised that he would be provided with a current timeline of progress. Ivan McConnell explained that the Isle of Axholme was an area that did not provide public transport which patients and relatives could utilise to get to hospitals but, in order to mitigate this, £40,000 funding had been agreed to enable patients there to utilise the local authority's voluntary car service.

5.2 **Community Diagnostic Centre Programme – Update including Key Risks**

Ivan McConnell advised the Committee that progress had been made but some build delays had been encountered due to unforeseen build and utility issues. The Go Live for the Hull & East Riding CDC had been postponed from 3 March 2025 to 14 April 2025. The SGH CDC had been deferred from 7 October 2024 to 2 December 2024, mainly due to the delays in the delivery of the LV panels, the need for lift shaft amendments and Council delays in connecting water supplies, the latter of which had been escalated. The Grimsby CDC had been deferred from 6 January 2025 to around the end of March/beginning April 2025. Delays were around second floor requirements where the fireproofing was found to be unsatisfactory and had needed replacement. Delays would reduce the activity forecast to 77%, which could result in a £238k revenue loss. Mitigations were in place which would involve activity being carried out at alternative non-acute sites.

There was a potential for the Scarborough CDC delay to have a c£2.2m impact on the ICB which might be apportioned across Providers and North Lincolnshire Council had not yet paid the £1.3m they agreed to contribute to the Scunthorpe CDC build.

The ICB had procured two MRI and two CT scanner vans which had been transferred to HUTH. The intention was for them to rotate around HNY, but NHS England's calculations of the number of tests that they would carry out had not taken into account set up time lost when the units were moved to new locations. As a result, this mobile fleet had a potential deficit of £510k, which would further increase when MRI contrast scanning commenced. An analysis of demand was to be undertaken with a view to leaving the units in the same location for longer to reduce set up time lost and enable more scans to be carried out.

Discussions were ongoing with North Lincolnshire Council about the Sports Hall on the CDC site at Scunthorpe, which was still not available, preventing a pad or turning circle being put in place.

Sean Lyons questioned whether the lack of fireproofing affected the whole building or not. Ivan McConnell replied to say it did and had been discovered on initial excavation.

Gill Ponder queried why the mobile fleet asset had been accepted when there was a potential liability. Jonathan Lofthouse replied that there had been no liability at the time the decision was made.

Highlight Report: Delays with CDCs' Go Live due to a number of unavoidable build related issues and the potential revenue impact and mitigations in place.

Assurance was noted as reasonable in that plans were clear and well understood and there was clear evidence of mitigation against the potential financial impact. The Committees agreed that significant assurance was not appropriate in view of the remaining risks outside the Group's control.

The Committee took a 10 minute break at 10.10am.

6. <u>Digital</u>

6.1 **Digital Plan Delivery – Update including Key Risks**

Neil Proudlove took the paper as read. He advised that the outcome of recent staff engagement sessions had highlighted that their biggest issues were the basics on equipment, EPR benefits and difficulties encountered with Lorenzo and WebV. There was a focus on EPR during discussions and the benefits it would bring Group wide. Andy Hayward was compiling a report for Executive and Board discussion before the final strategy was presented to Cabinet in December.

The EPR outline business case was still awaiting approval by NHS England and the Treasury. This had been delayed due to the pending autumn statement. Market engagement had commenced with suppliers for external support for clinical engagement and assessment of the Group's infrastructure readiness. Due to the aim to transfer 32 current systems into EPR, some work needed to be done on data migration, data quality and integration and some support was being sought for establishing the programme management structure and reporting lines across the Group.

Maternity implementation of Badgernet had been completed across the Group. Feedback had been positive. From September, Dr Doctor was being rolled out across HUTH initially and then it would be rolled out at NLAG. This would enable patient-led appointment booking. There was an obvious need to consolidate contracts from 3rd party suppliers and harmonise processes across the Group.

With regards to resilience and cybersecurity, Neil Proudlove advised that a new Uninterrupted Power Supply (UPS) in the Scunthorpe data centre would be installed by the end of November and the planned outage could now be cancelled as it had been determined that 120 minutes would be sufficient to get staff onsite and get generators running.

In conjunction with the EPR team, Care Groups have been asked to revise their business continuity plans and those plans would be tested by a Group wide tabletop, cyber security exercise, which would be followed by an ICB wide tabletop exercise.

A draft business case for Windows 11 upgrades had been produced, with a requirement for £2.5m capital and £500,000 for support to implement. The majority of the £2.5m should be recovered through existing capital budgets and once the discussions for the EPR business case for additional equipment and infrastructure upgrades was concluded, then the Windows 11 business case could be presented to Cabinet.

Tony Curry questioned whether the Group was on track with regards to the implementation of a patient-led service with Dr Doctor, moving away from Patient Knows Best (PKB). Neil Proudlove estimated there were around 280,000 patients signed up at HUTH alone with 180,000 patients actively using PKB. Both the PKB and Dr Doctor portals integrate with the NHS app. It seemed that PKB concentrated on clinical benefits but investigations found that patients used it mostly to look at their appointment summary letter and this could be transferred to Dr Doctor. PKB did not allow patients to change their appointments, which was a positive reason for moving to Dr Doctor. Tony Curry felt that there would be benefit from patient led appointment management.

Gill Ponder asked whether patients would still be able to see things such as hospital letters to GP with Dr Doctor. Neil Proudlove answered that at the very minimum, existing functionality with PKB would be transferred to Dr Doctor. There would be a single supplier for the SMS appointment text and the letter and therefore it would be easier to audit, unlike currently as separate suppliers are used. There were expected cost savings from the transmission of SMS and letters, plus an expected reduction in the number of patients that do not attend appointments.

Gill Ponder referred to the £14.5m EPR funding gap and asked what the contingency would be if the expected funding was not received and whether Procurement of a fit for purpose system would be constrained by the lack of sufficient funding to enable a range of mid-range suppliers to respond to the Procurement tender. Neil Proudlove felt the Group was already constrained due to affordability and Mark Brearley confirmed there were other products at a lower range.

Tony Curry referred to the business case and a large amount of the cost being accountable to the use of professional services rather than a capital cost of software and hardware. There was a challenge around capital versus revenue spend and the need to demonstrate a benefit return.

Assurance was noted as significant due to the level of grip and control of the programmes and issues. Sean Lyons asked for a Highlight to Board on work done so far.

Highlight Report: To note progress to date

Highlight Reports from Sub-Groups

7.

Group Capital Committee Meeting Minutes (NLAG & HUTH) – September

7.1 **2024**

Gill Ponder referred to Page 9 in that the Capital Committee had asked for the boiler house location to be raised to this Committees in Common but that did not appear to have happened. It was agreed to bring it to the next meeting and from there decide whether it would be more suitable for it to be raised at the Performance, Estates & Finance Committees in Common as an Estates and Facilities issue.

ACTION: Alex Best to bring the escalation of the boiler house location to the next Committee meeting

8. ANY OTHER URGENT BUSINESS

8.1 There were no items of any other business raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 **Matters to be Referred to other Board Committees**

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

9.2 **Matters for Escalation to the Trust Boards including any proposed changes to the BAFs**

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- Capital Plan underspend on 2024/25 but plans in place for 2025/26 expenditure to be brought forward
- Delays with CDCs Go Live and the potential revenue impact. Key risks remain
- To note progress to date with the Digital Plan Delivery

10. ITEMS FOR INFORMATION

There were no items for information.

11. DATE AND TIME OF THE NEXT MEETING

11.1 **Date and Time of the next Capital & Major Projects CiC meeting:**

Tuesday 26 November 2024, 9.00am -12.00pm Boardroom HRI

The committee Chair closed the meeting at 10.57am.

Cumulative Record of Attendance at the Capital & Major Projects Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Mark Brearley	Group Chief Financial Officer							Y					
Gill Ponder	Non-Executive Director	Y		Y		Y		Y					
David Sharif	Group Director of Assurance	Y		Y		Y		Y					
Helen Wright	Non-Executive Director	N		Y		Y		N					

REQUIRED ATTENDEES													
Julie Beilby	Non-Executive Director	Y		Y		N		N					
Alex Best	Interim Group Deputy Director of Capital Services	Y		Y		N		N					
Paul Bytheway	Interim Group Chief Delivery Officer	N		Y		Y		Y					
Stuart Hall	Non-Executive Director	Y		Y		Y		N					
Andy Haywood	Group Chief Digital Officer	N		Y		N		D					
Craig Hodgson	Associate Director of Commercial Services	N		N		N		N					
Linda Jackson	Vice Chair	N		N		N		N					
Jonathan Lofthouse	Group Chief Executive	N		Y		Y		Y					
Sean Lyons	Trust Chairman	N		N		N		Y					
Ivan McConnell	Group Chief Strategy and Partnership Officer	Y		Y		Y		Y					
Simon Parkes	Non-Executive Director	Y		Y		Y		D					
Alastair Pickering	Chief Medical Information Officer	Y		N		Y		N					
Ian Reekie	Chair of Governors	Y		Y		Y		Y					
Philippa Russell		N		N		N		N					
Rebecca Thompson	Deputy Director of Assurance	N		Y		Y		Y					
Simon Tighe	Deputy Director of Estates & Facilities	N		N		N		N					
Tony Curry	Non-Executive Director	Y		Y		Y		Y					

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)251

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 December 2024**
Director Lead	**Ivan McConnell, Group Chief Strategy & Partnerships Officer**
Contact Officer / Author	**Adam Creeggan, Group Director of Performance** **Jackie Railton, Deputy Director, Planning and Performance** **Louise Topliss, Head of Performance** **Maria Wingham, Head of Performance**
Title of Report	**Integrated Performance Report – NLaG and HUTH**
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 November 2024 and Quality and Safety Committees-in-Common November 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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Integrated Performance Report

MONTH 7: October 2024 Performance

September 2024 for Cancer data
Produced November 2024

Table of Contents

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.

Domain	HUTH Performance	NLAG Performance	Commentary
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	**October 2024** **0** **0** **14** **2,614**	**October 2024** **0** **1** **5** **577**	• Continued improvement in reducing >65week volumes at both Trusts. Care Groups focused on the clearance first outpatient waits over 40 weeks to sustain delivery of 65 weeks • Increase in 52 week waits at HUTH (+237). Slight reduction in 52 week waits at NLaG (-58). • One breach of the <78week standard at NLaG resulted from a historic pathway recording error that was identified and corrected in month.
Diagnostic 6w Performance	**October 2024** **17.4%**	**October 2024** **17.4%**	• HUTH has shown an improvement in performance in October of -6.1% set against the previous month and is ahead of planned trajectory. **NLaG deteriorated slightly by 0.5%.** In both cases the in-month change reflects (a) a significant increase in DEXA scans at HUTH, and (b) equalisation of DEXA access times across the Group via the transfer of patients from HUTH to NLAG. ○ Key modalities showing improvement in month at HUTH are DEXA 25.2% compared to 55.7% as detailed above. Gastroscopy 17.2% compared to 26.3% previously following the decontamination room refurbishment. ○ NLaG is showing a reduction in performance which is being driven by DEXA at 16.6% compared to 3.8% in the previous month – this relates to the acceptance of mutual aid patients from HUTH.
Cancer 62 day Performance (all sources)	**September 2024** **51.0%**	**September 2024** **52.5%**	• Both Trusts in Tier 1 for Cancer delivery; working with NE&Y Regional Office on recovery assurance • 62-day performance at NLaG improved by 5.0%. 62-day performance at HUTH impacted by radiotherapy (treatment), oncology capacity (treatment planning), and prostatectomy surgical (treatment option OPAs & treatments) capacity, compounded by late IPTs • +63 day backlog test and challenge meetings in place and resulting in improvement at NLaG (below trajectory & improving). HUTH remains static (IPTs very late in pathway, urology surgical capacity & LGI diagnostic delays).
ED: 4 hour standard (Type 1 & 3) 78% by March 2025	**October 2024** **58.9%** **Trust compliance** **70.3% (plan 76.5%)** **Acute Footprint compliance (incl. Bransholme & ERCH)**	**October 2024** **72.4%** **Trust compliance** **74.9% (plan 76.3%)** **Acute Footprint compliance (incl. Goole UTC)**	• In month attendance levels at both Trust were significantly highly than plan at both Trusts. • HUTH Type 1 performance in October of 40.4% as per plan (40.4%). Type 3 performance (HRI UTC) was 97.7% in October. • NLaG Type 1 performance was 51.2% and Type 3 was 99.4%. NLaG combined type 1 and 3 performance was 72.4% in September, slightly below the 73% target trajectory. • ED performance across both geographical footprints was below plan.

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Sep 24	0	2,377			23
RTT 65 Week Breach	Sep 24	-	15			63
RTT 78 Week Breach	Sep 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Sep 24	18.0	62.3			66
RTT 95th Percentile Non-Admitted Waiting Time	Sep 24	18.0	54.6			47
RTT Admitted Treatment Within 18 Weeks	Sep 24	90.0%	56.0%			62
RTT Average (Median) Admitted Waiting Time	Sep 24	9.0	13.8			62
RTT Average (Median) Non-Admitted Waiting Time	Sep 24	5.0	7.3			83
RTT Average Wait for Incomplete	Sep 24	7.00	14.8			42
RTT Incomplete 18 Week Standard	Sep 24	92.00%	57.0%			38
RTT Incomplete 92nd Percentile	Sep 24	-	44.2			38
RTT Incomplete Pathways With a DTA	Sep 24	25.0%	15.2%			45
RTT Non-Admitted Treatment Within 18 Weeks	Sep 24	95.0%	70.9%			72
RTT Total Clock Starts	Sep 24	-	19,717			91
RTT Total Clock Stops	Sep 24	-	18,403			92
RTT Total Incompletes	Sep 24	-	79,557			17

NLAG

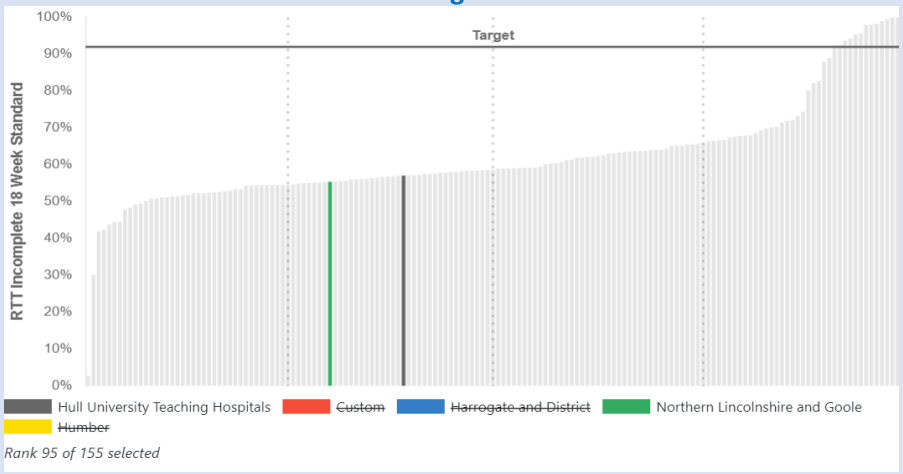
Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Sep 24	0	635			61
RTT 65 Week Breach	Sep 24	-	11			65
RTT 78 Week Breach	Sep 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Sep 24	18.0	59.0			75
RTT 95th Percentile Non-Admitted Waiting Time	Sep 24	18.0	51.9			57
RTT Admitted Treatment Within 18 Weeks	Sep 24	90.0%	53.7%			50
RTT Average (Median) Admitted Waiting Time	Sep 24	9.0	15.3			51
RTT Average (Median) Non-Admitted Waiting Time	Sep 24	5.0	12.9			27
RTT Average Wait for Incomplete	Sep 24	7.00	15.6			30
RTT Incomplete 18 Week Standard	Sep 24	92.00%	55.4%			29
RTT Incomplete 92nd Percentile	Sep 24	-	40.8			60
RTT Incomplete Pathways With a DTA	Sep 24	25.0%	13.7%			53
RTT Non-Admitted Treatment Within 18 Weeks	Sep 24	95.0%	59.7%			31
RTT Total Clock Starts	Sep 24	-	8,015			43
RTT Total Clock Stops	Sep 24	-	8,169			54
RTT Total Incompletes	Sep 24	-	42,857			45

2. Pathway Benchmarking & Trend – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

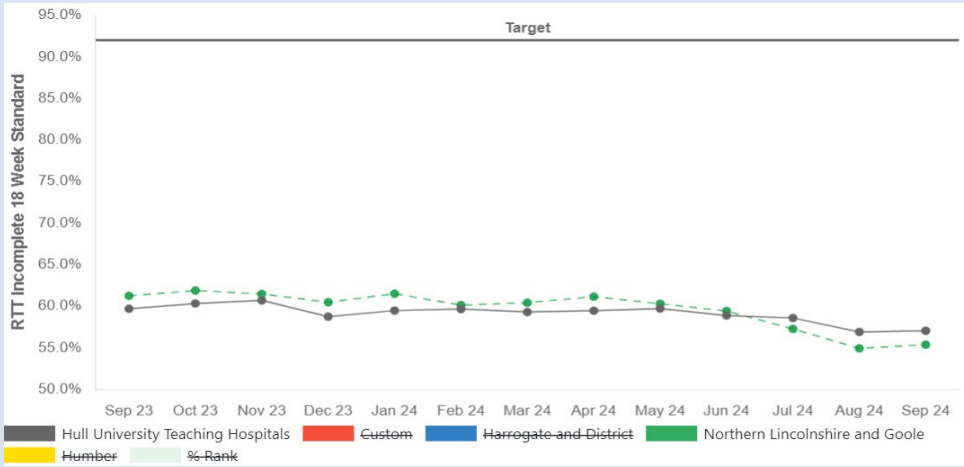
RTT – Incomplete Standard

Ranking Chart



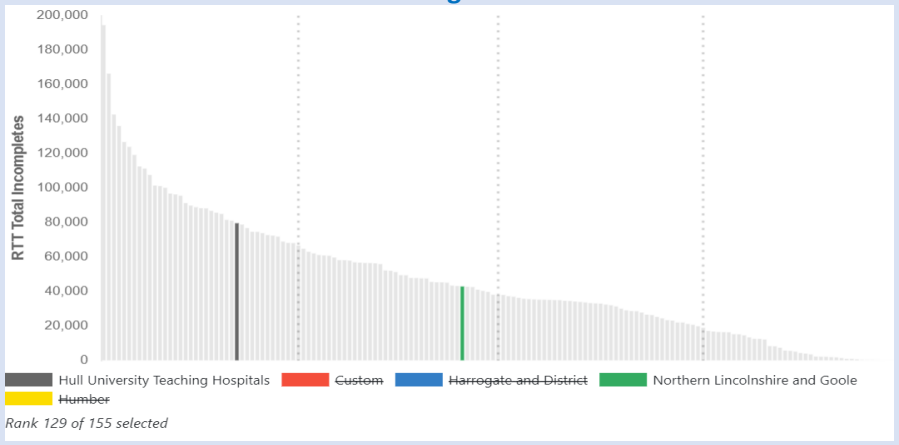
Rank 95 of 155 selected

Trend Chart



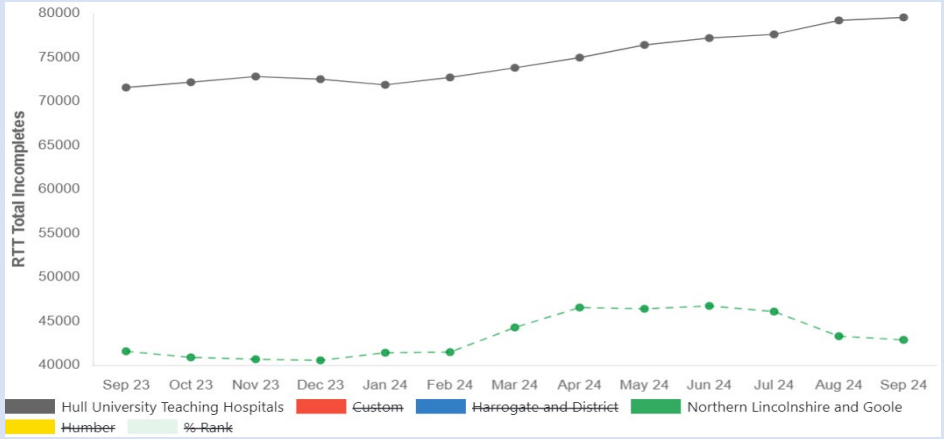
RTT – Total Waiting List Volume

Ranking Chart



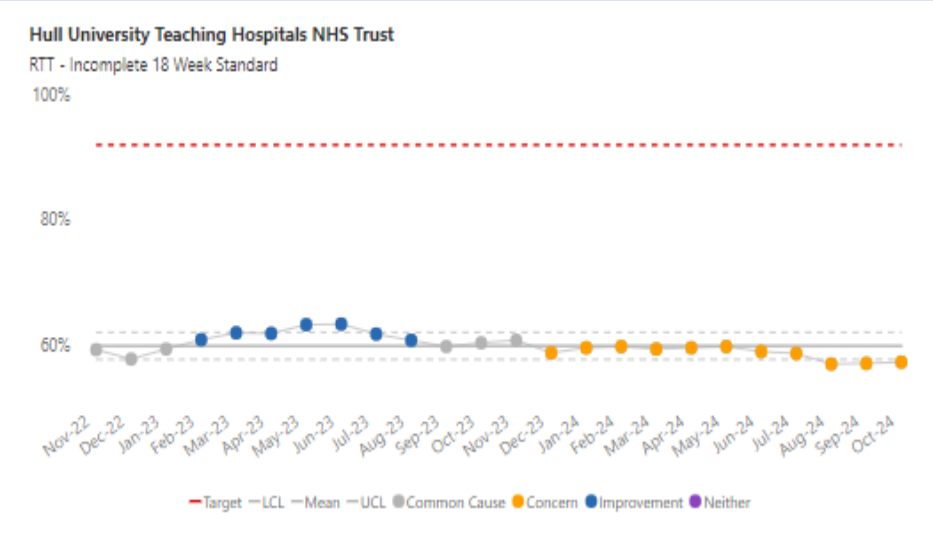
Rank 129 of 155 selected

Trend Chart



3. Referral to Treatment - HUTH

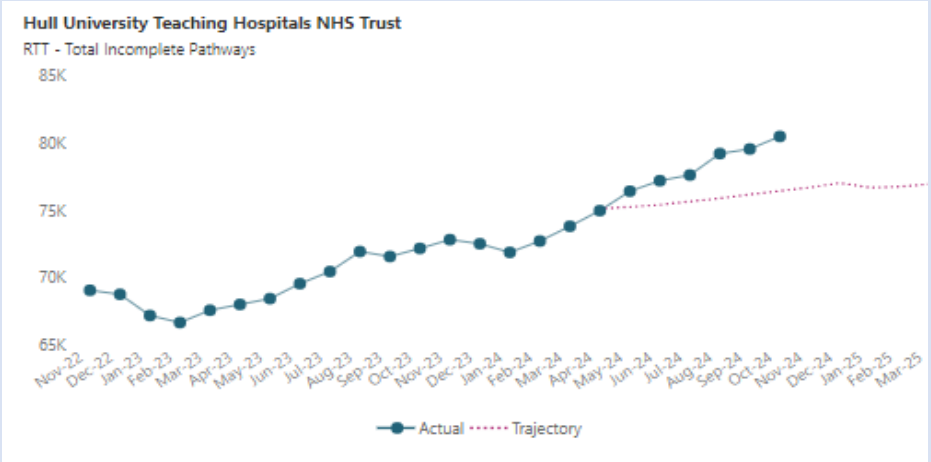
Compliance



Key Themes

- October 18 week RTT performance of 57.3% is broadly unchanged previous months.
- Waiting list volume continues to increase despite above plan pathway completion levels and now stands at 80,488. This predominately reflects an increase in referrals (all sources) of 6.4% YTD. Actions agreed with the wider HYN System to reduce GP referral demand specifically have not been deployed due, in part, to GP collective action.
- 58% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Ophthalmology, Dermatology, Cardiology and Neurology
- 3.2% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year.
- Average wait for incomplete pathway is 14 weeks but remains broadly stable i.e. not increased despite the increase in PTL size.

Critical Enabler



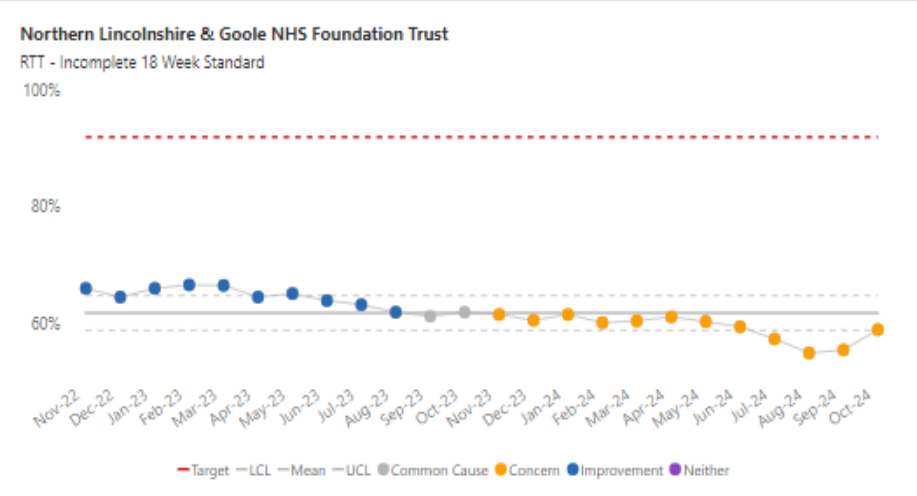
Actions

Critical actions being progressed through RTT Delivery Group:

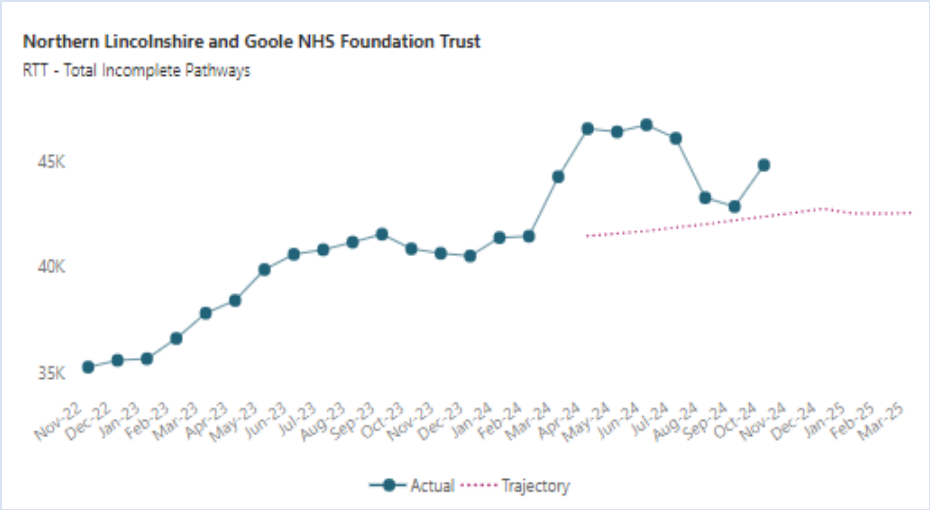
- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Care Groups reviews to decrease waits for first outpatient activity >40 weeks.
- Reallocate follow up outpatient activity without a procedure.
- Remedial admin action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume.

4. Referral to Treatment - NLAG

Compliance



Critical Enabler



Actions

Critical actions being progressed through RTT Delivery Group

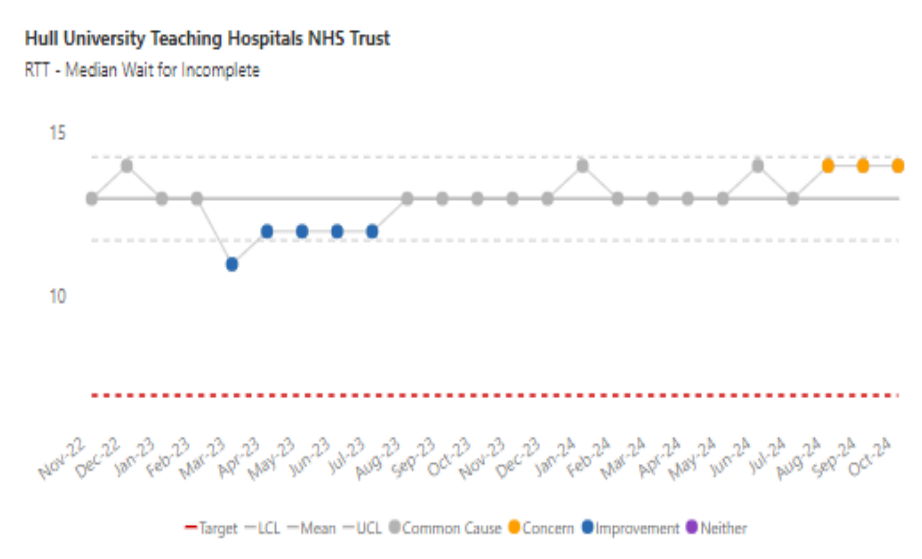
- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Care Groups have deployed additional activity over and above the 24/25 operational plan underpinned by Elective Recovery Funds
- Remedial action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume which have stabilised growth. Recruitment to 10 x validators underway and interim admin resourcing sourced via HUTH RTT team, medical records, etc.
- RTT Insights Model now deployed to NLAG improving management oversight and scrutiny of PTL.

5. Referral to Treatment – 65w Waits - HUTH

Key Themes

- 13 patients exceeded 65 weeks at the end of October which was a reduction of 2 on the previous month.
- The Trust position is among the best nationally.
- Risks identified relating to November delivery: -
  - ENT – additional weekend capacity is being delivered.
  - Plastic Surgery – a plan is in place for provision additional weekend lists to support the complex delayed breast reconstruction (DIEP requires 3 session day)
  - Sub-contract agreed with Trent Cliffe to provide mitigation in Plastic Surgery.
  - Delays in offering admission dates leading to unreasonable offers and patient choice breaches.

Critical Enabler



Actions

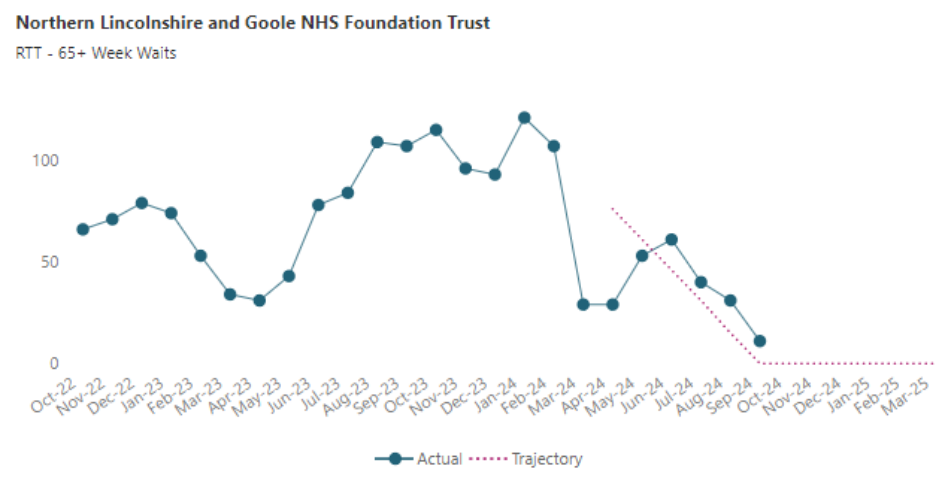
1. Elimination of >78w waits by end of June 2024 - delivered
2. Elimination >65w waits by end of September 2024 – not delivered
3. New control total of 8 x 65w waits for HHP at the end of December 2024
4. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Reduce first outpatient waits to <40 weeks, with the main challenge in ENT. Additional insourced activity in place.
- 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 October 2024
- Delivery of 24/25 operating plan activity extension plans.
- Additional weekend waiting list initiatives to create capacity in Plastic surgery, Breast Surgery and ENT.
- Current growth in 52 week backlog presents an ongoing risk.

6. Referral to Treatment – 65w Waits - NLAG

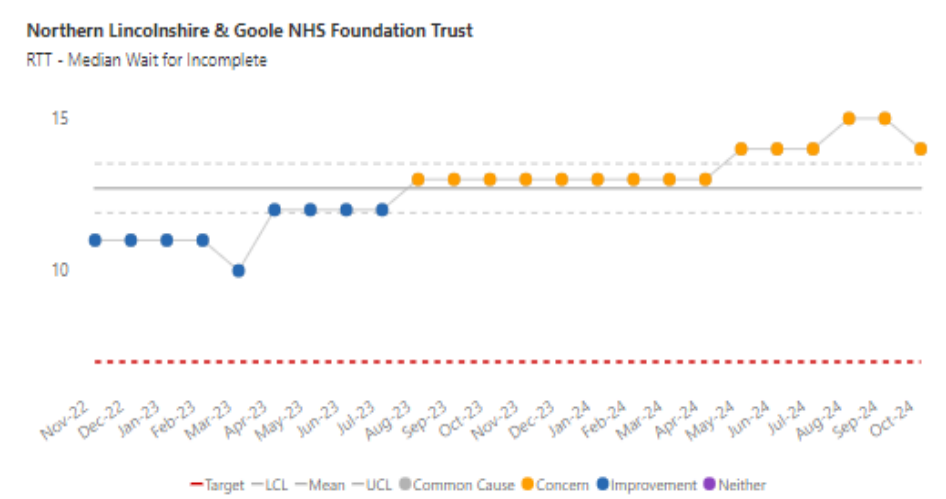
Compliance



Key Themes

- 1 x 78w breach reported at the end of October. This was an in-month validation of a pathway error in T&O. Unfortunately, the patient could not be accommodated due to clinical reasons prior to month end.
- Reduction in 65w waits at the end of October with 5 breaches compared to 11 in the previous month. Forecast for end of November is currently 4 with all risks being micro-managed.
- Deterioration in median waits from 10 weeks to 14 weeks (national standard 7 weeks) since March 2022

Critical Enabler



Actions

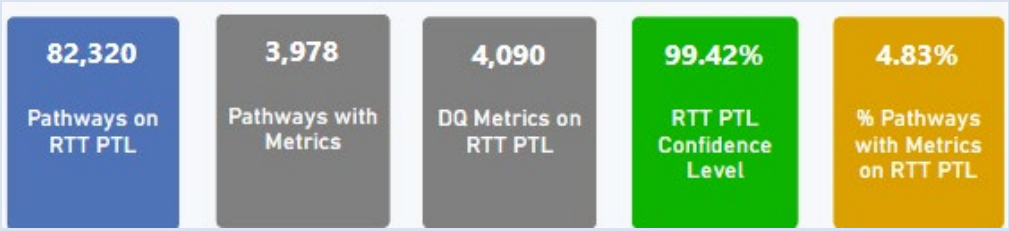
- Clear >78w waits by end of June 2024 - delivered
- Clear >65w waits by end of September 2024 – not delivered but reduced
- New control total of 8 x 65w waits for HHP at the end of December 2024
- Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Reduce first outpatient waits to <40 weeks, with the main challenge in Paediatrics (ADHD). Additional insourced activity in place.
- Delivery of 24/25 operating plan activity extension plans.
- Community Dental capacity and 65w breach risks – mitigated with weekend theatre lists but need sustainable solution
- Earlier planning of offering admission dates to reduce unreasonable offers and then patient choice breaches, alongside revised Group Access Policy.

7. Referral to Treatment – Data Quality - HUTH

Compliance

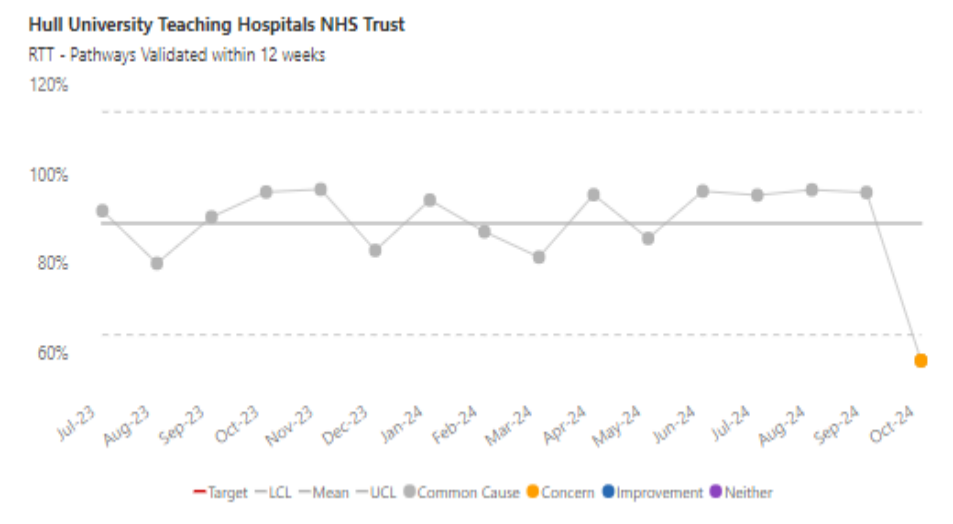


Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements 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 99.42% confidence level for RTT PTL data quality.

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
- Source Group Artificial Intelligence report commissioned to deliver a one-off insight into the data quality opportunity on the RTT PTL. Proof of concept sample validation of 500 pathways at each Trust underway w/c 11th November 2024 for 2 weeks.

8. Referral to Treatment – Data Quality - NLAG

Compliance

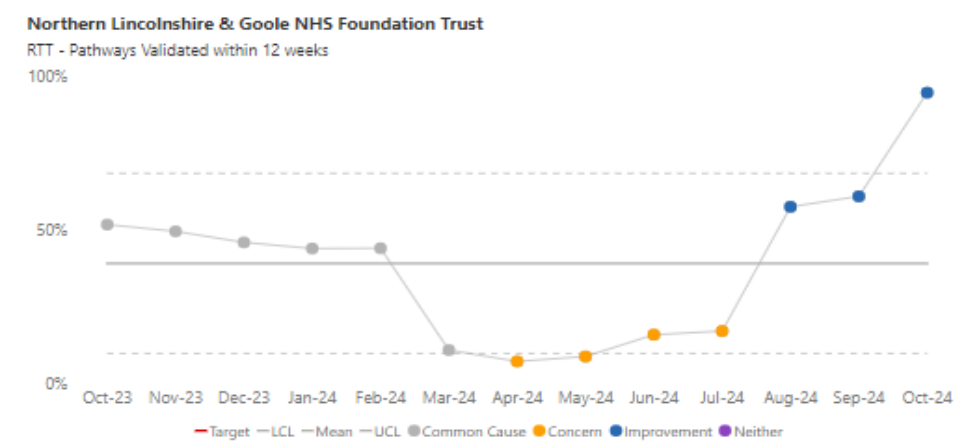
45,604	3,684	3,743	99.07%	8.08%
Pathways on RTT PTL	Pathways with Metrics	DQ Metrics on RTT PTL	RTT PTL Confidence Level	% Pathways with Metrics on RTT PTL

Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a reduction in the confidence rate to 99.07% which is an improved position.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks the latest data shows sustained improvement against the 90% standard following admin delays in transacting pathway events post Lorenzo deployment.

Critical Enabler

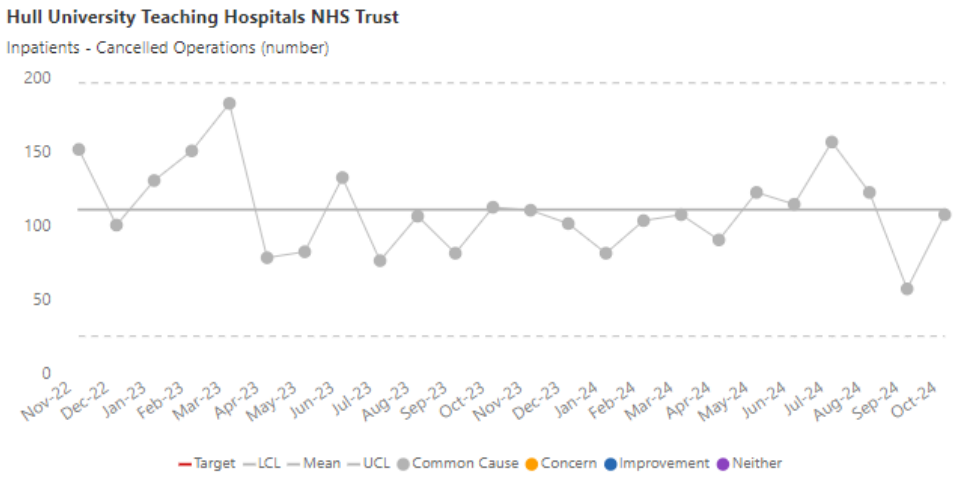


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments to
- RTT Insights Dashboard training completed in August/September 2024.
- Source Group Artificial Intelligence report commissioned to deliver a one-off insight into the data quality opportunity on the RTT PTL. Proof of concept sample validation underway w/c 11th November 2024 for 2 weeks.

9. Cancelled Operations - HUTH

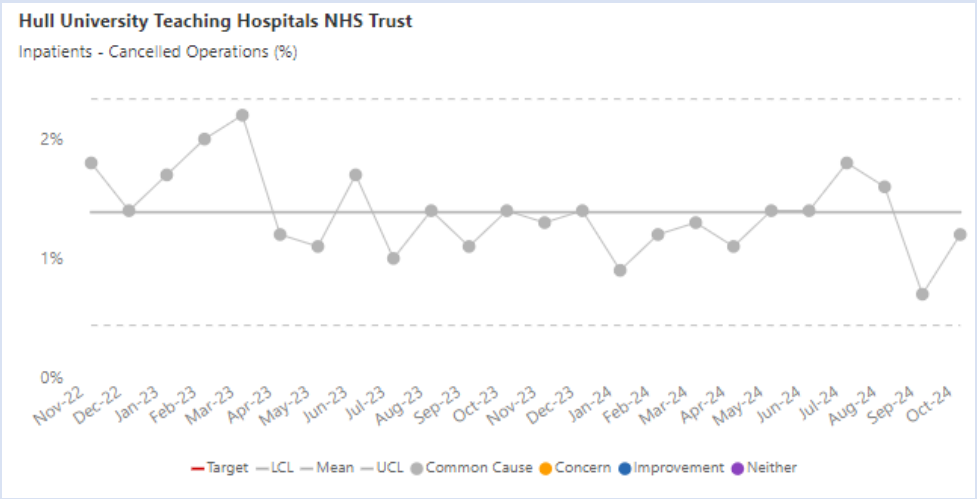
Compliance



Key Themes

- In October there were 107 cancelled operations on the day for non-clinical reasons which is a significant improvement on previous months and represents 1.2% of admissions.
- The largest reasons were –
  - No Theatre Time – 40
  - Emergency case – 17
  - Bed unavailable - 15
  - No anaesthetist – 12
- The main specialties for cancellations on the day are –
  - Interventional Radiology – 16 (Emergency cases)
  - Gynaecology – 14 (No Theatre Time)
  - Vascular Surgery – 13 (No Beds)

Critical Enabler

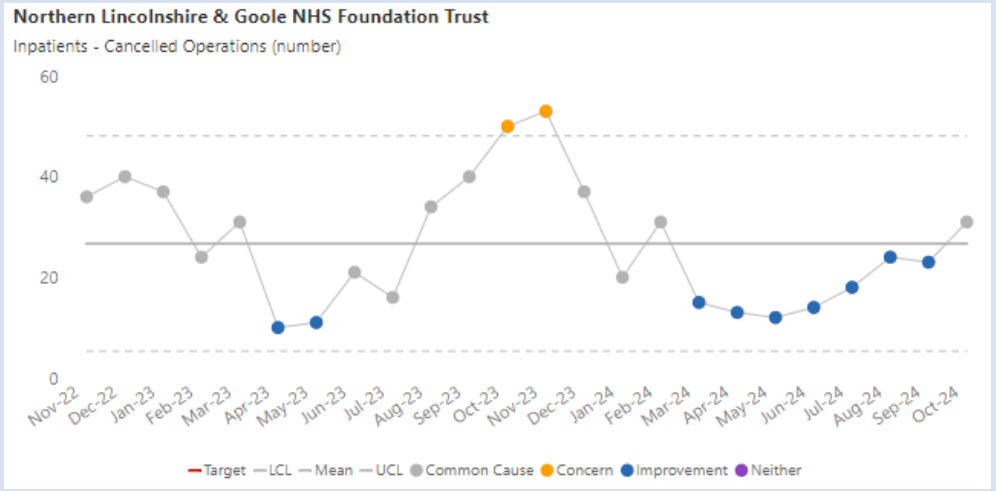


Actions

- Group level cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28 day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus in 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.
- 85% Capped utilisation report and actions going out to all Care Groups from 17th June.
- Progress GIRFT actions for High Volume Low Complexity activity.

10. Cancelled Operations - NLAG

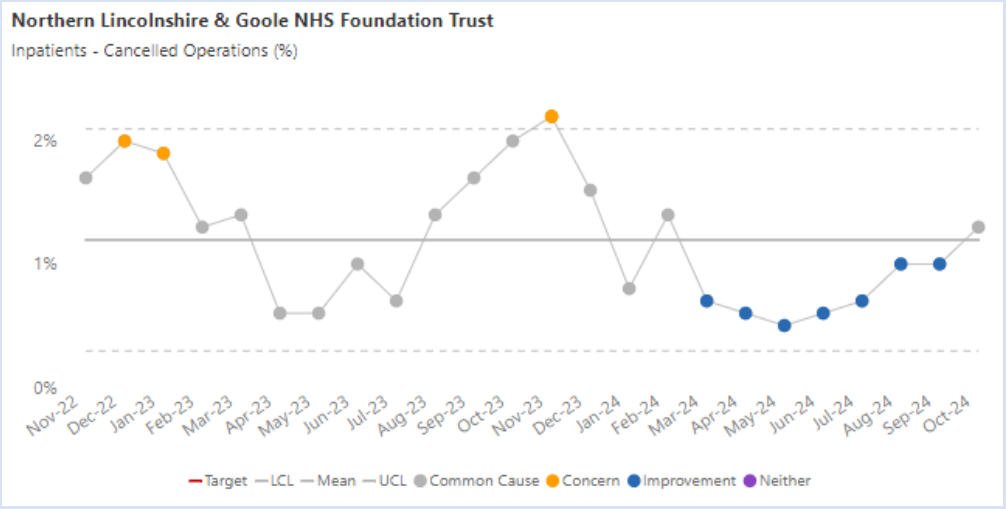
Compliance



Key Themes

- In October there were 31 cancelled operations on the day for non-clinical reasons which is a deterioration on previous months and represents 1.3% of admissions.
- The largest reasons were –
  - 12 Theatre list over-run
  - 8 Anaesthetist unavailable
  - 4 Emergency cases
  - 3 Surgeon unavailable
- The main specialties for cancellations on the day are –
  - General Surgery – 9 (No Anaesthetist)
  - Trauma & Orthopaedics – 8 (Emergency cases)
  - Ophthalmology – 5 (No Consultant)

Critical Enabler

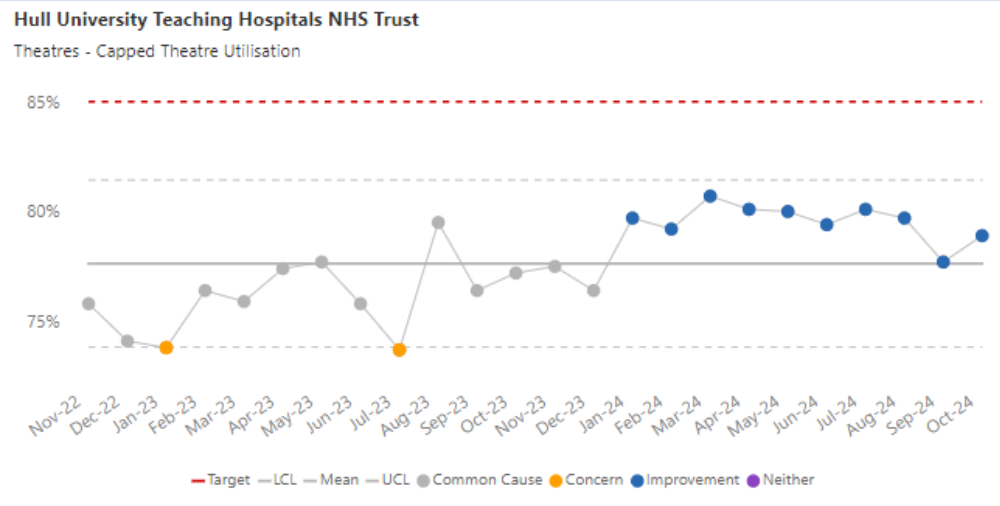


Actions

- Enhanced BIU support to report national data set and eliminate DQ issues.
- 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.
- HUB commenced at GDH 10th June 2024, to support LoS and GIRFT standards improvement.
- Working with NHSE/GIRFT on improvement recommendations
- Reviewing all opportunities to sweat current assets.
- Cancelled operations Standard Operating Procedure (SOP) has been reissued at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Standing down or lifting sessions SOP completed and deployed.

11. Capped Theatre Utilisation - HUTH

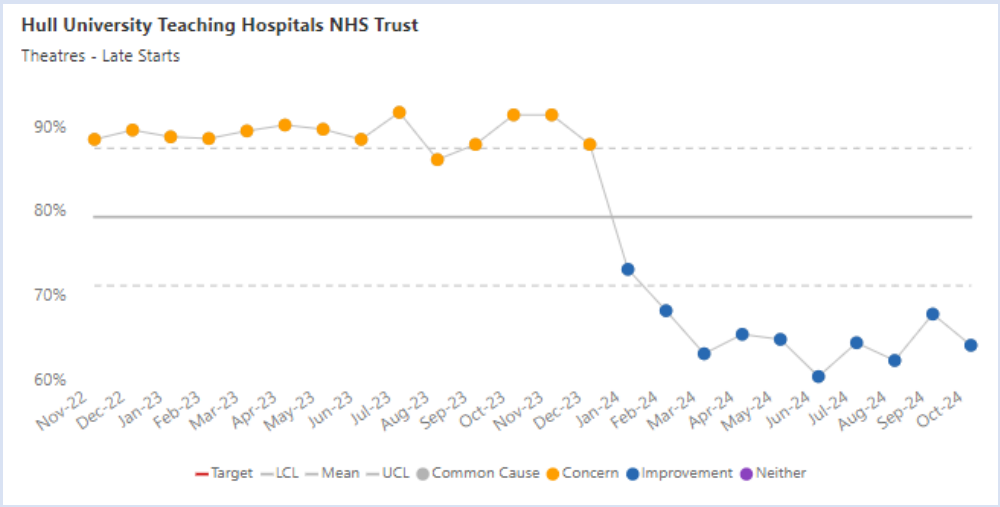
Compliance



Key Themes

- Improvement in capped theatre utilisation with latest Model Hospital data showing performance at 83% placing the Trust in the highest quartile nationally.
- Internal reporting at 78.9% for capped theatre utilisation for October.
- Day Case capped theatre utilisation has improved to 73.6% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- HUTH specifically commended on delivery of capped utilisation improvement by Professor Tim Briggs, Chair of GIRFT and NHSE National Director for Clinical Improvement & Elective Recovery.
- Decrease in late starts to 64% (methodology 0 minutes = late start)

Critical Enabler

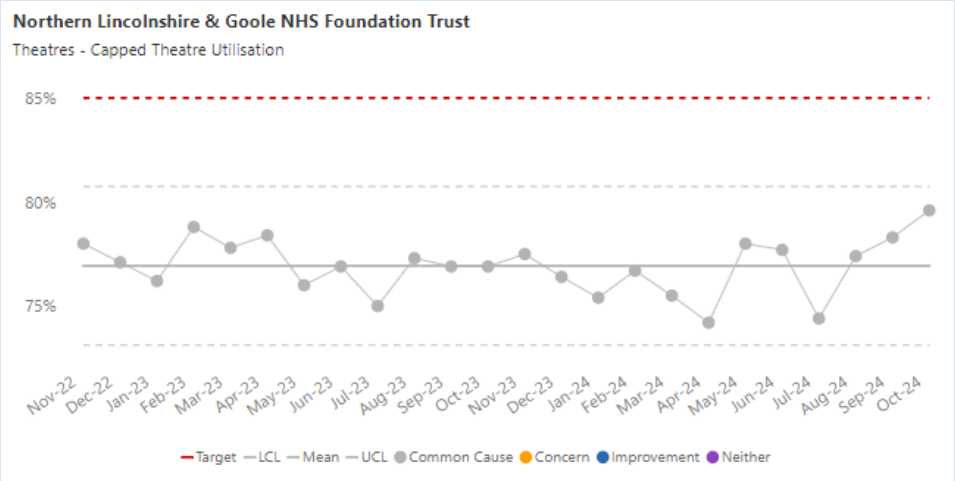


Actions

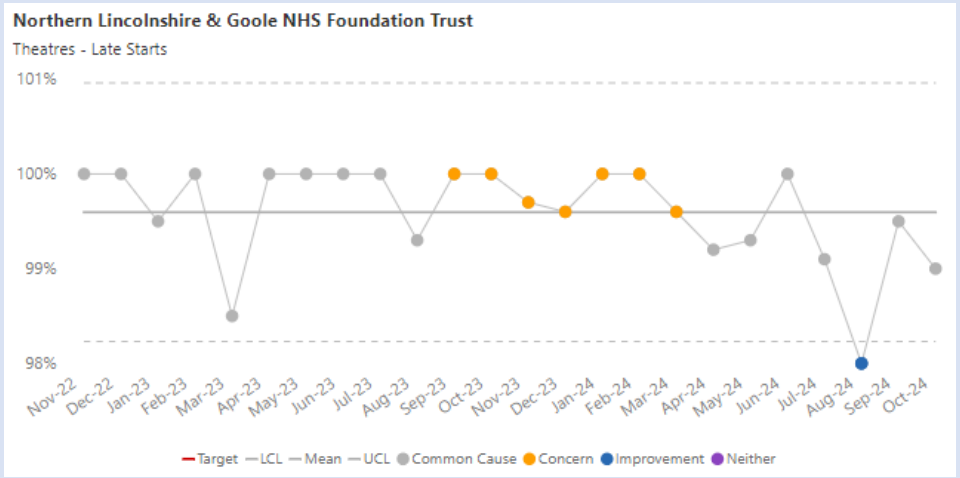
- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Theatres Insights Model being implemented –training roll out commenced at both Trusts.
- Improve recording of day case touch points in ORMIS
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

12. Capped Theatre Utilisation - NLAG

Compliance



Critical Enabler



Actions

- CAP working group established with Theatre and Analytical leads to apply learning from HUTH 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.
- Implementation of 1 extra patient per day case list for any list at <85% capped utilisation

13. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Audiology	Sep 24	5.00%	1.4%			82
Barium Enema	Sep 24	5.00%	0.0%			100
Colonoscopy	Sep 24	5.00%	**44.7%**			13
Computed Tomography	Sep 24	5.00%	**9.7%**			24
Cystoscopy	Sep 24	5.00%	**38.6%**			22
DEXA Scan	Sep 24	5.00%	**55.7%**			4
DM01 Waiting <13 Weeks	Sep 24	100.00%	**94.5%**			42
Diagnostic activity levels - Audiology Assessments	Sep 24	-	533			59
Diagnostic activity levels - Barium Enema	Sep 24	-	40			81
Diagnostic activity levels - CT	Sep 24	-	5,925			68
Diagnostic activity levels - Colonoscopy	Sep 24	-	162			30
Diagnostic activity levels - Cystoscopy	Sep 24	-	354			87
Diagnostic activity levels - Dexa Scan	Sep 24	-	681			94
Diagnostic activity levels - Echocardiography	Sep 24	-	594			34
Diagnostic activity levels - Endoscopy	Sep 24	-	899			44
Diagnostic activity levels - Flexi Sigmoidoscopy	Sep 24	-	97			54
Diagnostic activity levels - Gastroscopy	Sep 24	-	286			37
Diagnostic activity levels - Imaging	Sep 24	-	14,453			68
Diagnostic activity levels - Non Obstetric Ultrasound	Sep 24	-	4,875			64
Diagnostic activity levels - Total	Sep 24	-	17,062			63
Diagnostic activity levels - Urodynamics	Sep 24	-	33			68
Diagnostics - 6 Week Standard	Sep 24	5.00%	**23.5%**			36
Diagnostics - 6 Week Standard Reversed	Sep 24	95.00%	**76.5%**			36
Echocardiography	Sep 24	5.00%	**47.2%**			20
Electrophysiology	Sep 24	5.00%	-			-
Gastroscopy	Sep 24	5.00%	**26.3%**			28
Magnetic Resonance Imaging	Sep 24	5.00%	3.3%			62
Neurophysiology	Sep 24	5.00%	**17.8%**			45
Non-obstetric Ultrasound	Sep 24	5.00%	**16.2%**			30
Urodynamics	Sep 24	5.00%	**66.7%**			14

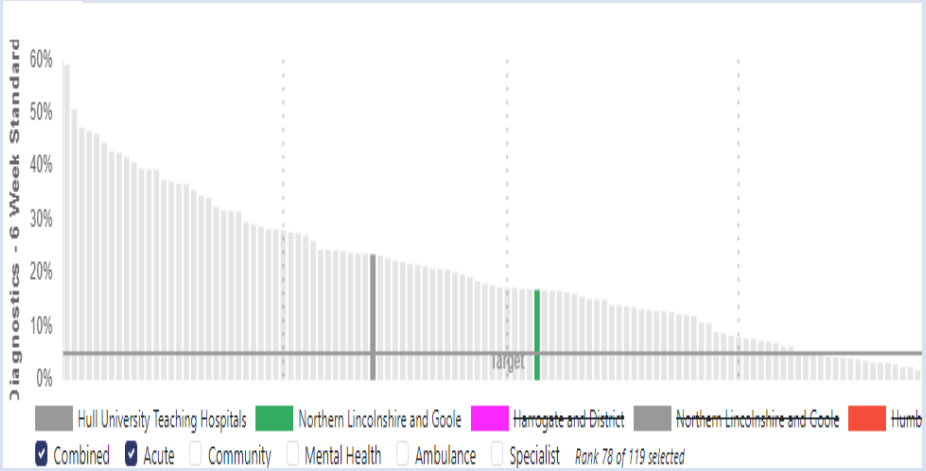
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Audiology	Sep 24	5.00%	**52.5%**			25
Barium Enema	Sep 24	5.00%	2.4%			45
Colonoscopy	Sep 24	5.00%	**7.8%**			61
Computed Tomography	Sep 24	5.00%	3.2%			49
Cystoscopy	Sep 24	5.00%	**23.8%**			41
DEXA Scan	Sep 24	5.00%	3.8%			34
DM01 Waiting <13 Weeks	Sep 24	100.00%	**96.5%**			53
Diagnostic activity levels - Audiology Assessments	Sep 24	-	457			54
Diagnostic activity levels - Barium Enema	Sep 24	-	134			96
Diagnostic activity levels - CT	Sep 24	-	11,241			97
Diagnostic activity levels - Colonoscopy	Sep 24	-	551			82
Diagnostic activity levels - Cystoscopy	Sep 24	-	583			99
Diagnostic activity levels - Dexa Scan	Sep 24	-	291			52
Diagnostic activity levels - Echocardiography	Sep 24	-	925			53
Diagnostic activity levels - Endoscopy	Sep 24	-	2,126			95
Diagnostic activity levels - Flexi Sigmoidoscopy	Sep 24	-	251			96
Diagnostic activity levels - Gastroscopy	Sep 24	-	741			88
Diagnostic activity levels - Imaging	Sep 24	-	20,200			88
Diagnostic activity levels - Non Obstetric Ultrasound	Sep 24	-	3,766			49
Diagnostic activity levels - Total	Sep 24	-	24,121			88
Diagnostic activity levels - Urodynamics	Sep 24	-	161			96
Diagnostics - 6 Week Standard	Sep 24	5.00%	**16.9%**			51
Diagnostics - 6 Week Standard Reversed	Sep 24	95.00%	**83.1%**			51
Echocardiography	Sep 24	5.00%	**36.9%**			30
Gastroscopy	Sep 24	5.00%	**5.2%**			65
Magnetic Resonance Imaging	Sep 24	5.00%	**10.4%**			40
Neurophysiology	Sep 24	5.00%	**46.8%**			26
Non-obstetric Ultrasound	Sep 24	5.00%	**9.6%**			42
Urodynamics	Sep 24	5.00%	**9.5%**			80

14. Pathway Benchmarking & Trend – Diagnostics

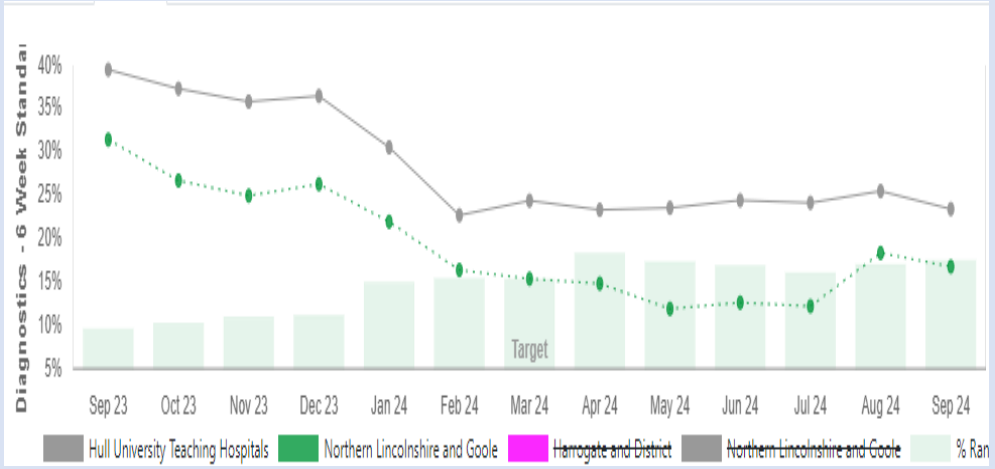
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

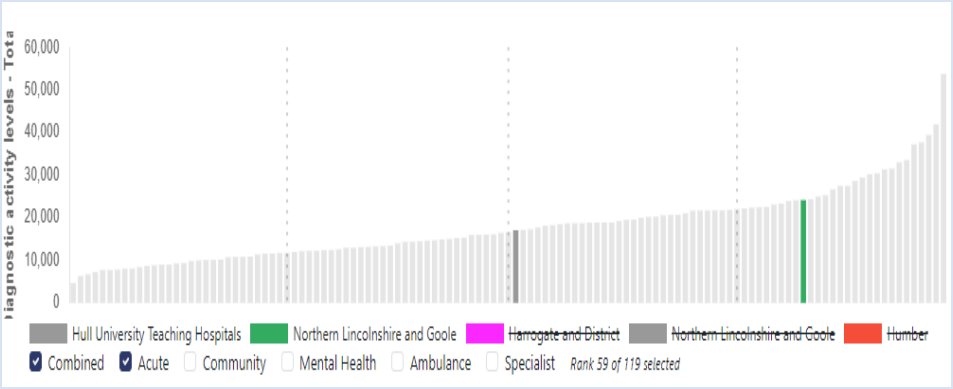


Trend Chart

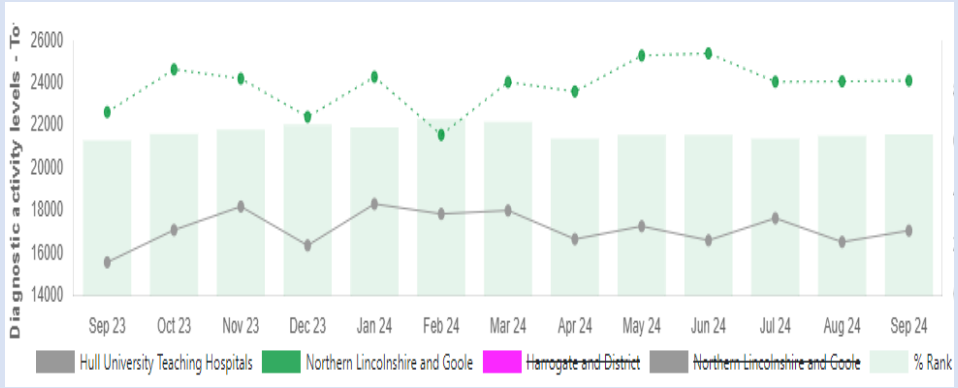


Diagnostics – Activity

Ranking Chart

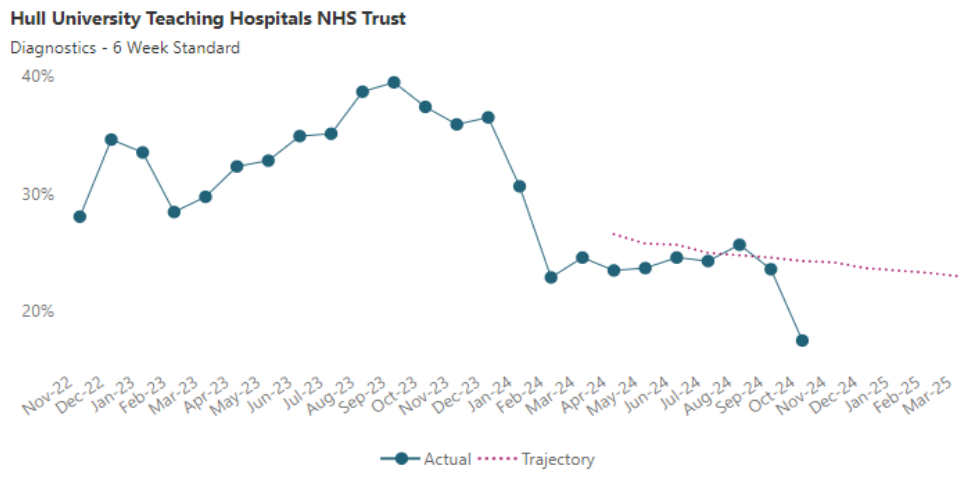


Trend Chart



15. Diagnostic 6 Week Standard - HUTH

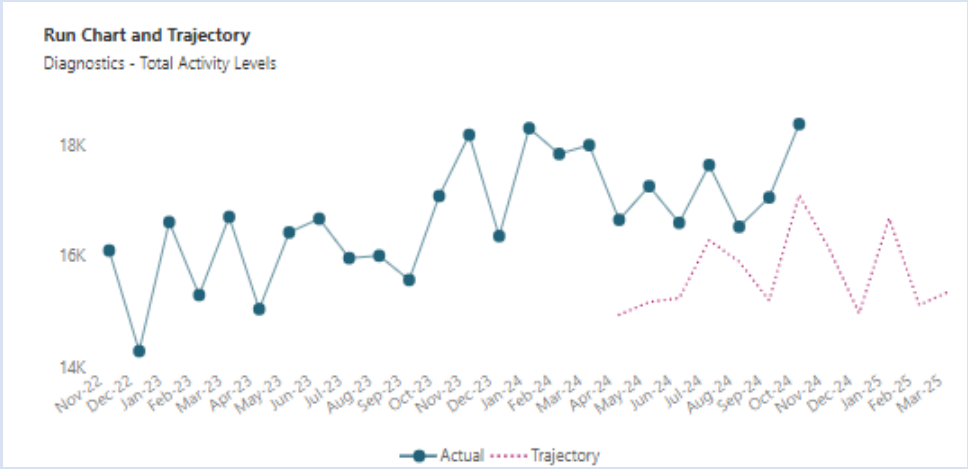
Compliance



Key Themes

- Improvement in performance in October to 17.4%, (an improvement of 6.1%). This places the Trust significantly ahead of trajectory.
- The most notable increase in performance was in DEXA which fell to 25.2% in October compared to 55.7% in September. This relates a significant increase in throughout at HUTS and to the transfer of 50 patient to NLaG to equalise wait times across the Group.
- Most modalities at HUTH increased activity levels over 23/24 and into 24/25. Whilst ahead of delivery trajectory, aggregate diagnostic compliance has remained static in recent months – noting the mathematical impact of DEXA mutual aid outlined above.

Critical Enabler

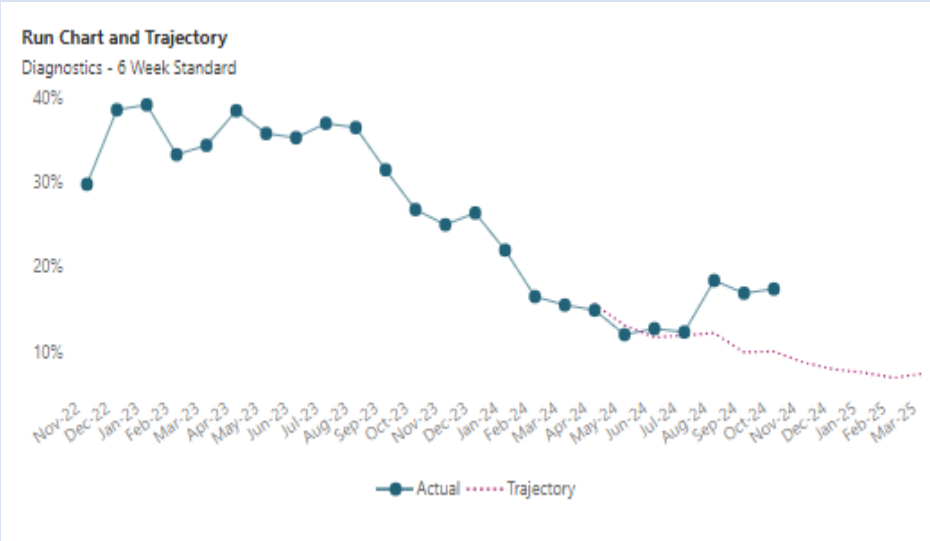


Actions

- Critical actions in place:
  - Services have developed improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
  - Dedicated investment case approved to address DEXA waiting list backlog via increased throughput and testing volume capacity.
  - Tender exercise completed for NOUS to create additional capacity.
  - Validation of DMO1 activity recording underway to support performance and forecasting going forward.

16. Diagnostic 6 Week Standard - NLAG

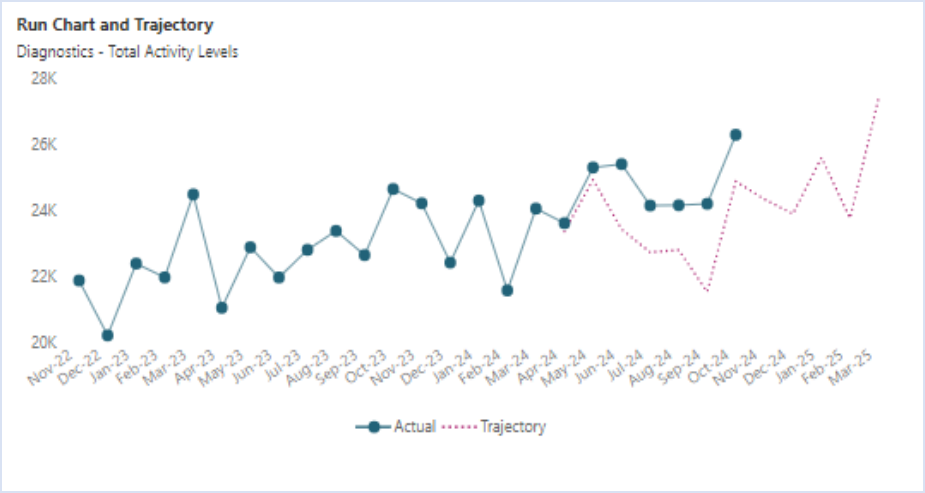
Compliance



Key Themes

- Slight reduction in performance for October at 17.4%, a 0.5% shift from 16.9% in September - noting this includes the impact of the mutual aid transfer of DEXA patients from HUTH.
- Aggregate (all modality) compliance is supported through the increased activity levels in imaging.
- Imaging activity recording varies at both Trusts. NLAG reports based on body parts scanned, rather than overall scan volume, which leads to NLAG having higher reported activity levels than HUTH. Both practices technically align to national guidance.

Critical Enabler



Actions

- Operating Plan commitments significantly extend diagnostic activity levels in 24/25.
- Further activity stretch plans have been deployed to create additional diagnostic activity levels above the annual plan and utilise mutual aid opportunities across the Group. Where associated investment plans have been approved operational teams are commencing implementation either through use of WLIs, locums, substantive appointments, or Independent Sector.
- To mitigate capacity shortfalls relating to staffing in Neurophysiology on the South Bank enhanced workforce arrangements have been deployed to reduce backlog.
- Ultrasound increasing capacity with use of IS. CDC comes online in November which will also improve the position.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Sep 24	93.00%	**78.4%**			36
Cancer 2 Week Wait Breast Symptomatic	Sep 24	93.0%	**60.5%**			20
Cancer 28 Day Faster Diagnosis	Sep 24	75.0%	76.7%			53
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Brain Tumours	Sep 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Breast Cancer	Sep 24	75.0%	96.5%			74
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Sep 24	75.0%	97.2%			74
Cancer 28 Day Faster Diagnosis - Children's Cancer	Sep 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Sep 24	75.0%	**62.2%**			39
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Sep 24	75.0%	**28.6%**			10
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Sep 24	75.0%	90.0%			92
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Sep 24	75.0%	**36.6%**			5
Cancer 28 Day Faster Diagnosis - Lung Cancer	Sep 24	75.0%	83.3%			67
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Sep 24	75.0%	84.5%			35
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Sep 24	75.0%	91.2%			93
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Sep 24	75.0%	**46.2%**			16
Cancer 31 Day All Stages	Sep 24	96.0%	**77.4%**			3
Cancer 31 Day First Treatment	Sep 24	96.00%	**80.7%**			4
Cancer 31 Day Subsequent Treatment	Jul 24	96.0%	**68.4%**			2
Cancer 31 Day Subsequent Treatment - Drugs	Sep 24	96.0%	96.2%			13
Cancer 31 Day Subsequent Treatment - Radiotherapy	Sep 24	96.0%	**71.6%**			10
Cancer 62 Day All Routes	Sep 24	85.00%	**51.0%**			7
Cancer 62 Day Consultant Upgrade	Sep 24	85.0%	**37.0%**			1
Cancer 62 Day Screening	Sep 24	90.0%	**46.8%**			22
Cancer 62 Day Urgent Suspected	Sep 24	85.00%	**53.6%**			19
Cancer of bronchus; lung	Sep 24	1.00	**1.1**			32

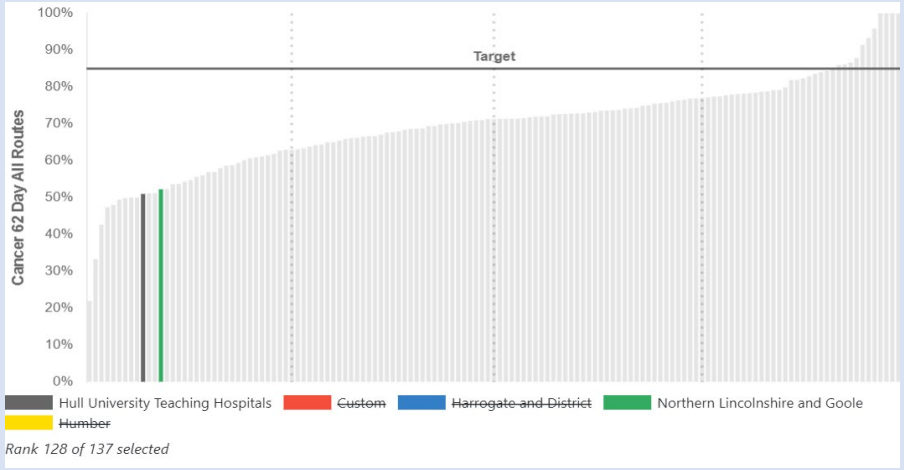
Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Sep 24	93.00%	96.2%			89
Cancer 2 Week Wait Breast Symptomatic	Sep 24	93.0%	100%			100
Cancer 28 Day Faster Diagnosis	Sep 24	75.0%	**73.6%**			30
Cancer 28 Day Faster Diagnosis - Breast Cancer	Sep 24	75.0%	96.3%			72
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Sep 24	75.0%	96.8%			68
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Sep 24	75.0%	**54.5%**			25
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Sep 24	75.0%	**59.6%**			8
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Sep 24	75.0%	**65.1%**			55
Cancer 28 Day Faster Diagnosis - Lung Cancer	Sep 24	75.0%	**66.7%**			20
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Sep 24	75.0%	**40.0%**			27
Cancer 28 Day Faster Diagnosis - Sarcoma	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Sep 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Sep 24	75.0%	82.4%			71
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Sep 24	75.0%	**74.5%**			84
Cancer 31 Day All Stages	Sep 24	96.0%	97.1%			80
Cancer 31 Day First Treatment	Sep 24	96.00%	96.9%			71
Cancer 31 Day Subsequent Treatment	Jul 24	96.0%	98.8%			74
Cancer 31 Day Subsequent Treatment - Drugs	Sep 24	96.0%	99.0%			42
Cancer 31 Day Subsequent Treatment - Radiotherapy	Sep 24	96.0%	100%			100
Cancer 62 Day All Routes	Sep 24	85.00%	**52.3%**			9
Cancer 62 Day Consultant Upgrade	Sep 24	85.0%	**45.2%**			1
Cancer 62 Day Screening	Sep 24	90.0%	**50.0%**			27
Cancer 62 Day Urgent Suspected	Sep 24	85.00%	**53.8%**			21
Cancer of bronchus; lung	Sep 24	1.00	**1.1**			38

18. Pathway Benchmarking & Trending – Cancer Waiting Times

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

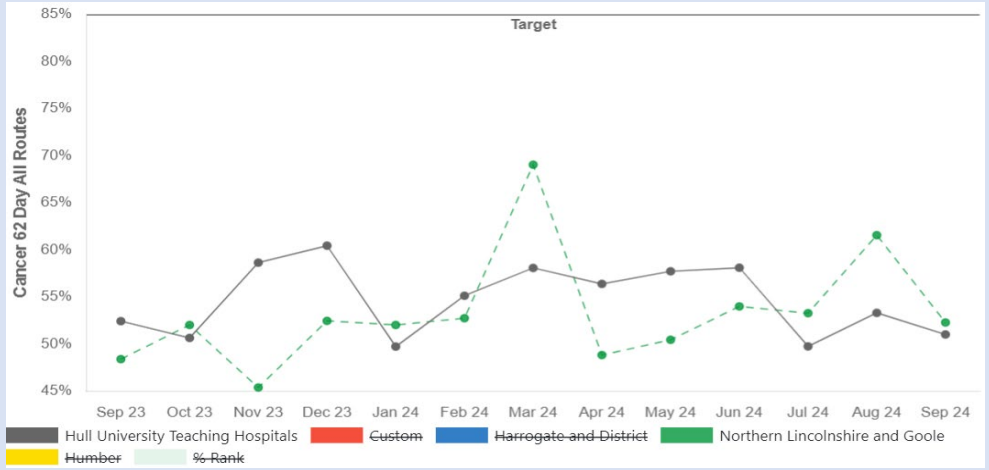
62 Day Performance

Ranking Chart



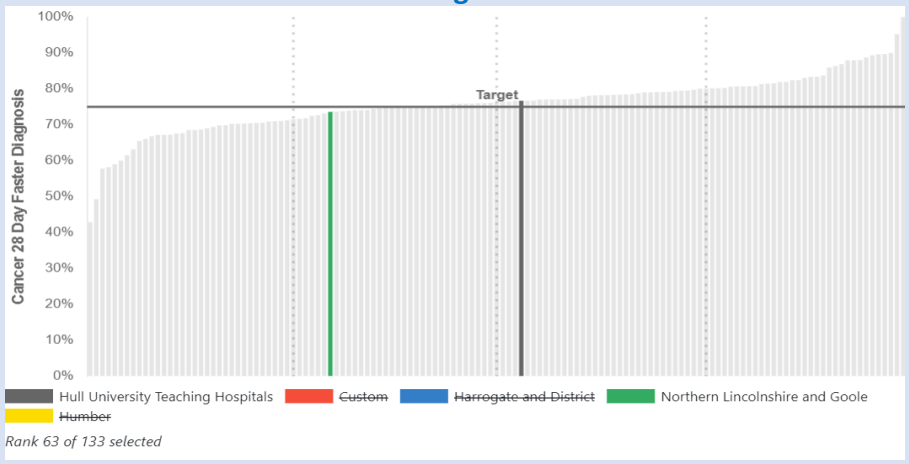
Rank 128 of 137 selected

Trending Chart



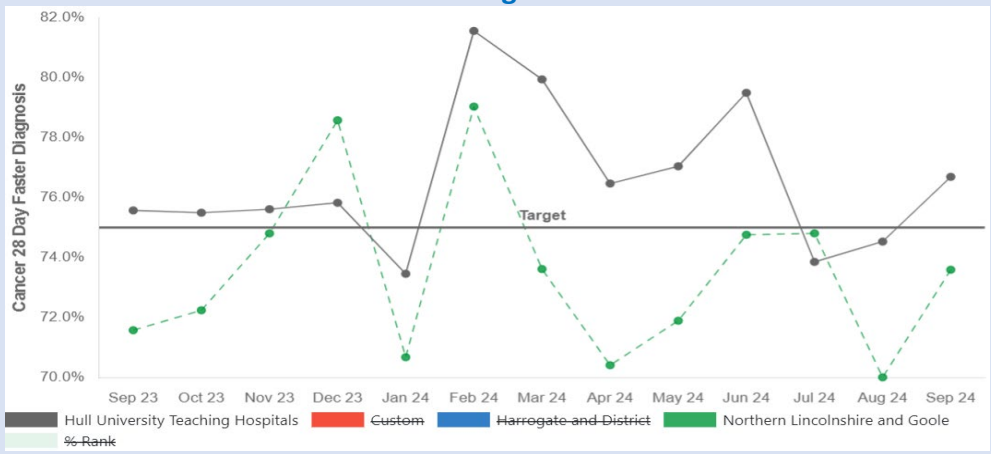
Faster Diagnosis Performance

Ranking Chart



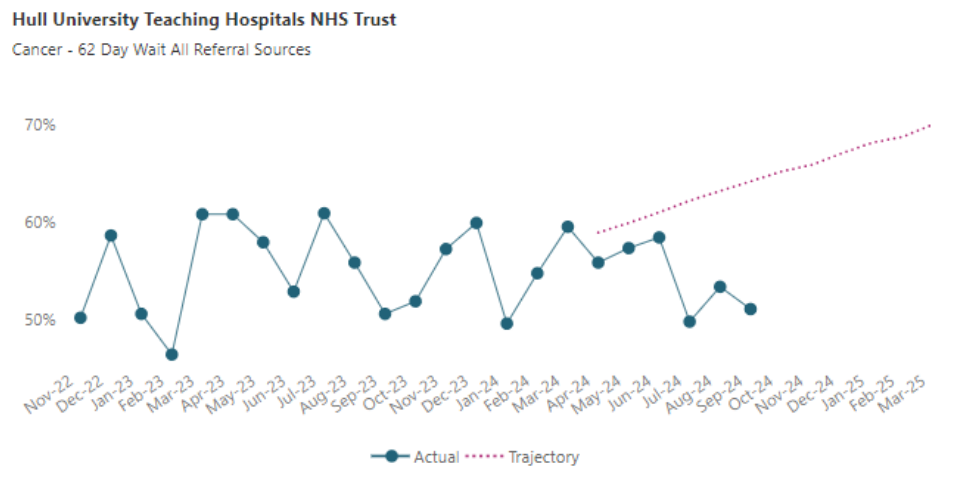
Rank 63 of 133 selected

Trending Chart



19. 62 Day Cancer Performance - HUTH

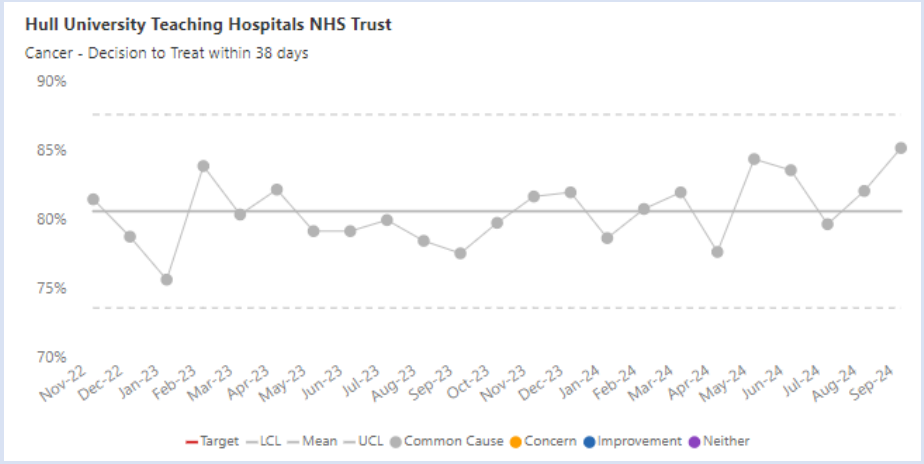
Compliance



Key Themes

- 51% performance for September 2024 (2.2% reduction compared to August 2024)
- Breast – delays in pathway related to 1st OPA capacity, not yet recovered into 62-day RTT
- Skin – delays in pathway related to 1st OPA capacity; consultant dermatologist & plastic surgeon vacancies – recovering in FDS & 62-day RTT
- Lung/Thoracic – Nav Bronch equipment failure; improvement required to pool patients to avoid differential waiting times in Thoracic service plus late IPTs and impact of radiotherapy/SABR capacity
- LGI - Endoscopy diagnostic capacity plus patient fitness, compliance & consultant capacity
- Upper GI deterioration under investigation – delays in front end triage highlighted to the Care Group
- Radiotherapy recovery plan continues (12 months from November 2023) & mutual aid from Lincoln
- Oncology capacity (vacancies plus increased demand) – clinical prioritisation in Breast & Urology
- Histology TATs - SHYPS TAT Improvement Plan; escalation to Oversight Committee (Aug 2024)
- Late IHTs – Lung, Gynae and Urology: focussed work in Urology within the Group & Lung with Y&S Trust

Critical Enabler



Actions

IHTs

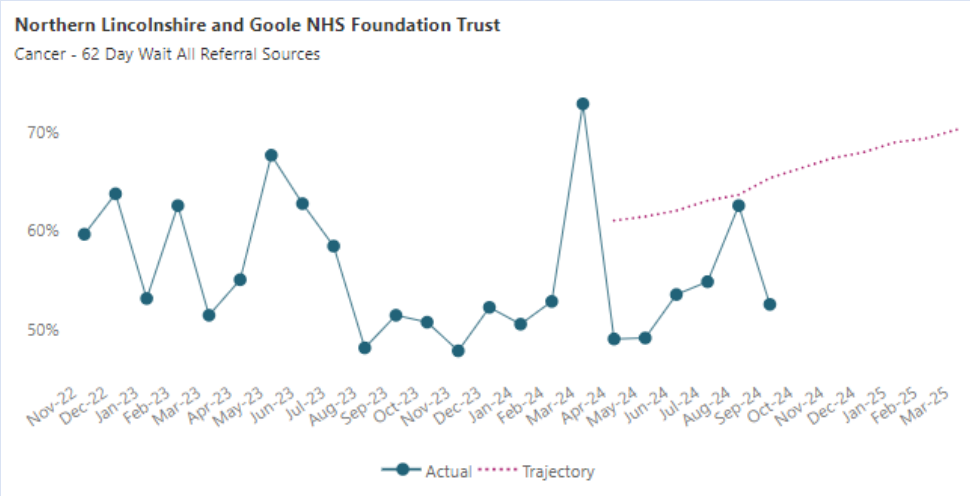
- Inter-Group review of the Urology IPTs – Group-wide urology improvement project
- Joint work with Y&S on Lung late IPTs, no specific themes identified; Y&S and NLAG consultant vacancies are a further concern
- Lung whole pathway review undertaken 28 June 2024 – North & South bank combined event, project plan to deliver including LHC
- Gynaecology (South Bank) workshop on 11/09/2024 – action plan to prioritise & deliver

Workforce

- Plastic Surgery & Dermatology capacity – x4 vacant consultant posts wef mid-April 2024; focussed effort to maintain PTL; delays in approval for recruitment
- Urology consultant vacancies – impacted by annual + compassionate leave, significant delays with outpatient & surgical capacity; x1 locum secured plus robotic surgeon mutual aid being explored
- Radiotherapy recovery plan mobilised – however increased referrals & increased complexity; formal review September 2024 at 9 months

20. 62 Day Cancer Performance - NLAG

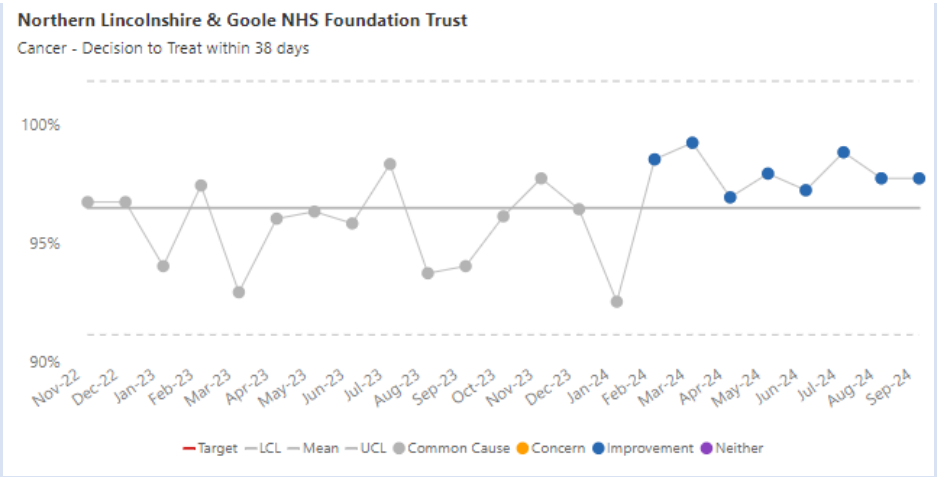
Compliance



Key Themes

- September performance at 52.5% (9.7% reduction on August 2024 performance) – main cause is LGI performance dip & much reduced +63 day backlog overall
- IPT transfer delays continue, performance impact 7-10% due to breach attribution in Lung & Urology pathways; both have front end pathway delays to be addressed.
- Lung - capacity for OPAs, diagnostics & oncology appointments (to determine surgical vs. oncology treatment). Lung physician vacancies x 2 – in recruitment, previous difficulties and retention issues Additional support for Lung cancer pathway tracking identified and in place
- LGI – endoscopy capacity/patient-initiated delays during August/September 2024 Urology surgical capacity (vacancy)
- H&N – pathways issues to resolve; multiple diagnostics and histology not marked 31/62
- Gynaecology – OPA and diagnostic capacity issues, review of tracking/pathway management underway. Additional tracking support identified and in place since end Aug.
- Histology TATs - % within 10 days and overall TATs being analysed by Path Links; provider continues to be below the England average for 10-day TATs

Critical Enabler

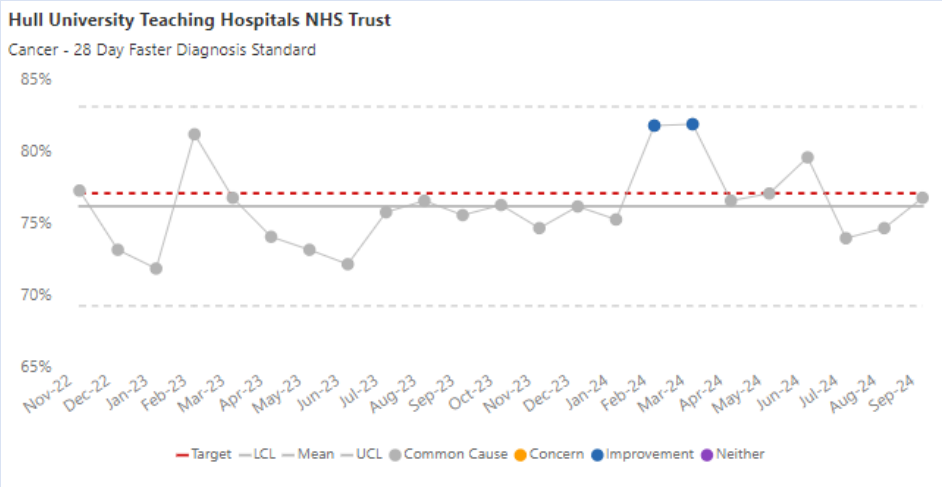


Actions

- Capacity constraints – consultant vacancies, imaging/diagnostic delays & pathology TATs
- Engagement with front end pathway improvement opportunities
- Histology TATs – TAT recovery plan Path Links
- Impact of Targeted Lung Health checks – increasing volume of patients on Screening pathway
- PET CT capacity constraints and PMSA dose limitations
- IPT – factors affecting the inter-Group performance

21. 28 Day Faster Diagnosis Standard - HUTH

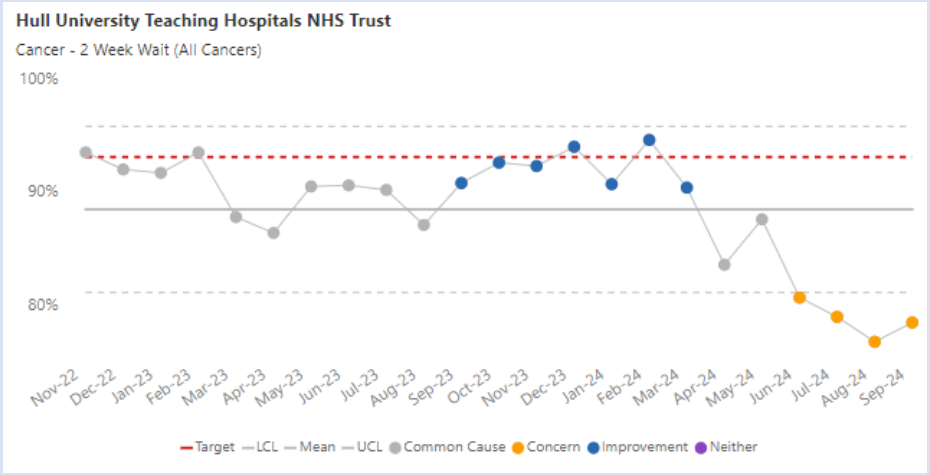
Compliance



Key Themes

- September 2024 –performance of 76.7% (10 more compliant pathways would have achieved 77%) against the national target/Trust trajectory of 77%
- Deterioration for Head & Neck and Skin – alerted to both Care Groups and through Group performance structure; related largely to workforce •Head & Neck: x18 breaches dated outside Day 28 – largely capacity constraints
- Skin: x 24 breaches dated outside Day 28 – Capacity constraints within the service (vacancies x4 plus compassionate leave)
- Significant improvement seen in Breast, now achieving from September 2024
- Lung achieving the trajectory for September 2024 following validation/review of breaches; also ongoing validation for October 2024
- Colorectal deterioration with endoscopy and consultant capacity being the issues
- Urology deterioration with reporting delays for prostate biopsies, consultant capacity (1st OPAs prostatectomy IPTs, surgical capacity & results clinic capacity), now compounded by compassionate leave

Critical Enabler



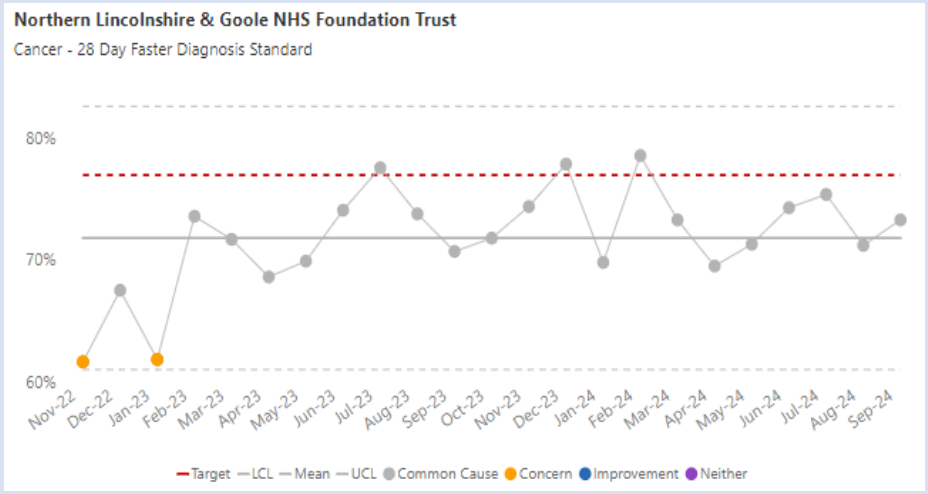
Actions

Increased focus on outpatient stage of treatment

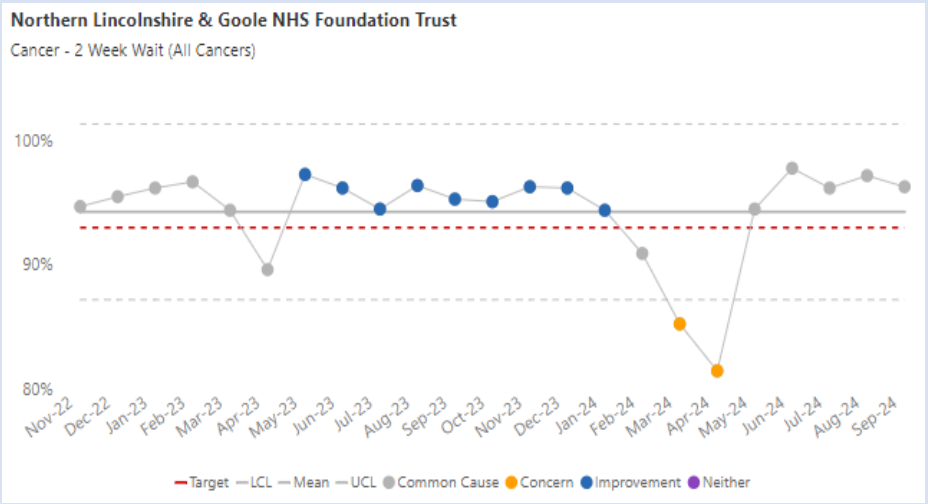
- Skin & Head and Neck – significant capacity constraints for 1st seen appointment impacting on FDS performance
- Improvement seen in Breast for September 2024 (provisional)
- Endoscopy recovery plan and actions to support LGI USC and Bowel Screening pathways
- LGI & Urology – on-going improvement projects, plus consultant recruitment

22. 28 Day Faster Diagnosis Standard - NLAG

Compliance



Critical Enabler



23. Pathway Summary – Benchmark Report – Unscheduled Care

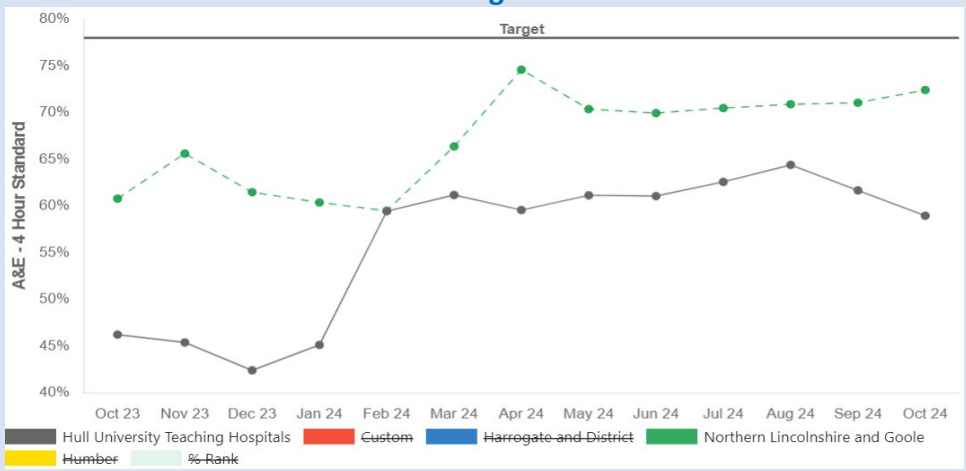
Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Oct 24	78.00%	**58.9%**			4
A&E - 4 Hour Standard (Type 1)	Oct 24	78.0%	**40.4%**			2
A&E - 4 Hour Standard (Type 2 or 3)	Oct 24	95.0%	97.7%			43
A&E - Conversion Rate	Oct 24	25.0%	24.9%			20
A&E - DTA to Admission >12 Hours	Oct 24	0.0%	**15.7%**			34
A&E - DTA to Admission >12 Hours#	Oct 24	0.0	**575.0**			25
A&E - DTA to Admission >4 Hours	Oct 24	10.00%	**42.1%**			36
A&E - Left Without Being Seen	Sep 24	5.00%	**9.4%**			4
A&E - Reattendance Rate	Sep 24	5.0%	**9.4%**			32
A&E - Time to Initial Assessment	Sep 24	15.0	**23.0**			8
A&E - Time to Treatment	Sep 24	60.0	**112.0**			8
A&E - Total Time in A&E	Sep 24	160.0	**235.0**			7
A&E - Total Time in A&E (Admitted)	Sep 24	180.0	163.0			83
A&E - Total Time in A&E (Non-Admitted)	Sep 24	140.0	**260.0**			1
A&E Attendances All	Oct 24	-	14,647			51
A&E Attendances Type 1	Oct 24	-	9,919			57
A&E Attendances Type 3	Oct 24	-	4,728			56
Emergency Admissions Type 1	Oct 24	-	3,652			38
Emergency Admissions via A&E	Oct 24	-	3,652			36
Friends & Family A&E Score	Sep 24	85%	**68%**			7
Other Emergency Admissions	Oct 24	-	2,344			10
Total Emergency Admissions	Oct 24	-	5,996			23

Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Oct 24	78.00%	**72.4%**			55
A&E - 4 Hour Standard (Type 1)	Oct 24	78.0%	**51.2%**			24
A&E - 4 Hour Standard (Type 2 or 3)	Oct 24	95.0%	99.4%			71
A&E - Conversion Rate	Oct 24	25.0%	**35.5%**			0
A&E - DTA to Admission >12 Hours	Oct 24	0.0%	**15.3%**			35
A&E - DTA to Admission >12 Hours#	Oct 24	0.0	**859.0**			9
A&E - DTA to Admission >4 Hours	Oct 24	10.00%	**27.0%**			64
A&E - Left Without Being Seen	Sep 24	5.00%	2.3%			82
A&E - Reattendance Rate	Sep 24	5.0%	**9.0%**			43
A&E - Time to Initial Assessment	Sep 24	15.0	**19.0**			13
A&E - Time to Treatment	Sep 24	60.0	50.0			74
A&E - Total Time in A&E	Sep 24	160.0	146.0			77
A&E - Total Time in A&E (Admitted)	Sep 24	180.0	-			-
A&E - Total Time in A&E (Non-Admitted)	Sep 24	140.0	130.0			77
A&E Attendances All	Oct 24	-	15,820			45
A&E Attendances Type 1	Oct 24	-	8,854			70
A&E Attendances Type 3	Oct 24	-	6,966			37
Emergency Admissions Type 1	Oct 24	-	5,610			10
Emergency Admissions Type 3	Oct 24	-	-			-
Emergency Admissions via A&E	Oct 24	-	5,610			9
Friends & Family A&E Score	Sep 24	85%	**78%**			41
Other Emergency Admissions	Oct 24	-	497			61
Total Emergency Admissions	Oct 24	-	6,107			20

24. Pathway Benchmarking & Trending – Unscheduled Care

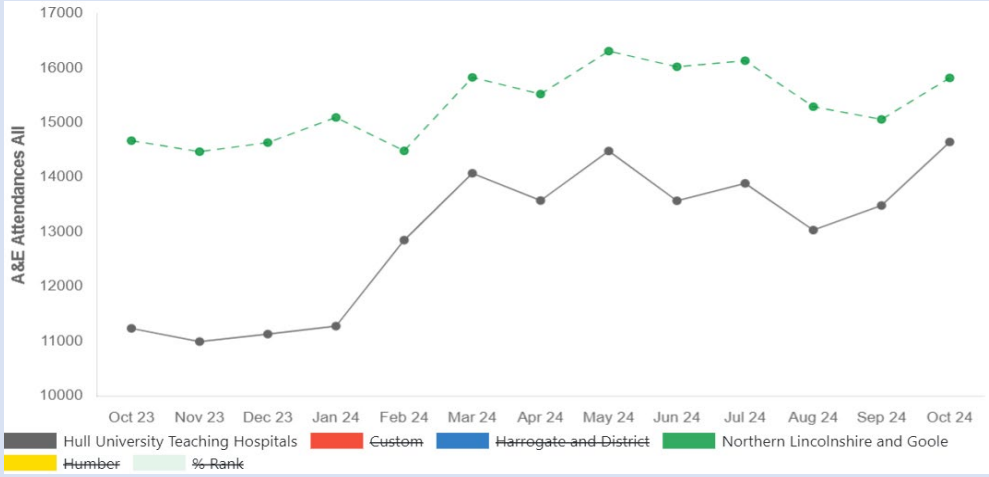
A&E - 4 Hour Performance

Trending Chart



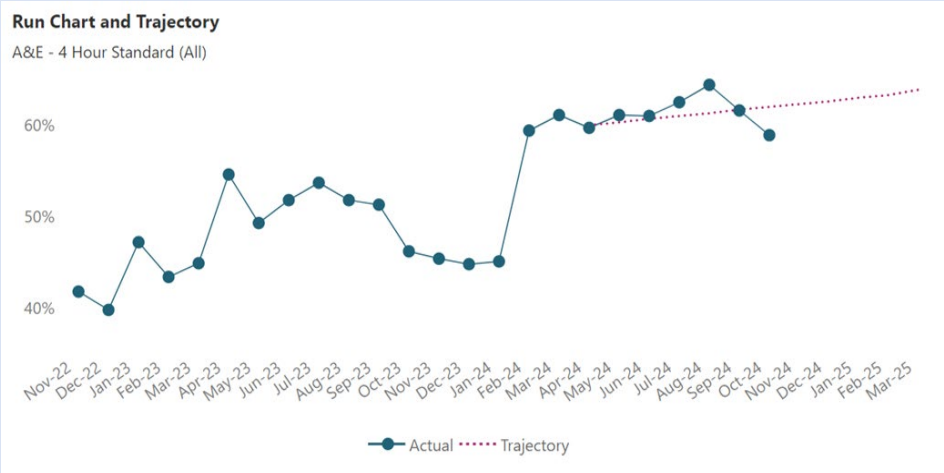
A&E – Attendances

Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

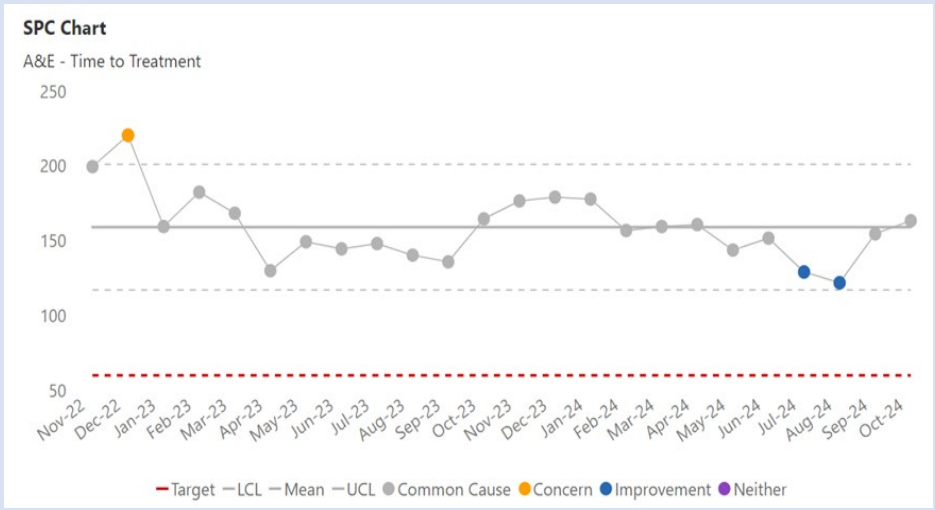
Compliance



Key Themes

- Compliance step change relates to inclusion of HRI UTC in HUTH formal reporting from Feb '24
- A&E 4 Hour standard (all types) was 58.9% in October (plan 62%)
- Type 1 performance in October of 40.4% is in line with the 24/25 operating plan target of 40.0%.
- Type 3 performance (HRI UTC) was 97.7% in October against the 95% target. Attendances at UTC remain significantly below planned levels.
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival. Time to treatment was 163 minutes in October against 60 minutes target time (a deterioration from August at 122 mins)

Critical Enabler



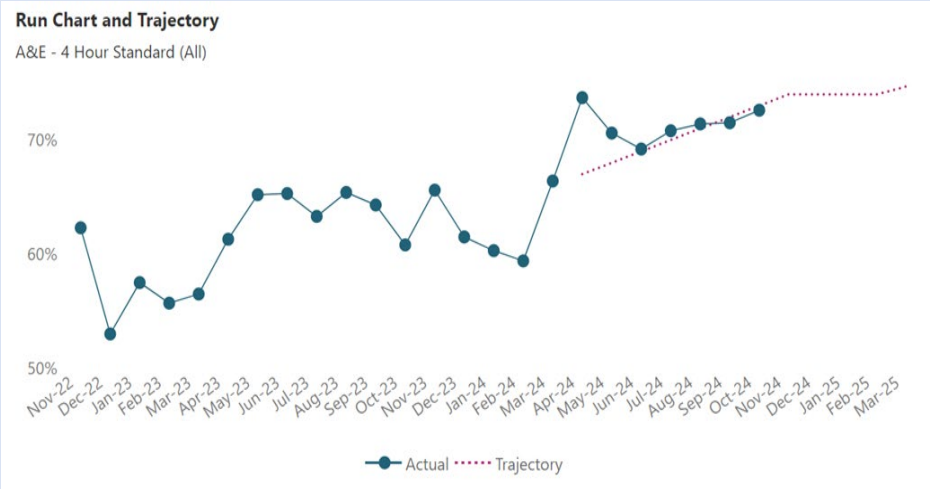
Actions

3 critical objectives identified. Improvement since project initiation in February 2024, however flow pressures experienced within the ED during September have led to a deterioration in performance:

1. Reducing non-admitted breaches:- Increased from 2,497 in August to 3,710 in October
2. Time to first clinician:- Deterioration from mean of 121.9 in August to mean of 176 in October
3. Improved frailty assessment: :- Deterioration from 457.2mins in August to 609 mins in October for total time in department for patients >65 years of age (target time of 160 minutes)
4. Patient flow outside ED also being prioritised: - Implementation of SAFER Bundle, Discharge Lounge, Surgical SDEC, designated cover of GIM wards and reduction of NCTR.
   Community capacity including diversionary pathways from ED being progressed with partners

26. Emergency Care Standards – 4 hour Performance - NLAG

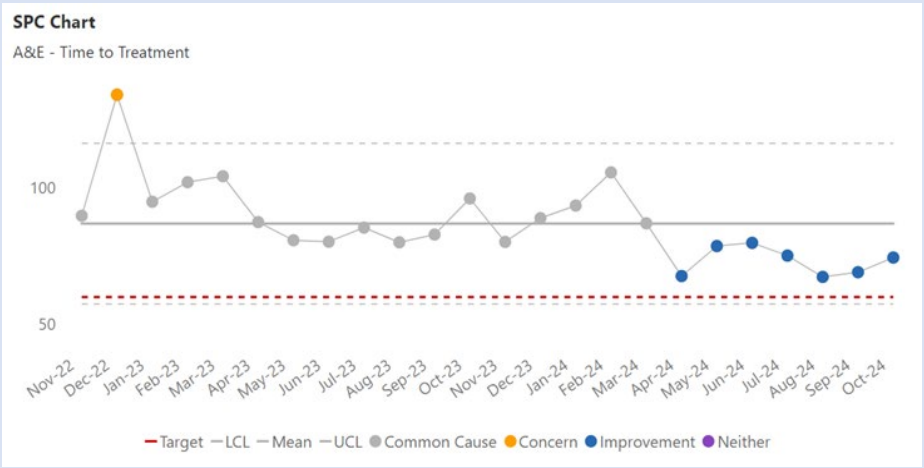
Compliance



Key Themes

- Combined type 1 and 3 performance was 72.4% in October, slightly below the 73% target trajectory.
- Total attendances in October were 15,819, comprising 8,853 Type 1 attendances (below plan) and 6,966 Type 3 attendances (above plan).
- Time to treatment was 74 minutes in October, a slight deterioration on the August position.

Critical Enabler



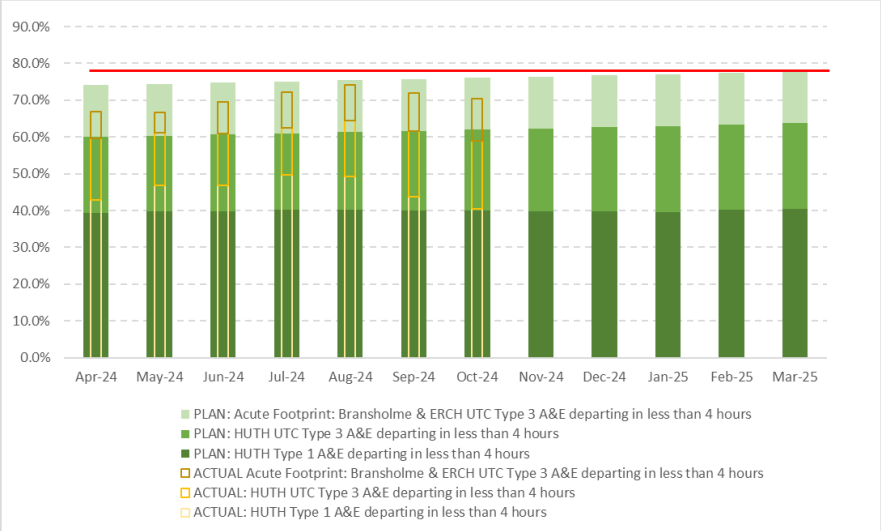
Actions

3 critical objectives identified. Improvement since project initiation in February 2024: Reducing non-admitted breaches.

1. Reducing non-admitted breaches: - slight increase from 2,318 in August to 2,406 in October.
2. Time to first clinician: - Slight deterioration in performance against this metric in October (74 minutes compared to 67.4 mins in August)
3. Improved frailty assessment: - Increase in waiting time from 239.3mins in August to 252 minutes in October for total time in department for patients >65 years of age (target time of 160 minutes)
4. Patient flow outside ED also being prioritised: - CDU now functional across both sites, impact being monitored. Patient flow outside ED also being prioritised. Implementation of SAFER Bundle, designated cover of GIM wards and reduction of NCTR.

27. Acute Footprint Compliance – A&E

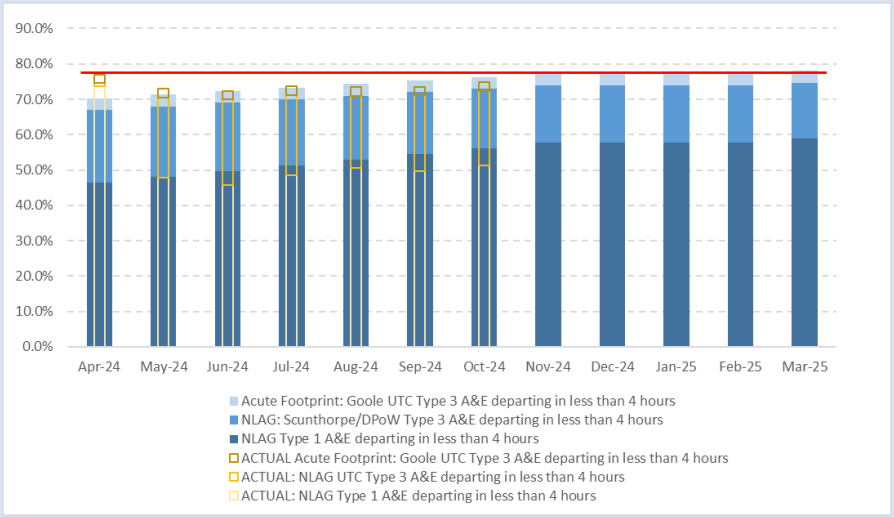
Compliance - HUTH



Key Themes

- As per NEY Region/HNY ICB instruction, 2024/25 trajectories are predicated on 78% delivery as an Acute Footprint by March '25.
- Acute footprint delivery of 70.3% against a plan of 76.3%.
- Breaking the plan/delivery into constituent parts:
  - Type 1 compliance was 40.4% in line with plan of 40.4%.
  - Type 3 co-located activity compliance of 18.5% versus plan of 22%
  - Non co-located compliance was 11.4% versus plan of 14.1%

Compliance - NLAG

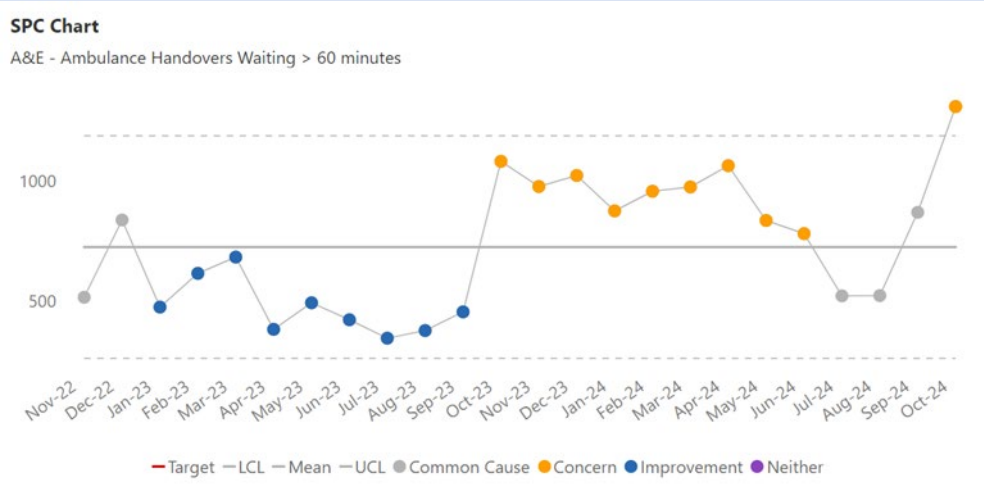


Key Themes

- Acute footprint delivery of 76.3% against a plan of 73%
- Breaking the plan/delivery into constituent parts:
  - Type 1 compliance was 51.2% versus plan of 56.2%.
  - Type 3 co-located activity compliance of 21.2% versus plan of 16.8%
  - Non co-located compliance was 2.5% versus plan of 3.0%

28. Ambulance Handovers >60 minutes - HUTH

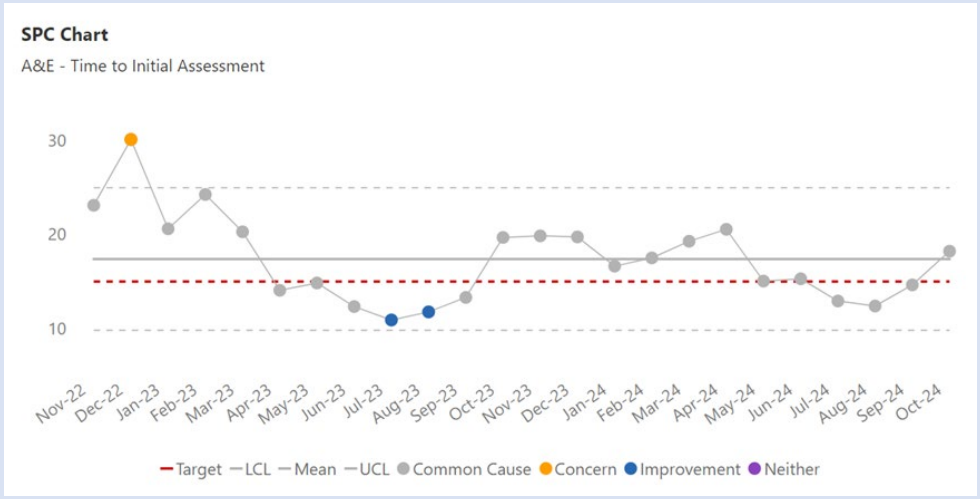
Compliance



Key Themes

- Month on month reduction in the number of ambulance handovers >60 minutes from Feb to August as part of recovery programme, however, notable deterioration at HUTH in September (869) and October (1,311).
- Root cause of handover delays linked to patient volumes in A&E which increased sharply in October, resulting in compression of available assessment spaces.
- Pressure on staffing levels that cover all elements of ED has increased due to an increase in non-admitted activity seen via ECA/ED. Action plan being progressed to align capacity and demand within ED establishment.

Critical Enabler

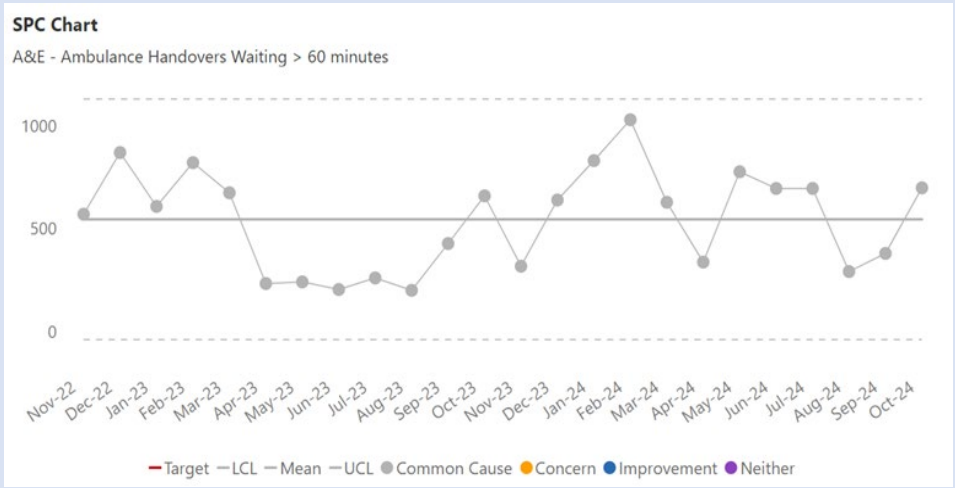


Actions

- Time to initial assessment in October was 18 minutes, a slight deterioration in performance compared to previous months
- Triggers and Escalation/SOP for ambulance handovers is being reviewed and adapted linked to national OPEL system, enabling 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

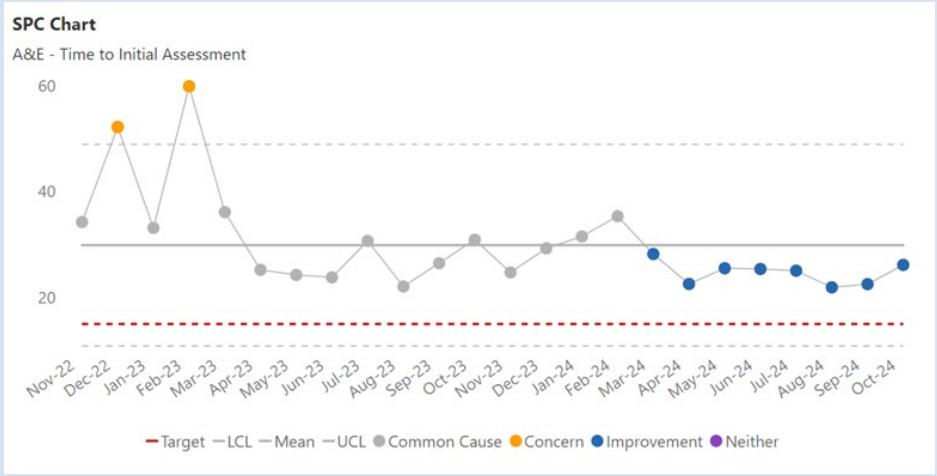
Compliance



Key Themes

- Performance in ambulance handovers >60 minutes increased marginally to 380 mins in September and to 698 in October, but remains within the normal operating range
- Time to initial assessment in October was 26 minutes against target of 15 minutes, a slight deterioration on the previous month

Critical Enabler



Actions

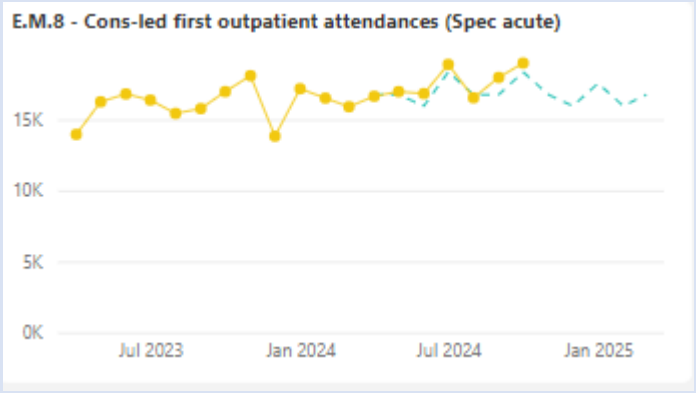
- Rapid Assessment and Treatment (RAT) model to be embedded to reduce waiting time to be seen.
- Audit of current practices planned to ensure handover principles are being adhered to. Working toward zero tolerance of >45-minute handover, aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.
- Improvement of flow/ LOS through Discharge rounds in wards will reduce congestion.
- Impact and timelines for recovery programme being finalised with system partners.

30. Activity

HUTH

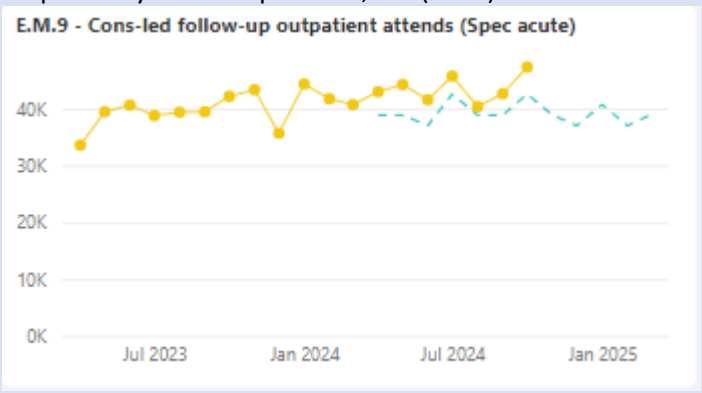
New Outpatient Attendances vs Plan

YTD New consultant-led activity is above plan at +3,131 (2.6%).



Follow up Outpatient Attendances vs Plan

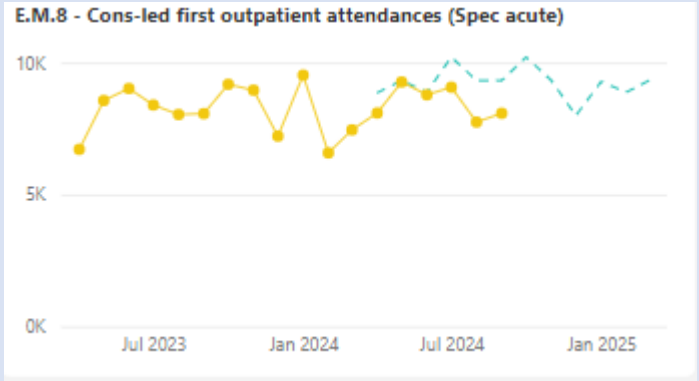
YTD Follow up activity is above plan +27,215 (9.8%).



NLAG (data shown to Month 6)

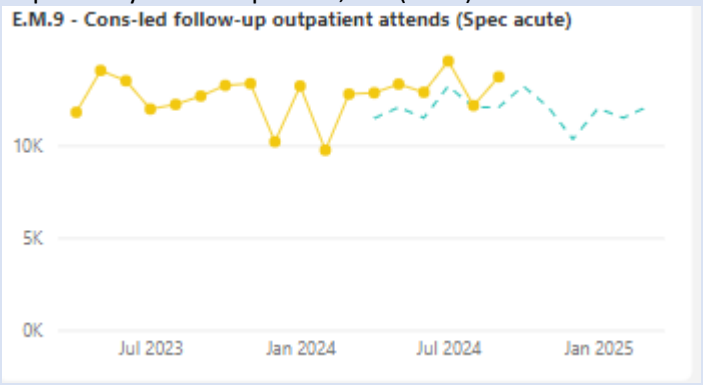
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -4,881 (8.7%).



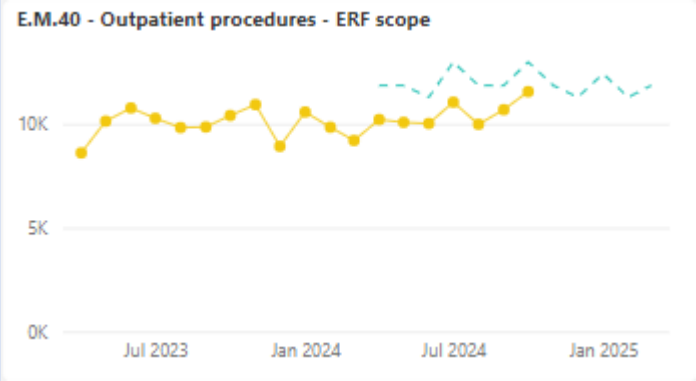
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is above plan +7,117 (9.8%).



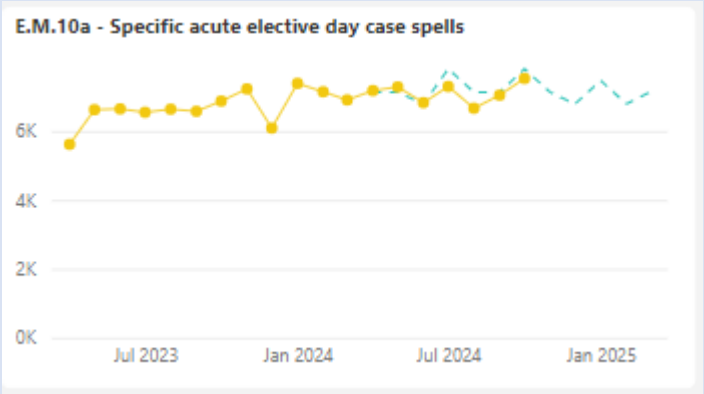
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -11,063 (13.1%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



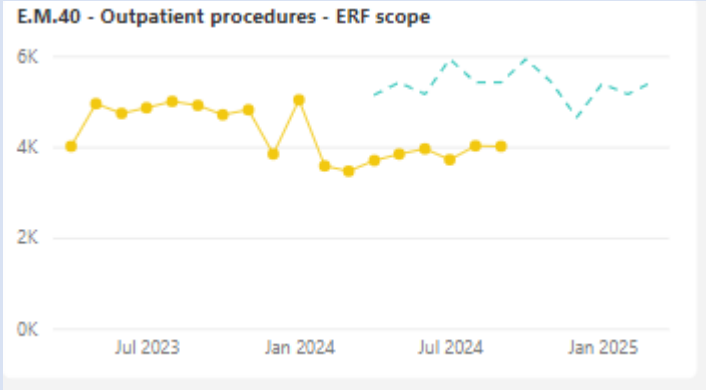
Day Case Admissions vs Plan

YTD Day case elective spells is below plan at -1,096 (2.2%).



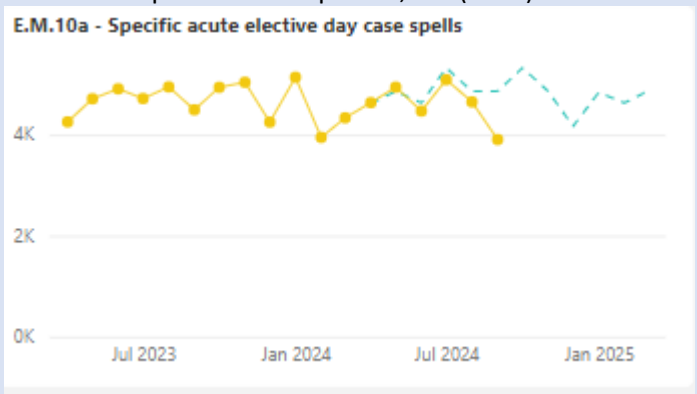
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -9,239 (28.5%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



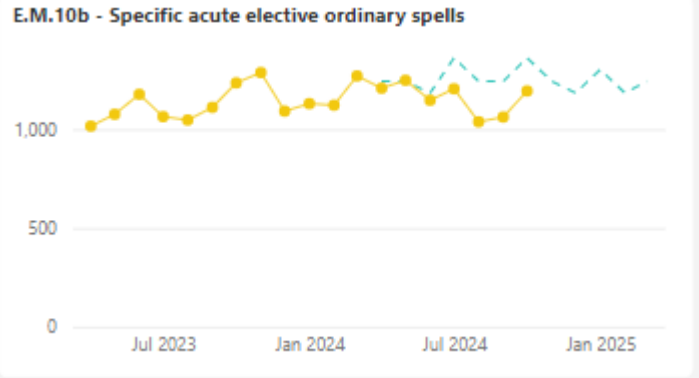
Day Case Admissions vs Plan

YTD Day case elective spells is below plan -1,460 (5.0%).



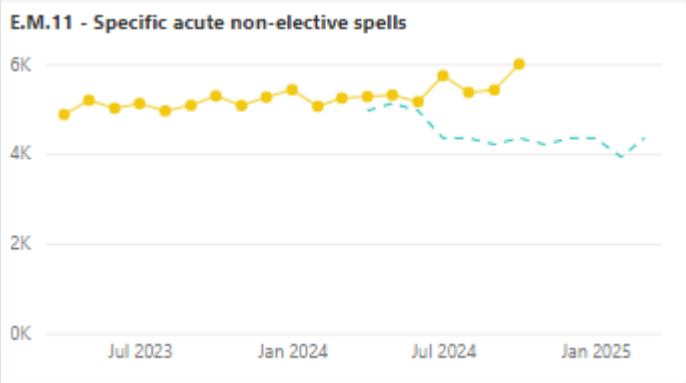
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -776 (8.7%).



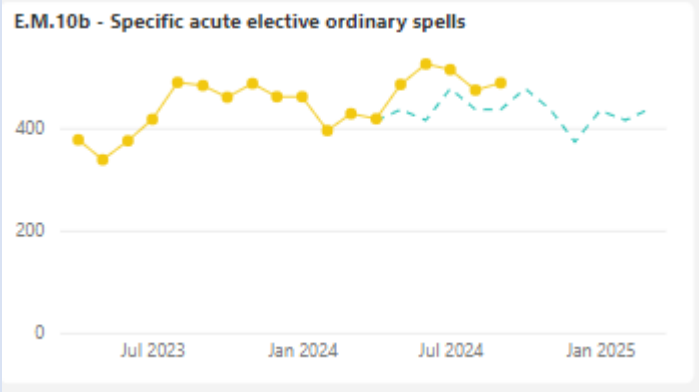
Non-Elective Admissions vs Plan

YTD non-elective spells +5,968 (18.5%) over plan.



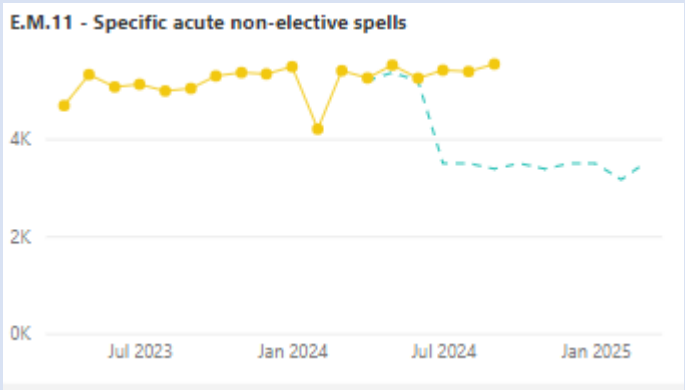
Elective Admissions vs Plan

YTD Inpatient spells is above plan +290 (11.1%), however data is subject to further evaluation of correct operational recording of intended management (Daycase versus zero LOS inpatient). A recent audit has evidenced this to be a recording issue.



Non-Elective Admissions vs Plan

Non-elective spells above plan YTD +6,223 (23.8%).



31. Elective Recovery Fund - HUTH

Hull University Teaching Hospitals	ERF Performance (%)							
	Apr	May	Jun	Jul	Aug	Sept	Oct	YTD
DAYCASE	115%	119%	118%	105%	102%	117%	114%	113%
ELECTIVE	107%	109%	104%	93%	97%	94%	93%	99%
OP FIRST ATTENDANCE	112%	116%	117%	116%	107%	118%	121%	115%
OP FIRST PROCEDURE	118%	114%	121%	117%	117%	128%	115%	119%
OP F/UP PROCEDURE	160%	158%	163%	152%	156%	163%	170%	160%
Total	**113%**	**116%**	**115%**	**105%**	**104%**	**111%**	**110%**	**111%**

Notes

This data is an early pull of data and as such this is not fully coded and may omit clinics/discharges that were cashed up late.

32. Elective Recovery Fund - NLAG

Northern Lincolnshire & Goole Hospitals	ERF Performance (%)							
	Apr	May	Jun	Jul	Aug	Sept	Oct	YTD
DAYCASE	115%	117%	115%	114%	113%	106%	108%	112%
ELECTIVE	97%	104%	122%	104%	108%	109%	104%	107%
OP FIRST ATTENDANCE	97%	112%	115%	102%	91%	97%	99%	102%
OP FIRST PROCEDURE	90%	96%	95%	84%	96%	90%	90%	91%
OP F/UP PROCEDURE	68%	66%	76%	66%	72%	76%	82%	72%
Total	**101%**	**108%**	**113%**	**103%**	**103%**	**102%**	**102%**	**104%**

Notes

This data is an early pull of data and as such is not fully coded and may omit some clinics/discharges that were cashed up late.

This data is from the new Insource Data Warehouse and contains some known DQ errors.

This data will not fully match to the SUS national position, as this the SUS position is being generated through the old Data Warehouse to avoid the known errors.

Known errors are:

- Length of stay is overstated where a second or subsequent critical care stay exists, this may overstate excess bed-day value.
- Nurse led activity is being treated as Consultant led due to some errors in clinic set up in implementation. A call has being logged to get this addressed.

NHS
Hull University Teaching Hospitals
NHS Trust

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NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: 4.6

Name of the Meeting	Quality and Safety Committees-in-Common
Date of the Meeting	28 November 20204
Director Lead	Amanda Stanford, Group Chief Nurse Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Rob Chidlow, Interim Group Director of Quality Governance Michela Littlewood, Associate Director of Quality Richard Dickinson, Associate Director of Quality Governance
Title of the Report	**Integrated Performance Report (IPR): quality and safety metrics**
Executive Summary	The data provided is a product of key parts of the national outcomes framework and available data that can be reported on across both Trusts. The report provides key highlights and lowlights for each organisations quality performance. Key areas to draw attention to are: • Production of the report is challenged by information issues with PAS migration issues for NLAG impacting on reporting of some datasets, including bed-days, HSMR and links to previous Power BI datasets • The Group position for Quality Metrics subset of the IPR is in development with weekly check-in sessions with Quality Governance and Information representatives to maintain focus. • The HUTH SHMI continues to be “higher than expected” but there has been further improvement in Fracture Neck of Femur (FNOF) which is now categorised “as expected”. • NLAG IPC rates are above trajectory for C.difficile, P.aeruginosa Klebsiella and E Coli. The Committee is invited review the content and determine their assessment of assurance of improvements being made and management of issues identified.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial implication(s) (if applicable)	None specifically
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None specifically
Recommended action(s) required	☐ Approval ☐ Discussion ☑Assurance ☐Information ☐ Review ☐ Other – please detail below:

Quality Performance Metrics

NHS
Humber Health Partnership

October 2024

United By Compassion: Driving For Excellence

Highlights and Lowlights

NHS Humber Health Partnership

The IPR is under development with the Information Team, building a refreshed reporting tool for the Group. Some of the content from the IPR is provided where it is available. Other data sources are used from legacy Trust systems and externally reported datasets.

	HUTH	NLAG
Highlights	• HSMR has reduced, although higher than average. • Bateraemia rates for E.coli, Pseudomona and Klebsialla remain below trajectory.	• SHMI value is 0.97, below the 1.00 national average, continuing improved performance seen over recent months. • HSMR rate is 89 for the rolling 12 months, below the 100 national average. • FFT rates for Inpatient, Maternity and Outpatients remain above the national target

Lowlights	• Duty of candour compliance is lower than target and undergoing a change in process to ensure compliance with Regulation 20.
	• After a period of month on month improvement, the A&E Friends and Family test reduced by 13% in September, reflecting the pressures on waiting times in the HUTH ED.
	• HUTH is identified as having a 'higher than expected' SHMI, with an overall SHMI of 1.1536. The HHP Mortality Improvement group is targeting areas for improvement, including those diagnosis groups where SHMI is "higher than expected":
	  • Secondary malignancies
	  • Septicaemia
	• VTE data remains below the 95% target.
	• IPC, C.Difficile rate is over the target for the year.
	• There was one MRSA bacteraemia case in October, making 5 in the year to date against a zero target.
	• Patient complaint rate of completion within timescales remains below target consistently.
		• Residual issues to resolve the medical beds, trolleys and equipment entrapment or falls reduction Patient Safety Alert are progressing with collation of evidence to assure closure of the alert actions.
		• VTE data validation and reporting capture being pursued following change to capture from ePMA, since Lorenzo implementation.
		• IPCC C.difficile rate is higher than trajectory target for the year.
		• IPCC P.aeruginosa is higher than the trajectory target for the year.
		• Infection rates are above trajectory targets for Klebsiella and E Coli.

Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | Data Table | Metadata | Spotlight (BETA)

Metric Group: All

Trust | Group

Hull University Teaching Hospitals NHS Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Complaints - 40 day compliance	Oct-24	90.0%	25.0%	Common Cause
Complaints - 60 day compliance	Oct-24	90.0%	47.2%	Common Cause
Complaints - PALS	Oct-24		201	Common Cause
Complaints - Received	Oct-24		49	Common Cause
Complaints - Received (per 1,000 bed days)	Oct-24		1.57	Common Cause
Complaints - Reopened	Oct-24		6	Common Cause
Falls - per 1,000 bed days	Oct-24		7.82	Improvement (Lo...
Friends & Family - A&E Score	Sep-24	85.0%	67.7%	Common Cause
Friends & Family - Inpatient Score	Sep-24	95.0%	91.5%	Improvement (Hi...
Friends & Family - Maternity Score	Sep-24	95.0%	100.0%	Improvement (Hi...
Friends & Family - Outpatient Score	Sep-24	95.0%	94.7%	Improvement (Hi...
Infections - C.Difficile	Sep-24		8	Concern (High)
Infections - C.Difficile (per 1,000 bed days)	Sep-24		0.32	Concern (High)
Infections - E.Coli	Sep-24		8	Common Cause
Infections - E.Coli (per 1,000 bed days)	Sep-24		0.30	Common Cause
Infections - Klebsiella	Sep-24		1	Common Cause
Infections - Klebsiella bacteraemia (per 1,00...	Sep-24		1.00	Common Cause
Infections - MRSA	Sep-24		0	Common Cause
Infections - MRSA (per 1,000 bed days)	Sep-24		0.00	Common Cause
Infections - MSSA	Sep-24		6	Common Cause
Infections - MSSA (per 1,000 bed days)	Sep-24		5.00	Common Cause
Infections - Pseudomonas aeruginosa	Sep-24		1	Common Cause

Northern Lincolnshire and Goole NHS Foundation Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Complaints - 40 day compliance	Oct-24	90.0%	41.9%	Common Ca
Complaints - 60 day compliance	Oct-24	90.0%	77.4%	Common Ca
Complaints - PALS	Oct-24		277	Common Ca
Complaints - Received	Oct-24		31	Common Ca
Complaints - Received (per 1,000 bed days)	Oct-24		16.27	Common Ca
Complaints - Reopened	Oct-24		5	Common Ca
Friends & Family - A&E Score	Sep-24	85.0%	81.7%	Common Ca
Friends & Family - Community Score	Sep-24	95.0%	95.6%	Common Ca
Friends & Family - Inpatient Score	Sep-24	95.0%	96.8%	Improvemen
Friends & Family - Maternity Score	Sep-24	95.0%	100.0%	Improvemen
Friends & Family - Outpatient Score	Sep-24	95.0%	97.0%	Common Ca
Infections - C.Difficile	Sep-24		0	Common Ca
Infections - C.Difficile (per 1,000 bed days)	Sep-24		0.00	Common Ca
Infections - E.Coli	Sep-24		8	Common Ca
Infections - E.Coli (per 1,000 bed days)	Sep-24		0.44	Common Ca
Infections - Klebsiella	Sep-24		4	Common Ca
Infections - Klebsiella bacteraemia (per 1,00...	Sep-24		4.00	Common Ca
Infections - MRSA	Sep-24		0	Common Ca
Infections - MRSA (per 1,000 bed days)	Sep-24		0.00	Common Ca
Infections - MSSA (per 1,000 bed days)	Sep-24		1.00	Common Ca
Infections - Pseudomonas aeruginosa bacter...	Sep-24		1.00	Common Ca
Mortality - HSMR	May-24	100	92.3	Improvemen

Hull University Teaching Hospitals NHS Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Mortality - HSMR	Jul-24	100	105.0	Improvement (Lo...
Mortality - SHMI	May-24	1	1.153	Concern (High)
Never Events	Oct-24		0	Common Cause
Pressure Ulcers - Category 1	Oct-24		9	Common Cause
Pressure Ulcers - Category 2	Oct-24		38	Common Cause
Pressure Ulcers - Category 3	Oct-24		0	Common Cause
Pressure Ulcers - Category 4	Oct-24		0	Common Cause
Pressure Ulcers - Device related	Oct-24		15	Common Cause
Pressure Ulcers - Hospital acquired	Oct-24		73	Concern (High)
Pressure Ulcers - Suspected deep tissue injury	Oct-24		23	Common Cause
Pressure Ulcers - Total community acquired	Oct-24		397	Concern (High)
Pressure Ulcers - Unstageable	Oct-24		3	Common Cause
VTE risk assessment	Sep-24	95.0%	92.7%	Improvement (Hi...

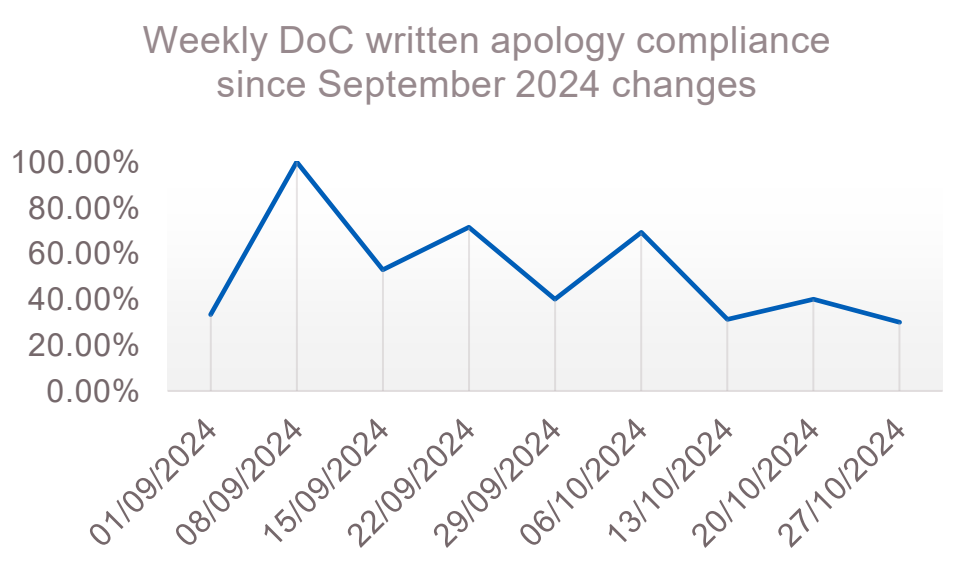
Northern Lincolnshire and Goole NHS Foundation Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Mortality - HSMR	May-24	100	92.3	Improvement (Lo...
Mortality - SHMI	Mar-24	1	0.990	Improvement (Lo...
Never Events	Sep-24		0	Common Cause
Pressure Ulcers - Category 1	Sep-24		8	Common Cause
Pressure Ulcers - Category 2	Sep-24		51	Common Cause
Pressure Ulcers - Category 3	Sep-24		2	Common Cause
Pressure Ulcers - Category 4	Sep-24		1	Concern (High)
Pressure Ulcers - Device related	Sep-24		12	Common Cause
Pressure Ulcers - Hospital acquired	Sep-24		88	Common Cause
Pressure Ulcers - Suspected deep tissue injury	Sep-24		24	Improvement (Lo...
Pressure Ulcers - Total community acquired	Sep-24		80	Common Cause
Pressure Ulcers - Unstageable	Sep-24		2	Common Cause
VTE risk assessment	Oct-24	95.0%	91.1%	Common Cause

- The development of the national reporting quality metrics has progressed with more of the metrics now available for the HUTH sites, and the expansion of this is ongoing. The above view reflects a snapshot of those metrics that are commonly presented for the Group on the IPR tool. Other metrics such as Duty of Candour are locally available and in process of being uploaded to IPR for both Trusts.
- There are still some challenges with drill down into care group splits across both Trusts.
- Weekly touch points between the Interim Group Director of Quality Governance and Information team continue.
- Some data refresh periods vary and depending on the source of data feed to the dashboards may be updated between production of this report.
- IPC metrics are annual target focused, so will need reporting on cumulative trajectory rate for the year to date.
- A key focus is to incorporate the metrics underpinning the Group's 2024/25 Quality Priorities, in addition to key metrics for Maternity.

Duty of Candour

HUTH



Key themes

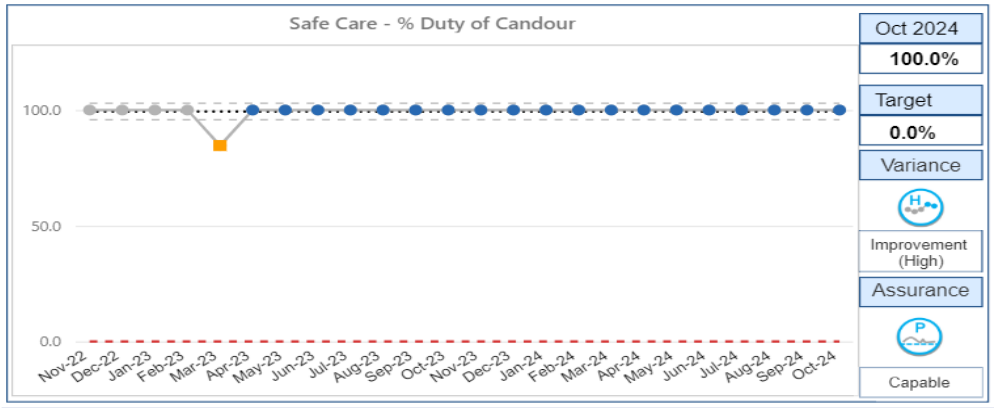
Alignment of monitoring and reporting processes across the Group continues. A number of immediate measures have been effective from 20 September 2024 at HUTH to reflect the policy amendments to fully comply with written duty of candour requirements under Regulation 20.

Weekly rates utilised as part of enhanced monitoring are shown with an increase seen from the 2nd week of September 2024 onwards, although more recent incidents see a lag in demonstrated completion, with improvement seen gradually each week.

Education and engagement activities from the Patient Safety Team have helped some staff understand the changes needed in processes.

Review of actual harm caused, including individual patient impact is being promoted, rather than a blanket harm for an incident category, such as pressure ulcer healing and recovery projections. Data is being circulated weekly to support measures to achieve full compliance, with the BI finalising the revised metric definitions to go live from 1 December 2024.

NLAG



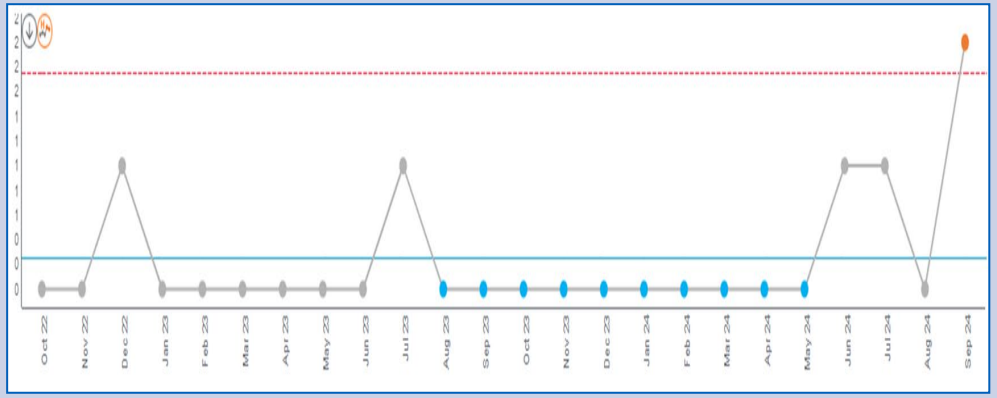
Key themes

100% for October 2024 for the proportional investigation and PSII/SI casework.

The overall compliance for NLAG in September was 82% (32/39) completion with follow up of 7 cases in progress. Follow-up feedback on investigations was 100%. Reporting through BI is being standardised.

Never Events

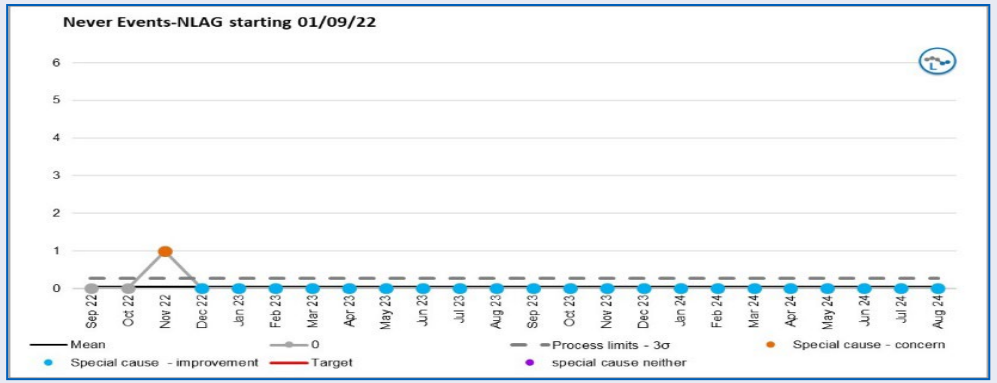
HUTH



Key themes

- The Trust has reported 4 Never Events in 2024/25 to date (1 April 2024 to 30 September 2024). The Trust had previously reduced the number of never events to 1 in 2023/24, following 7 in 2022/23.
- There have been two never events declared in September 2024, following previous declarations in June and July 2024.
- NE case 1 – Laterality error - incorrect femoral component was used, recognised after iatrogenic injury in theatre. Delayed recovery as a consequence.
- NE case 2 - Retained swab post caesarean section, requiring return to theatre when developed pain and some deterioration, following CT scan identification. Good recovery once removed.

NLAG



Key themes

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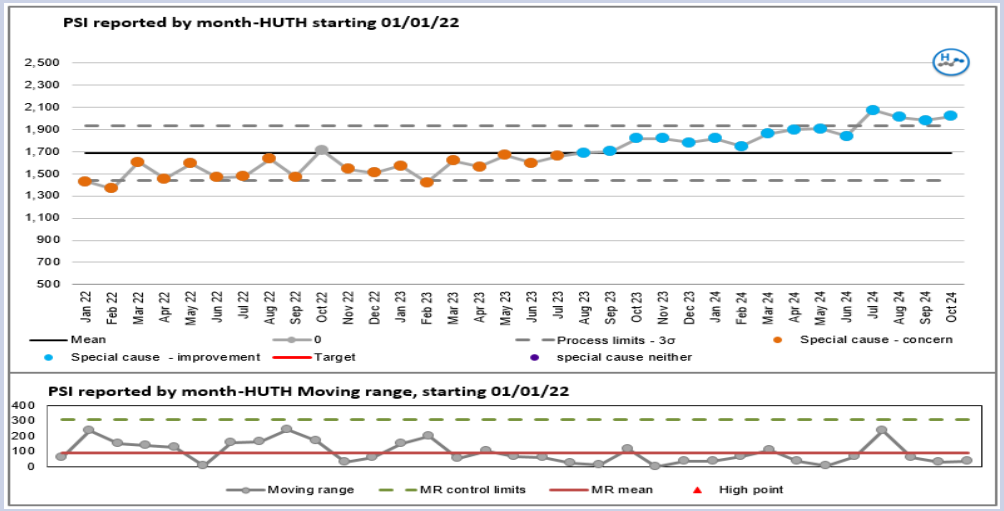
- The Trust has had a Never Events in October 2024, Retained Guidewire following CVP Line insertion. No harm identified, with thorough clinical review and assessment. Investigation underway as PSII.
- Review with the service and Deputy CMO undertaken to assess immediate actions and risk.

Patient Safety Incident (PSI) reporting

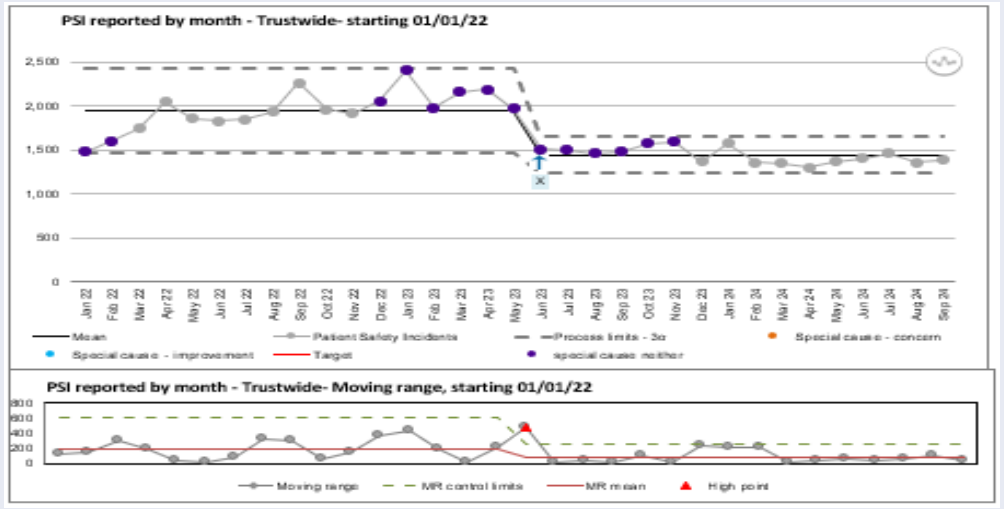
HUTH



Key themes

- The rate of patient safety incident reporting has risen over time, following the CQC report publication, action planning that followed and subsequent developments of the group arrangement.
- Reporting incidents, including no harm and near misses is a property of the safety culture and so the intent is to continue promoting incident reporting.
- Benchmarking data is limited currently due to NRLS changes to LFPSE and the transition period.

NLAG

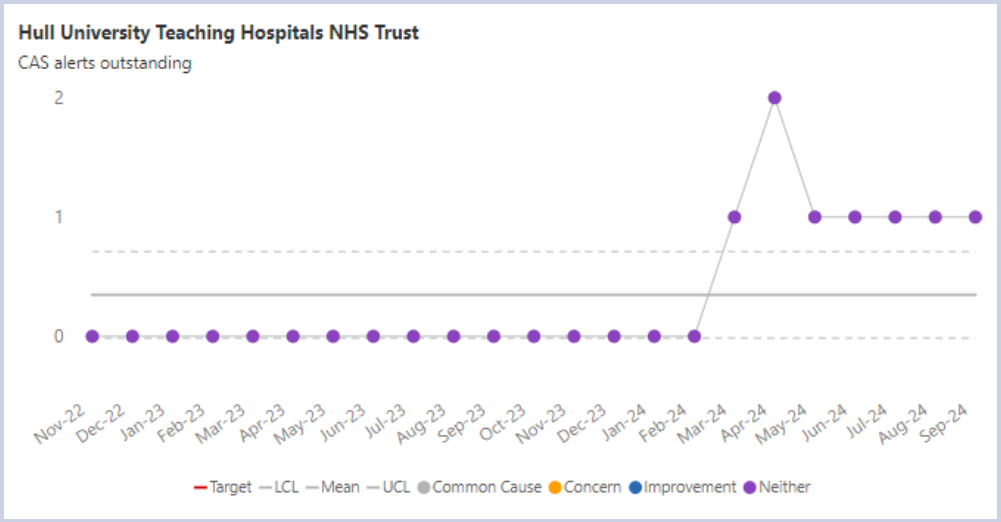


Key themes

- The chart illustrates historical step changes when ED 12 hour waits were changed to cumulative daily reports rather than individual patient reports. Subsequently this has moved to capture only patients where harm is identified, with DTA delays reported though other methods.
- Reporting incidents, including no harm and near misses is a property of the safety culture and so the intent is to continue promoting incident reporting.
- Direct comparison methods are being explored to enable effective benchmarking.

Patient Safety Alerts

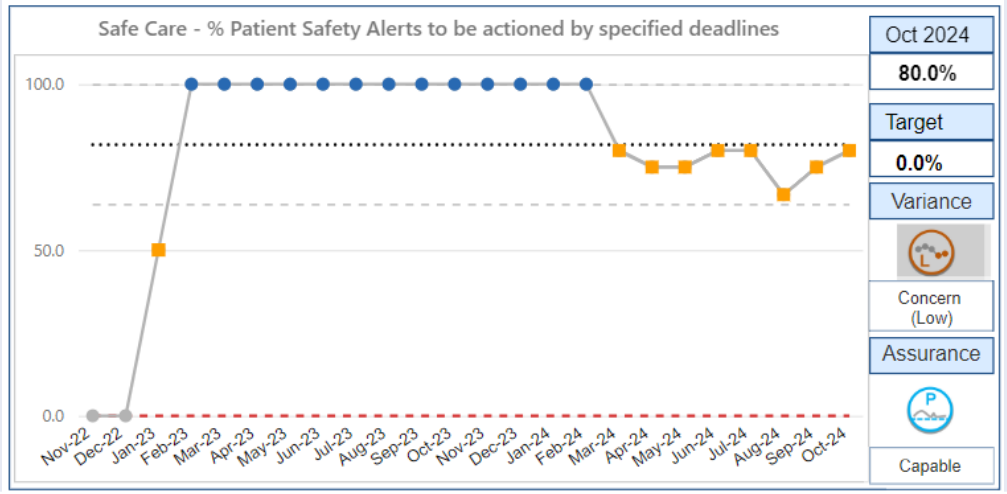
HUTH



Key themes

The one Patient Safety Alert that remains open is in relation to Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts. The ICB have stood down their working group and issued a letter advising on the locally agreed approach. HUTH/ NLAG meeting monthly to progress.
Policy work is positioned to take forward with input from Paediatric and Maternity teams to complete and enable implementation across the Trust,

NLAG

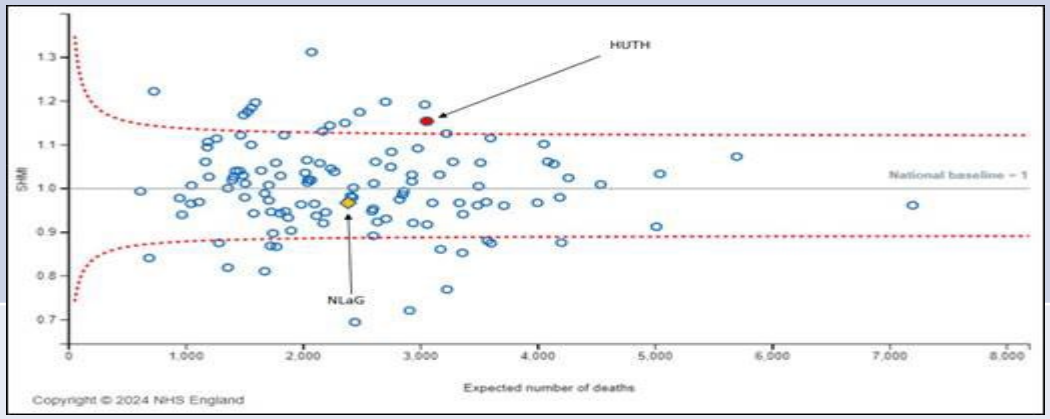


Key themes

The one Patient Safety Alert that remains open is in relation to Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts. The ICB have stood down their working group and issued a letter advising on the locally agreed approach. HUTH/ NLAG meeting monthly to progress.
NLAG is collating evidence to agree for closure.

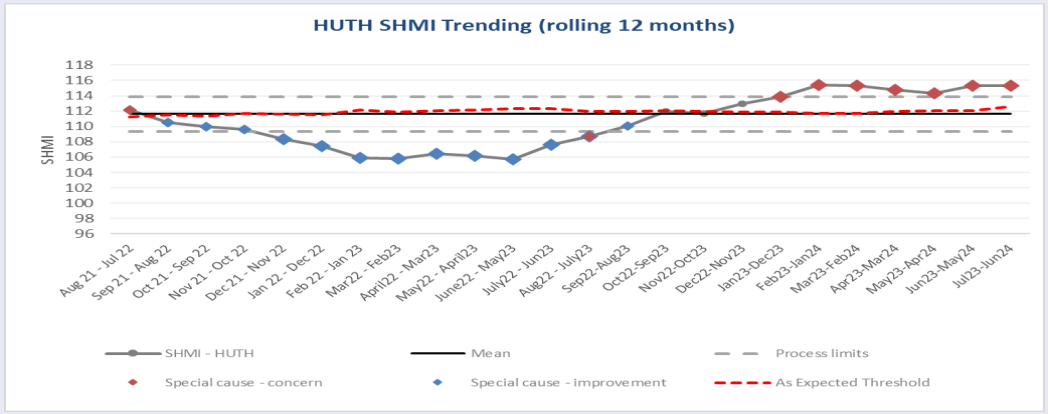
Mortality - SHMI

Benchmark



SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings.
The latest SHMI values for each site are:
Castle Hill – 1.3452; 'higher than expected' (previously 1.3490 and 'higher than expected')
Hull – 1.0987; 'as expected' (previously 1.0971 and 'as expected')
Grimsby – 0.9296; 'as expected' (previously 0.9563 and 'as expected')
Scunthorpe – 1.0010; 'as expected' (previously 1.0201 and 'as expected')
Goole – insufficient activity for SHMI to be calculated

HUTH



Key themes

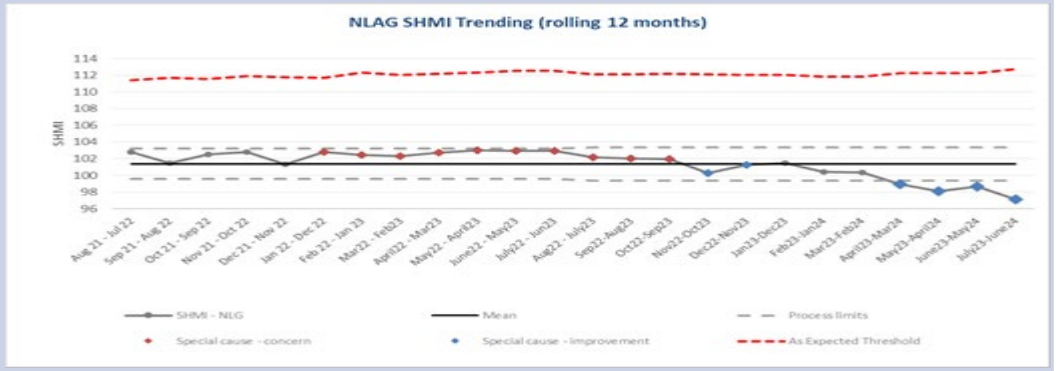
HUTH identified as having a 'higher than expected' SHMI, with an overall SHMI of 1.1536. This is higher than last month's value of 1.1529 and is in the 'higher than expected' banding. There are nine Trusts with a higher SHMI Score than HUTH (out of 119 Trusts).

For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher than expected SHMI for:

- Secondary malignancies - most recently 1.38 to June 2024. Detailed work has been undertaken and presented to Mortality Improvement Group in respect of pathway changes and recording of admissions at the Queen's Centre (which impacted on the denominator). It is anticipated that the corrections to recording from July 2024 will be reflected in the data published for that period from Dec 24.
- Septicaemia - most recently 1.31 to June 2024 which reflects significant reduction since 2021 but remains one of the Group's quality priorities for 2024/25 and workstreams have been cascaded to reinforce progress.

Within month, Fracture Neck of Femur has reduced to a SHMI of 1.28, down from 1.7 in November 2023 and is now "as expected". A detailed action plan is in place to address further opportunities identified for improvement.

NLAG

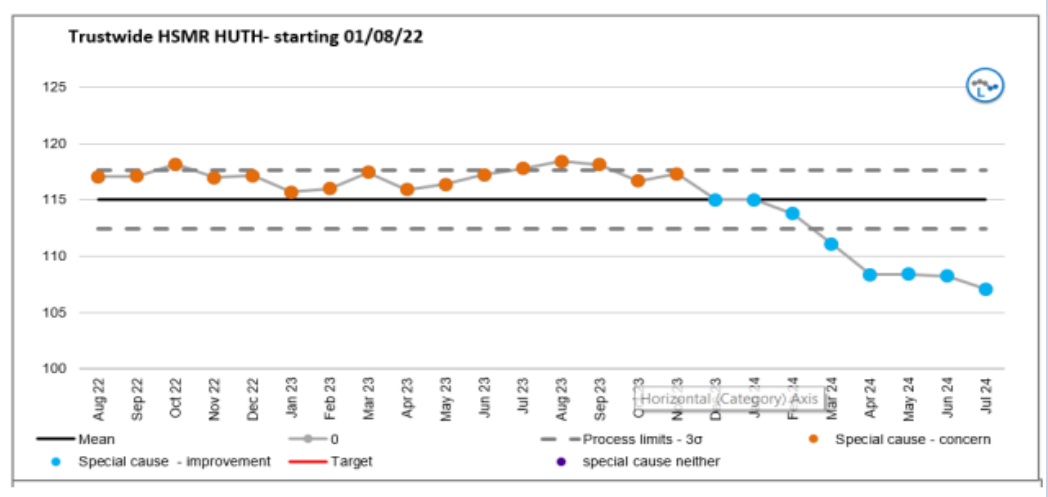


Key themes

NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of **0.9714**. This is lower than last month's value of 0.9870.
All diagnosis group specific SHMI values are 'as expected'.

Mortality - HSMR

HUTH

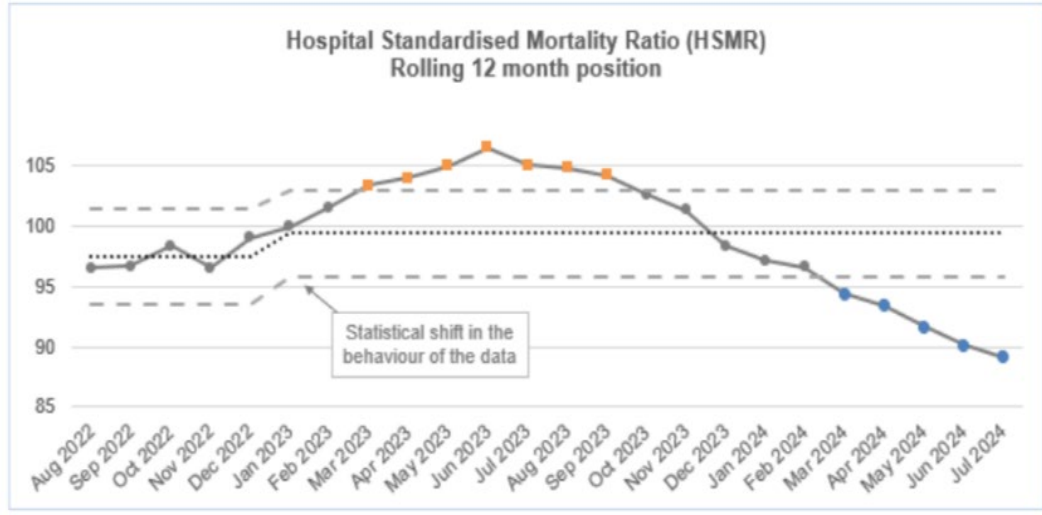


HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

Key themes

The latest HSMR data available is July 2024, with a 12 month rolling value of 107.09. There has been statistically significant improvement with the past 6 points below the mean and the latest 5 points also below the lower control limit.

NLAG

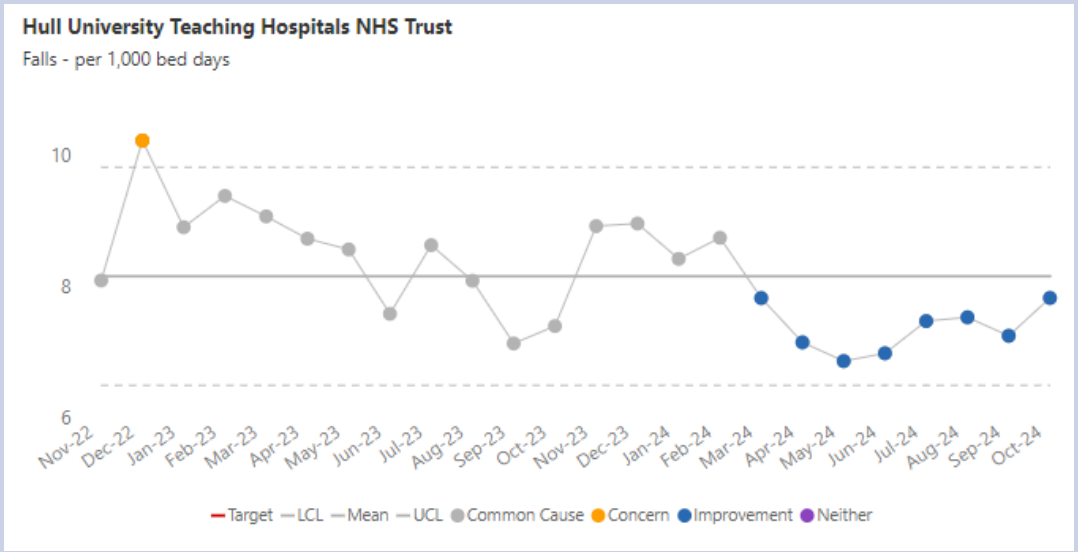


Key themes

The latest HSMR data available is July 2024, with a 12-month rolling value of 89.15. There has been a statistically significant improvement with successive reduction in the HSMR over the past thirteen months.

Falls

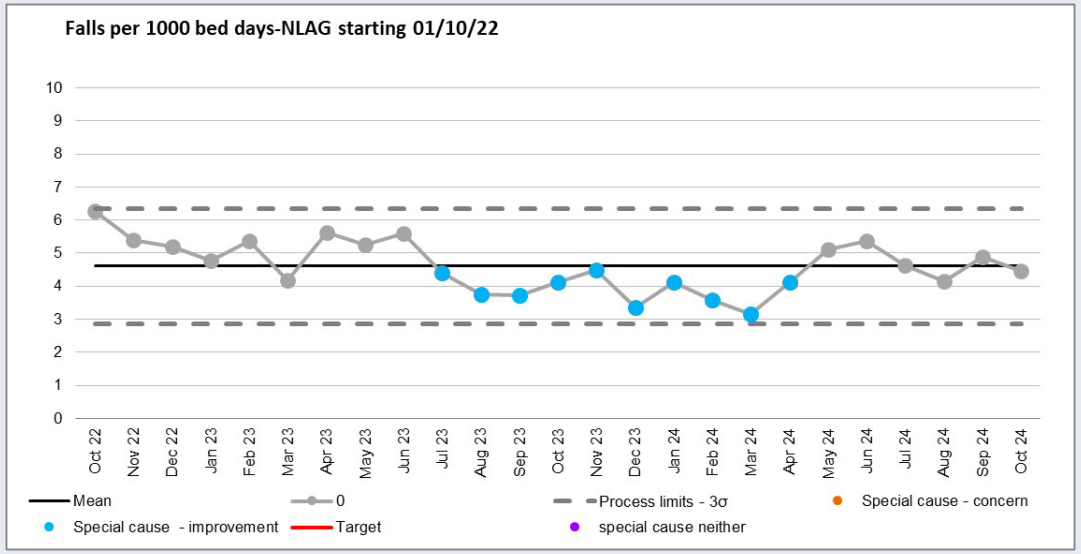
HUTH



Key themes

HUTH – The Falls Improvement Programme has been successful in driving a reduction in the number of falls across the Trust, through the appointment of key leads, focus on risk assessments and environment and learning from incidents.

NLAG

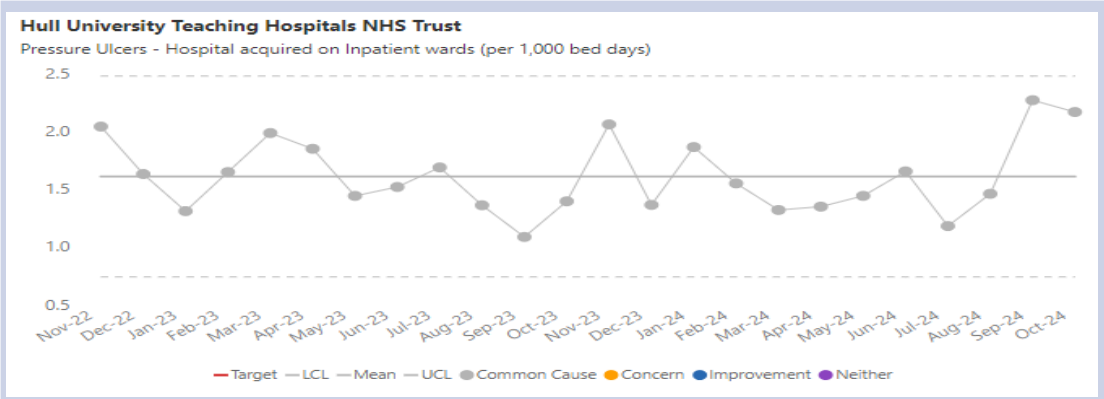


Key themes

NLAG Falls rate data shows common cause variation following a reduction in rate evident from July 2023. Repeated fall cases are reviewed by Matrons and Swarm huddles are used to review care provision. A strategic action plan is in place. Note: the rate is all falls regardless of harm caused.

Pressure Ulcers

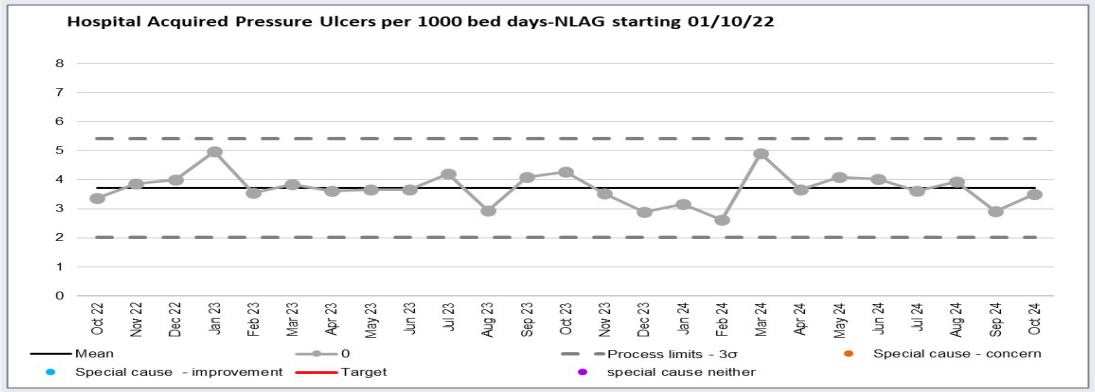
HUTH

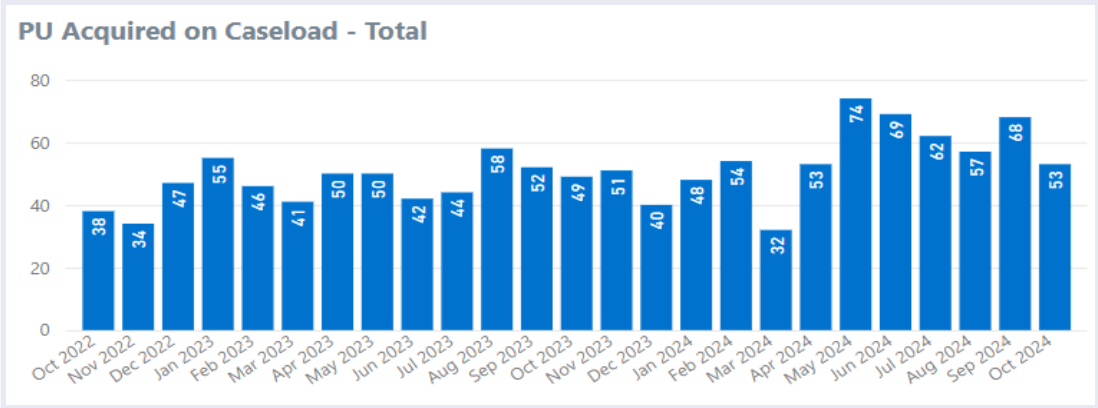


Key themes

- There is normal variation seen in the rate per 1000 bed days

NLAG





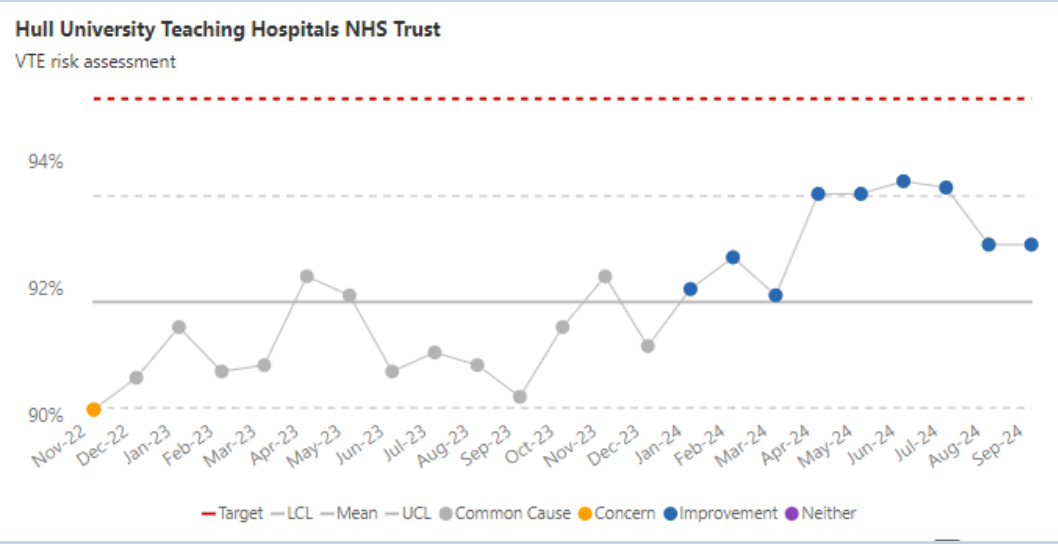
Key themes

NLAG – The top chart is hospital data. Pressure ulcer rate demonstrates normal variation.

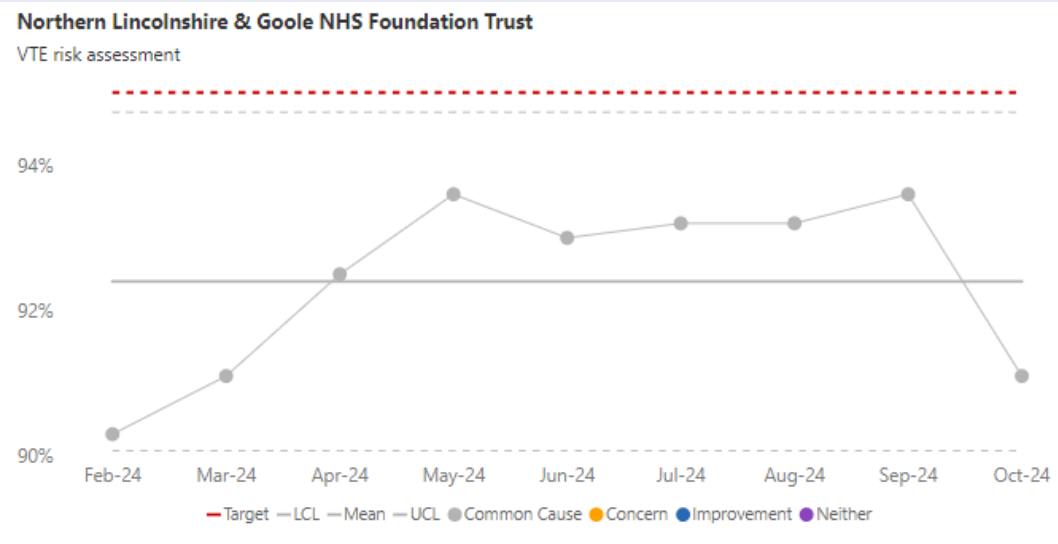
North Lincolnshire Community - The bar chart illustrates the data. Development to use SPC is being explored.

VTE Risk assessment rate

HUTH



NLAG



Key themes

In 2024/25, VTE support has been provided by the Quality Improvement team targeted at HUTH to roll out a series of improvement actions previously put in place at NLAG. Pilot wards were agreed in March 2024, working with digital nurse team some areas of non-compliance to target further improvement.

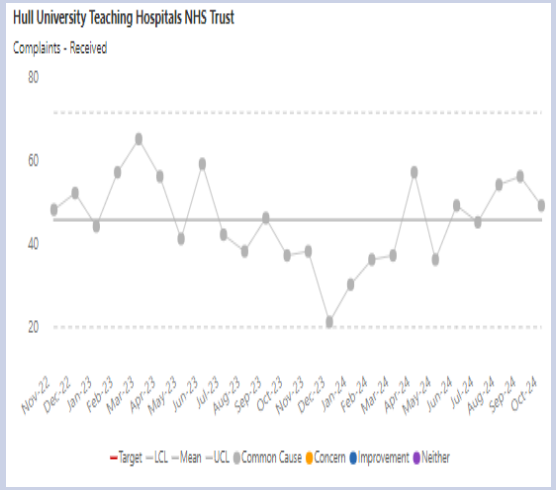
During the year, the support has reverted to a Group focus on the basis of:

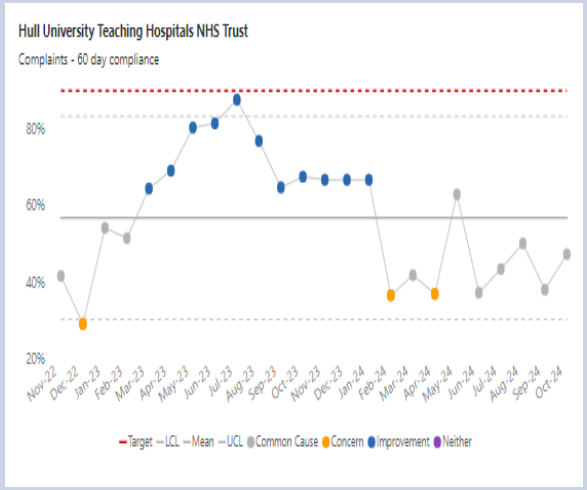
- The NLAG Lorenzo implementation resulted in a period where data was received less timely and resulted in some resource changes. For example, ePMA became the main source of VTE assessment capture rather than Webv.
- During the year the national collection of VTE data (on a quarterly basis) has been re-established. This guidance is clear that providers should submit data reflecting the % of assessments completed within 14 hours of admission, recognising this is the specified time to start pharmacological thromboprophyxlasis should the assessment reflect this. It is important to note that the data reported in the IPR remains total assessments. The BI team are completing their work to align both HUTH and NLAG reporting to reflect compliance with VTE risks assessments within 14 hours (and then 24 hours) of admission in line with guidance.

The revised data definition (reflecting cohorts pending Medical Director ratification) will be reflected in the December 2024 IPR.

Patient Experience: Complaints – received and compliance with KPIs

HUTH

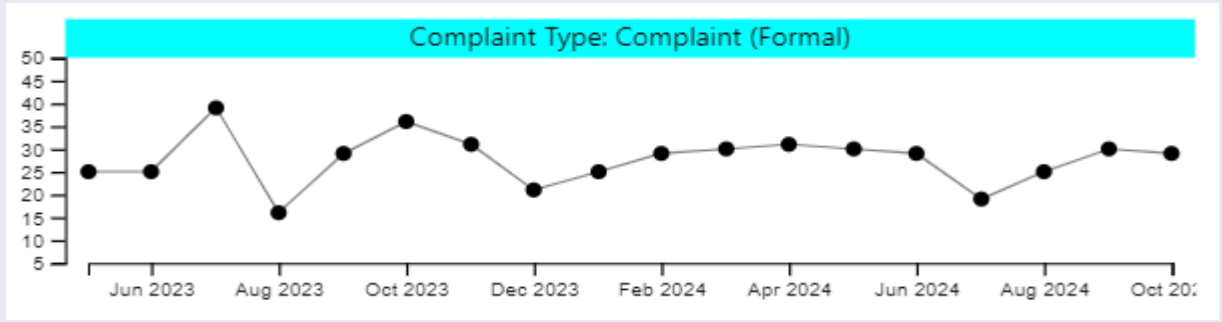


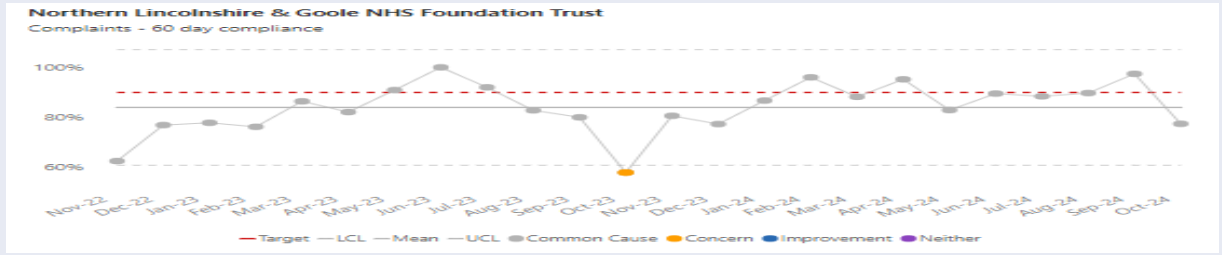


Key themes

- 49 complaints were received in October 2024. Completion rates remain below the 60 day target, which is driven by the recovery of a backlog of complaints. The Trust recovered a backlog from the covid period prior to Group Collaboration, but changing roles in care groups led to a small decline in position as new leadership teams assumed responsibilities. At the end of October there were 39 complaints outstanding more than 60 days, a reduction from September 2024 (43).
- The focused closure of those aged complaints therefore impacts this metric, but a trajectory is in place with escalation to Site Nurse Directors to resolve remaining aged complaints on the HUTH site.
- It should be noted that although HUTH achieved high compliance rates in 2023, the quicker sign off was at the cost of quality. The Group Chief Executive sign off and additional quality checking has reduced the number of follow up complaints from c12 (20%) a month in Summer 2023.

NLAG



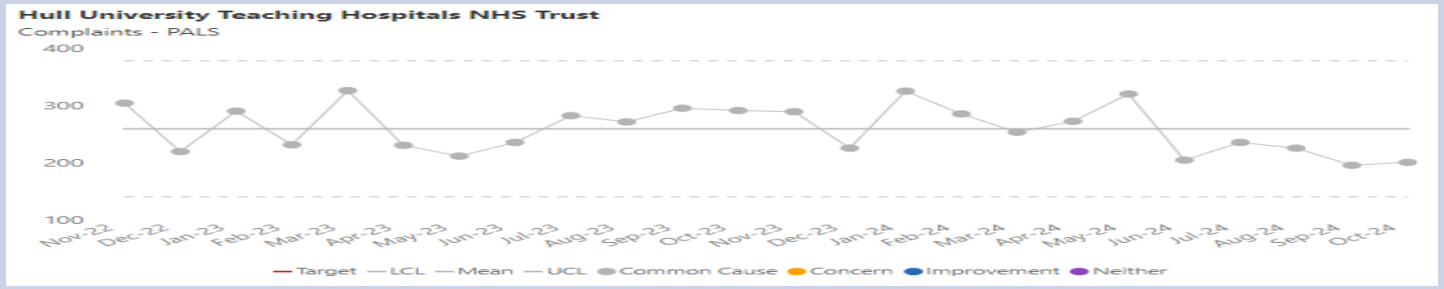


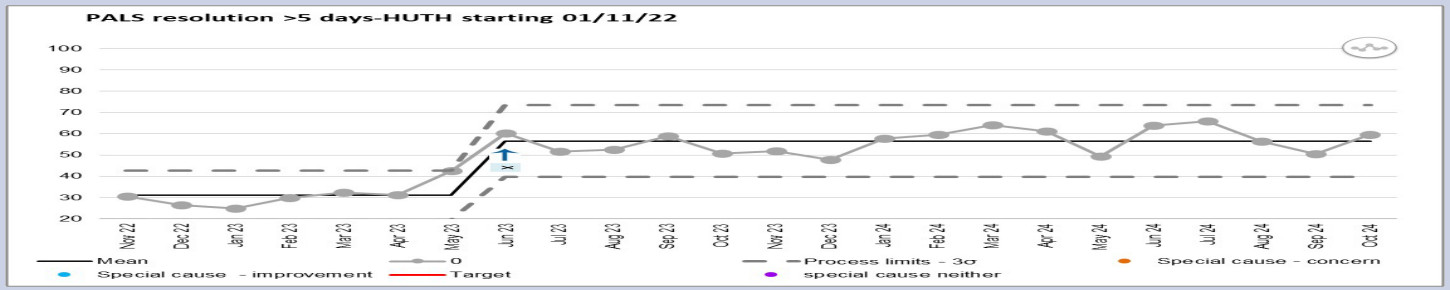
Key themes

- 31 complaints were received in October 2024 and through a new Information Services SPC tool, this shows normal variation.
- Completion performance dipped in October 2024 due to staff sickness and cover across the Group.
- The Group will collectively adopt a 40 day target from April 2025 as part of improvement initiatives. Staff across the Group have been aligned to care groups, with established meetings now in place and the roll out of the NLAG letters now in progress.

PALS – received and compliance with KPIs

HUTH

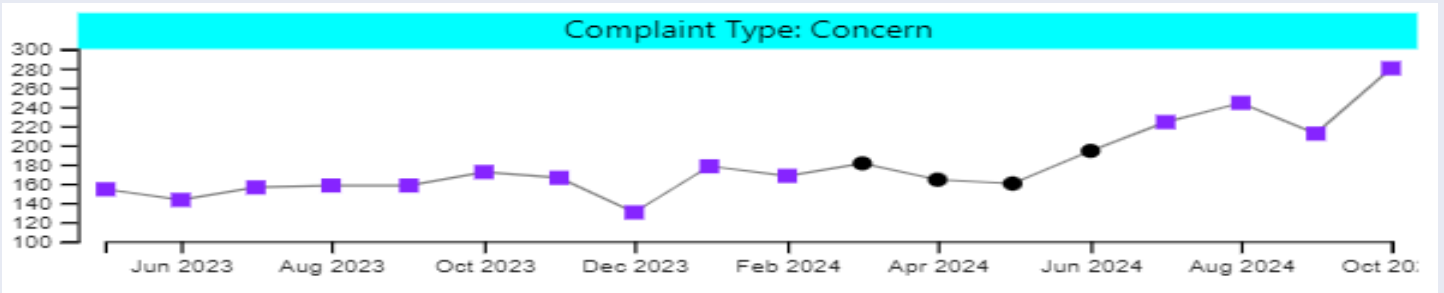


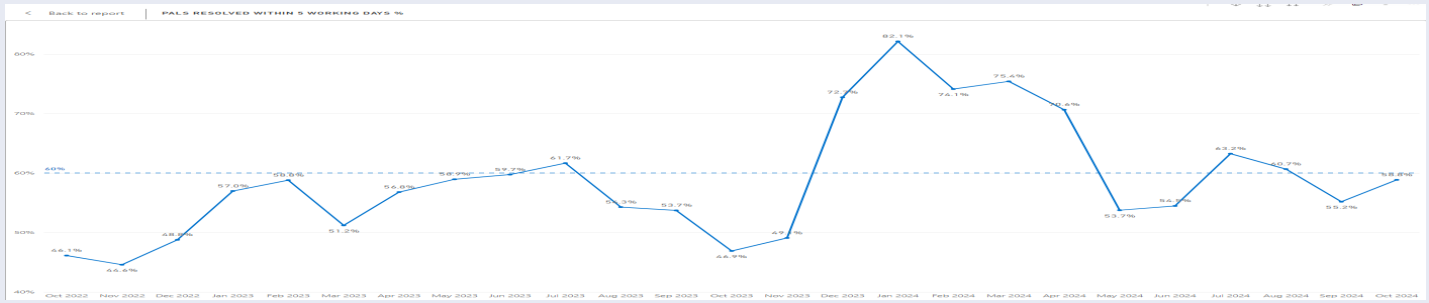


Key themes

- There is normal variation in the rate of PALS contacts for the most recent period. This does show potential for a sustained reduction in PALS contacts.
- Resolution timescales are remain static at 60% with normal variation, with improvement targeted.
- Additional bank resource has been sourced to cover a period of sickness.

NLAG



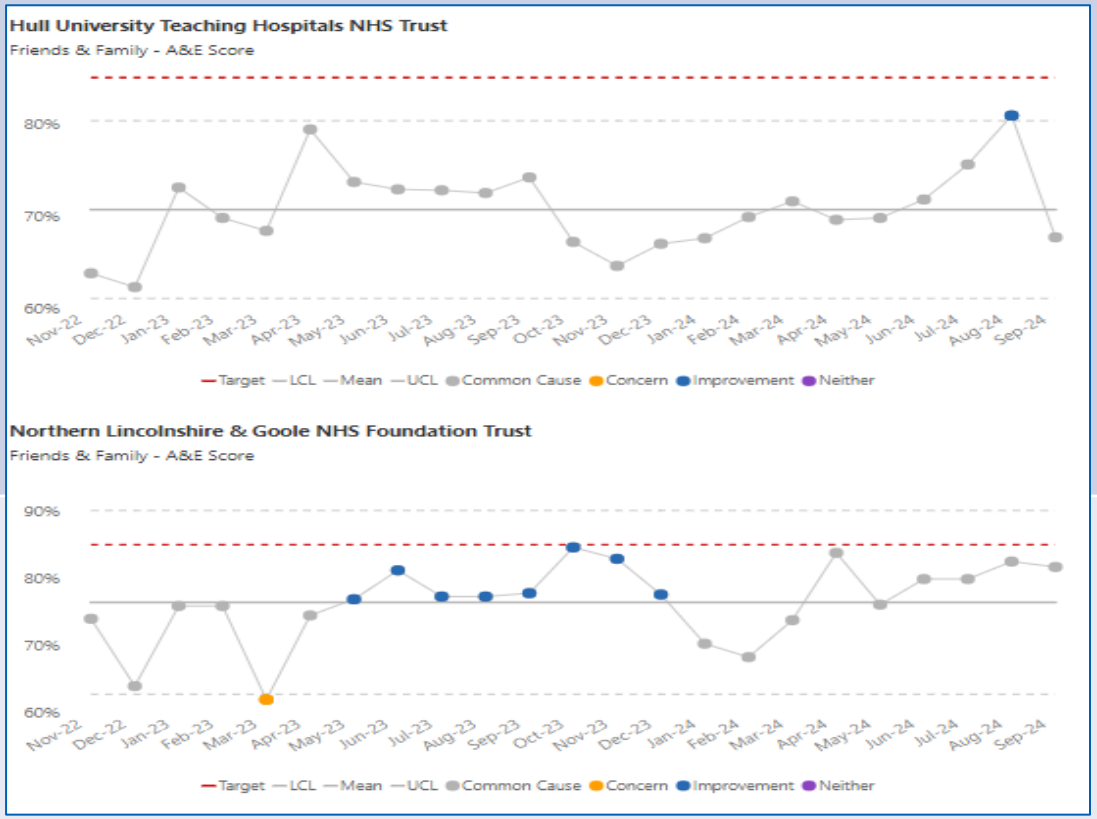


Key themes

- Information services have introduced a different SPC tool, which uses colours to show changes of significance and black is normal variation,
- The top chart shows the rate of PALS contacts. There has been a significant increase in the number of contacts relating to communication with patients particularly within the Emergency departments.
- The bottom chart shows completion with 5 days at 59%
- The Group is exploring consolidated telephony options to be able to more flexibly share capacity to respond to demand.

Patient Experience – Friends and Family Test A&E

HUTH



Key themes

- 877 patients completed the survey in September 2024, with 67.94% providing positive feedback, compared to 80.94% in August 2024.
- By number of responses collected, the Trust is the 54th highest collector.
- The Trust's feedback improved over the summer period, with August achieving the highest positive feedback in the three years since adopting SMS anonymous feedback.
- The top 3 themes continue to be Staff Attitude, Waiting times, environment.
- The additional pressures seen in September 2024, particularly waiting times are reflected in the feedback scores for September against these themes.

NLAG

Key themes

- 640 patients completed the survey in August 2024, with 81.7% providing positive feedback.
- By number of responses collected, the Trust is 74th.

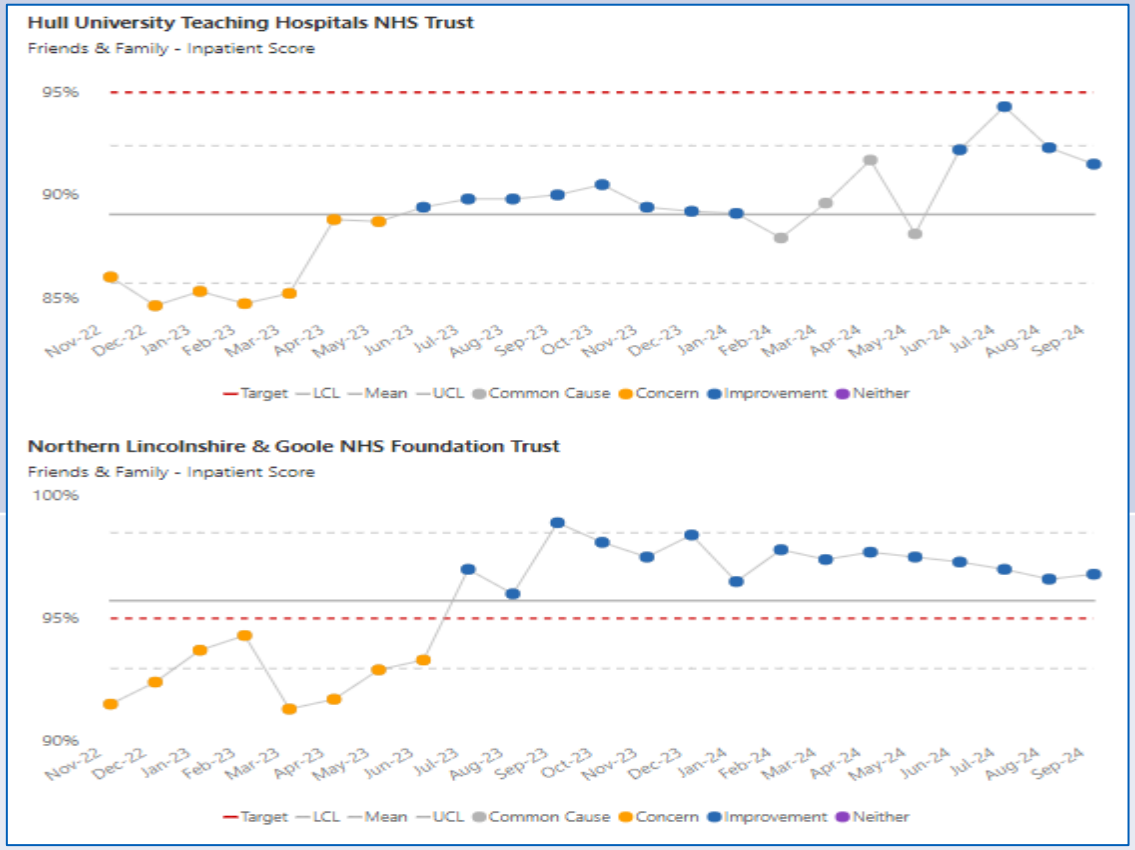
Benchmark

NLAG was ranked 74/124 providers in August and HUTH was ranked 116/124.

HUTH is represented by the black line, NLAG the red line, with system peers highlighted in blue.

Patient Experience – Friends and Family Test Inpatient and daycase

HUTH



Key themes

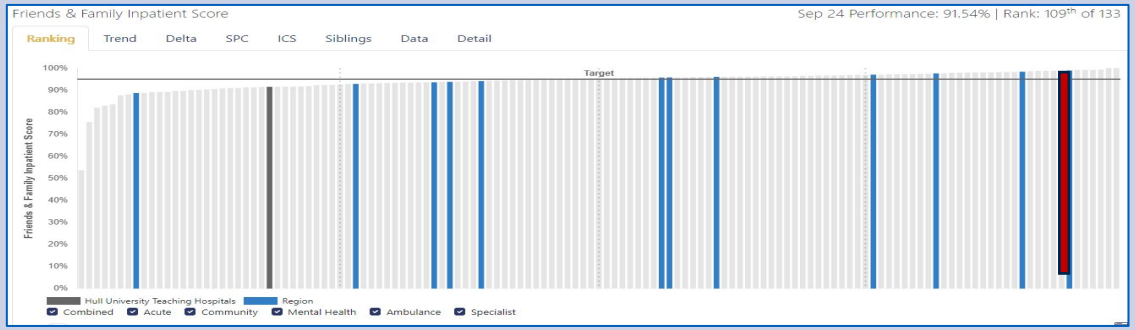
- 2,293 patients completed the survey in September2024, with 91.54% providing positive feedback.
- The Trust is the 21st highest collector of responses nationally, having corrected its submissions in June 2024 to include daycase responses for national comparability.
- The Trust remains below the national target of 95% and remains in the bottom quartile, although improved to be ranked 109/133 trusts in September 2024.
- Negative responses are disseminated to care groups for learning which is a key focus of improvement across the themes of staff attitude, communication and environment.

NLAG

Key themes

- 639 patients completed the survey in September 2024, with 96.8% providing positive feedback.
- There is a desire to increase response rates through the anonymous SMS platforms. Phase 2 of the roll out (including inpatient and outpatient areas) has been delayed due to Information Service priorities but this support has been escalated in order to redeploy manual collection activity to proactive work to improve patient experience across the Group.

Benchmark

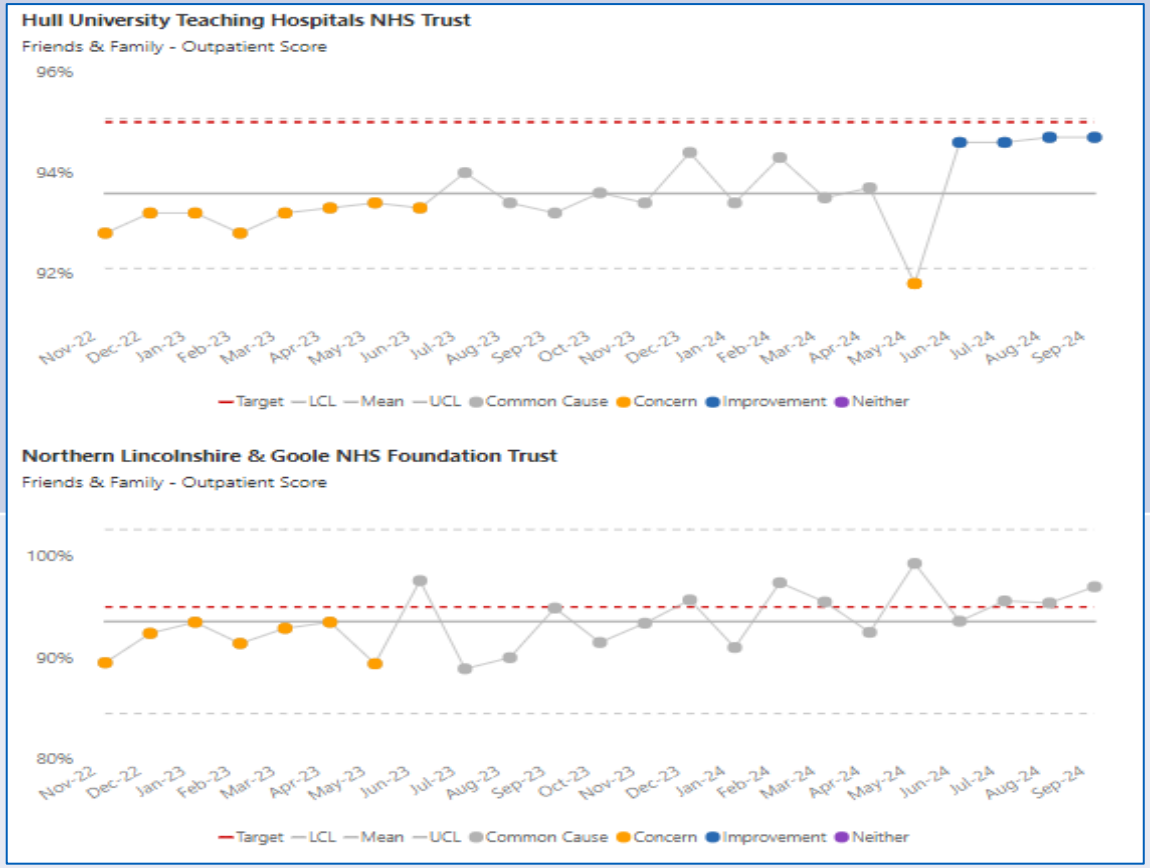


HUTH was ranked 109/133 providers in August and NLaG 7/133 providers.

HUTH is represented by the black line, NLAG the red line, with system peers highlighted in blue.

Patient Experience – Friends and Family Test Outpatient

HUTH



Key themes

- 5,292 patients completed the survey in September 2024, with 94.71% providing positive feedback.
- The Trust is the 20th highest collector of responses nationally.
- In June 2024, there was a correction to data submissions to incorporate radiology / diagnostic responses which had previously been excluded to allow for national comparability.
- The Trust's position has incrementally improved since 2022 towards the 95% target, with the exception of May 24 which was due to a supplier collection issue of our SMS responses.
- The Trust is gradually seeing a reduction in the number of negative responses for waiting times, but communication and environment remain key themes.

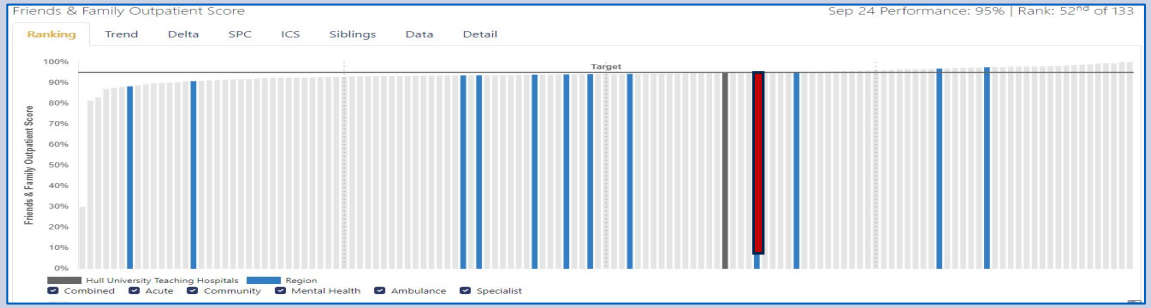
NLAG

Key themes

- 285 patients completed the survey in September 2024, with 95.40% providing positive feedback.
- Responses are collected manually through a paper based system. The Trust has plans in place to utilise SMS to increase its response rate which it is seeking to prioritise with Information Services support.

Across the NHS HHP Group, negative responses are shared with care groups to form the basis of future improvement.

Benchmark

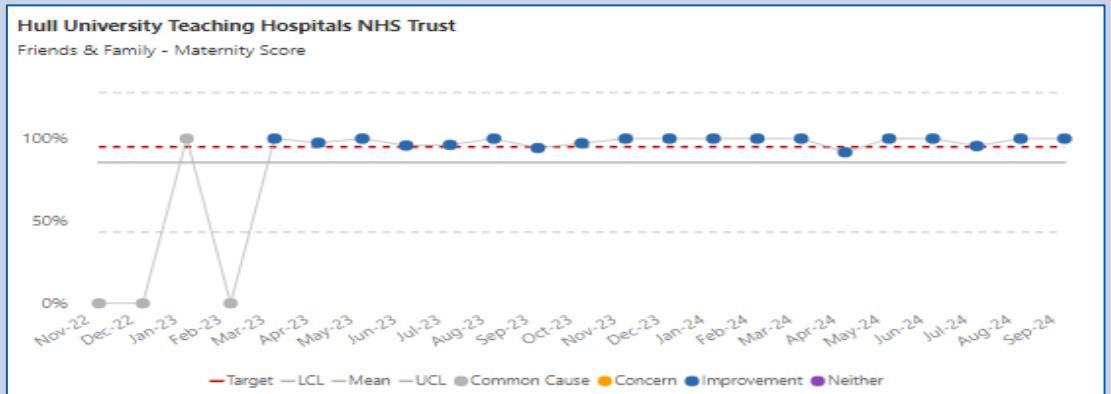


HUTH was ranked 52/133 providers in August and NLaG 48 /133 providers.

HUTH is represented by the black line, NLAG the red line, with system peers highlighted in blue.

Patient Experience – Friends and Family Test Maternity (Birth)

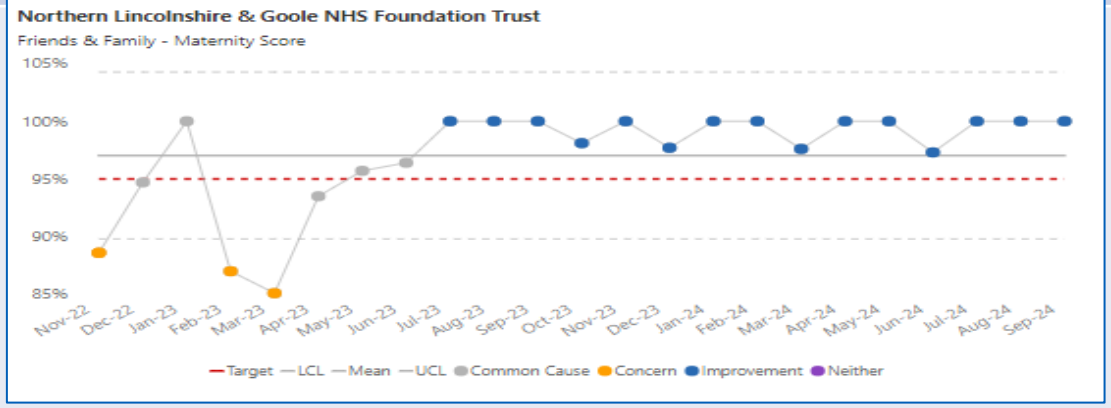
HUTH



Key themes

- 17 patients completed the survey in September 2024, with 100% providing positive feedback.
- The Trust is focusing on increasing its response rates post badgernet implementation and is working with BI teams to ensure the SMS system is utilised (currently feedback is predominantly received via thank you cards and facebook groups).

NLAG



Key themes

- 24 patients completed the survey in September 2024, with 100% providing positive feedback.

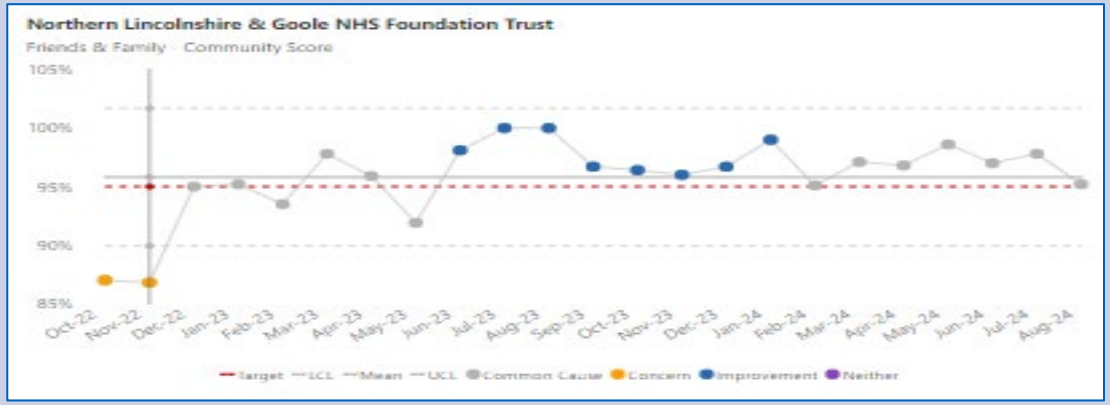
Benchmark

Both trusts achieved 100% scores, although the sample size for both Trusts is in the bottom quartile nationally.

There are FFT measures for antennal and post natal which will be drawn out in more detail (and have increased responses) to reflect the patient experience in these areas.
HUTH is represented by the black line, NLAG the red line, with system peers highlighted in blue.

Patient Experience – Friends and Family Test Community (NLAG only)

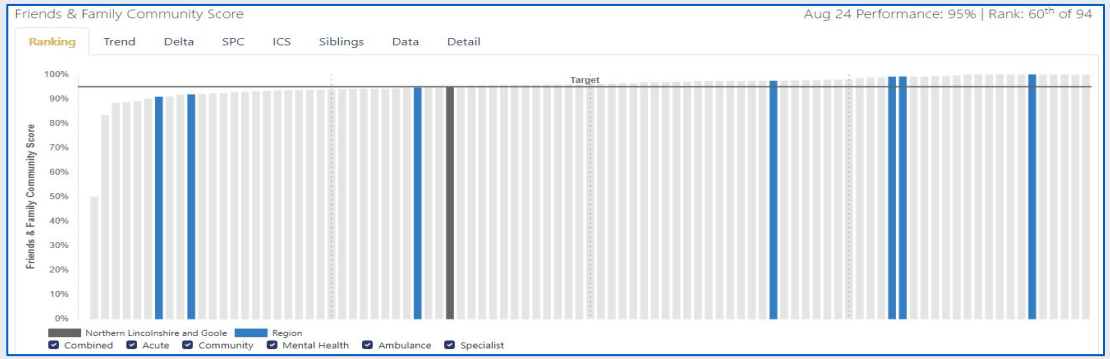
NLAG



Key themes

- 270 patients completed the survey in August 2024, with 95.2% providing positive feedback.
- The Trust is consistently achieving the 95% target.
- Responses are collected manually through a paper based system. The Trust has plans in place to utilise SMS to increase its response rate.

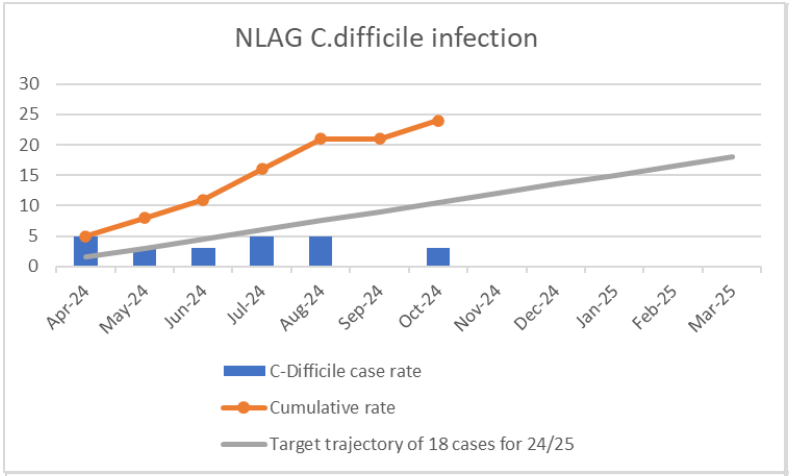
Benchmark

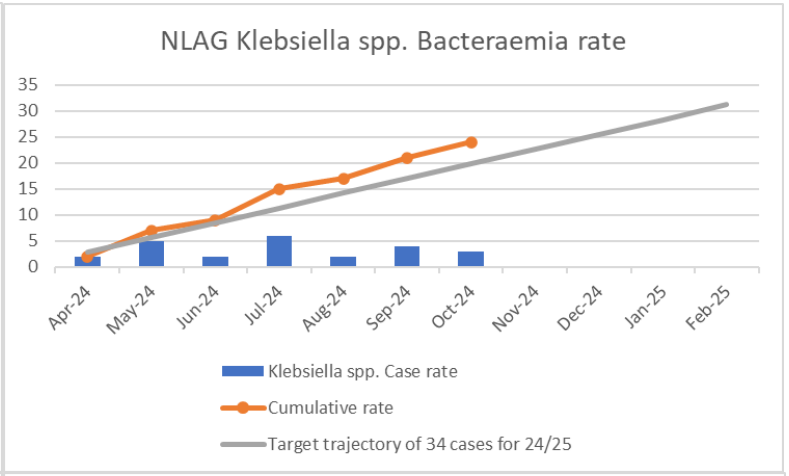


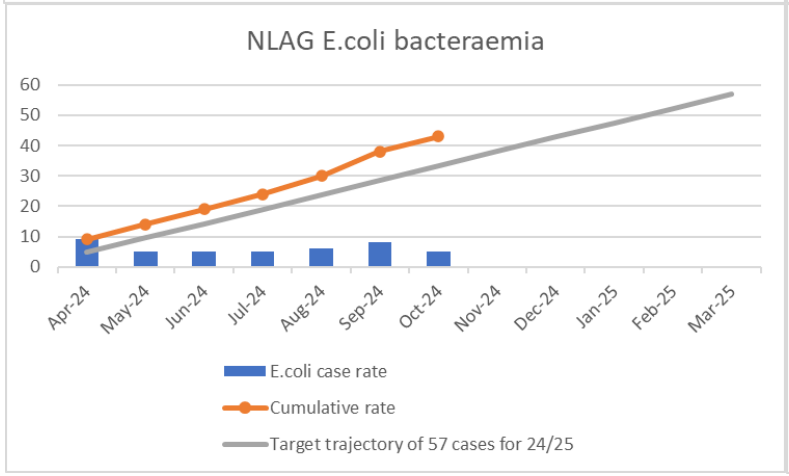
- NLAG is ranked 60/94 providers of community services.
- *NLAG is represented by the black line with system peers highlighted in blue.*

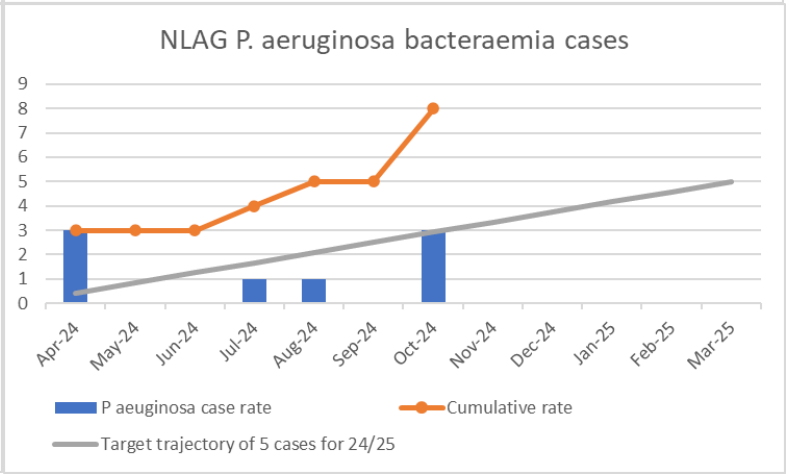
Infection Control - NLAG

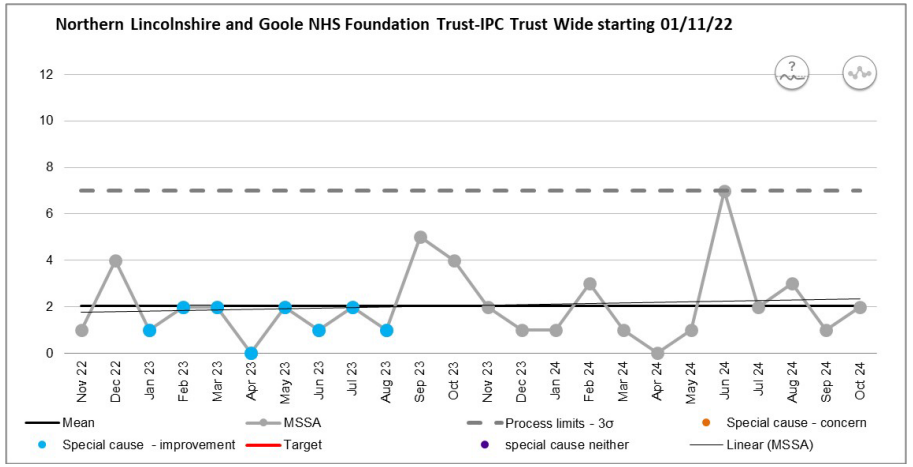
Humber Health Partnership



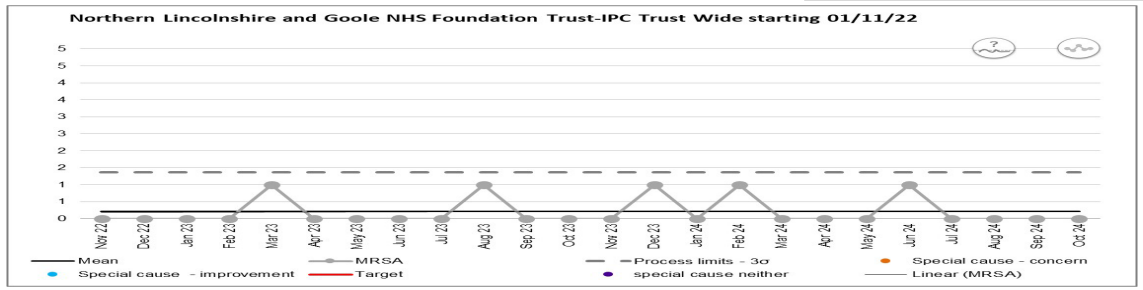








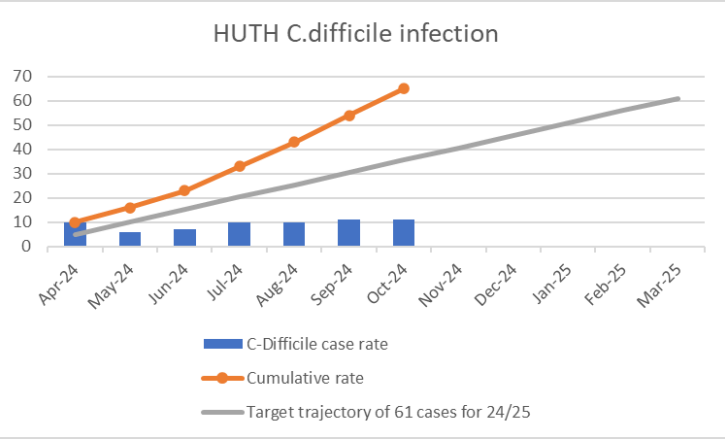
Alert organism	2024 Target	M7	YTD rate	Trajectory RAG
C. Difficile	18	3	24	
		5		
P. Aeruginosa	5	3		
Klebsiella spp.	34	3		
MRSA bacteraemia	0	0	1	
MSSA bacteraemia				
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory				

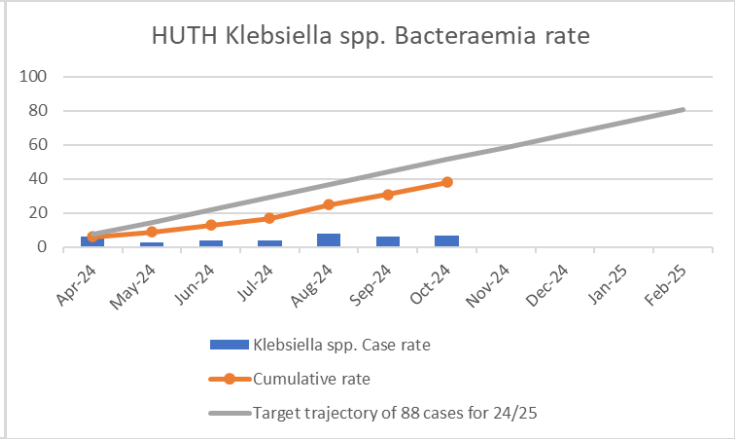


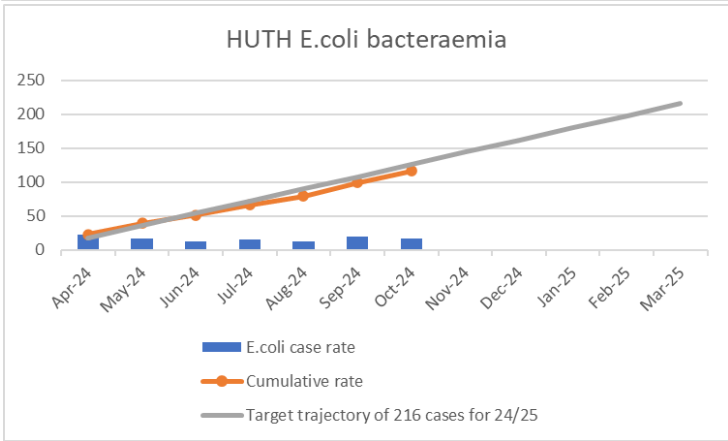
- C.difficile – this now over the target for the year with increases reported nationally. Further investigation of issues is being identified through PIR investigation processes.
- P. Aeruginosa – three cases in October have taken the cumulative rate over the annual target. The cases are in different departments and no apparent links. PIR processes will explore if there are learning opportunities from this.
- E-coli and Kelbisella are both over the trajectory but have not breached the annual target at Month 7.
- MRSA bacteraemia - No cases during October 2024.

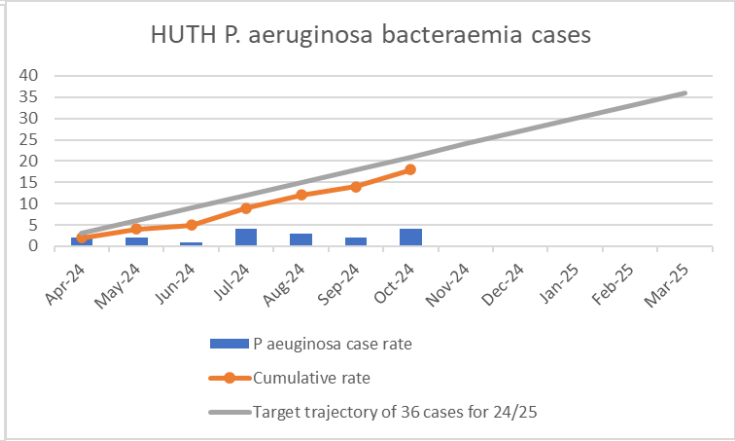
Infection Control - HUTH

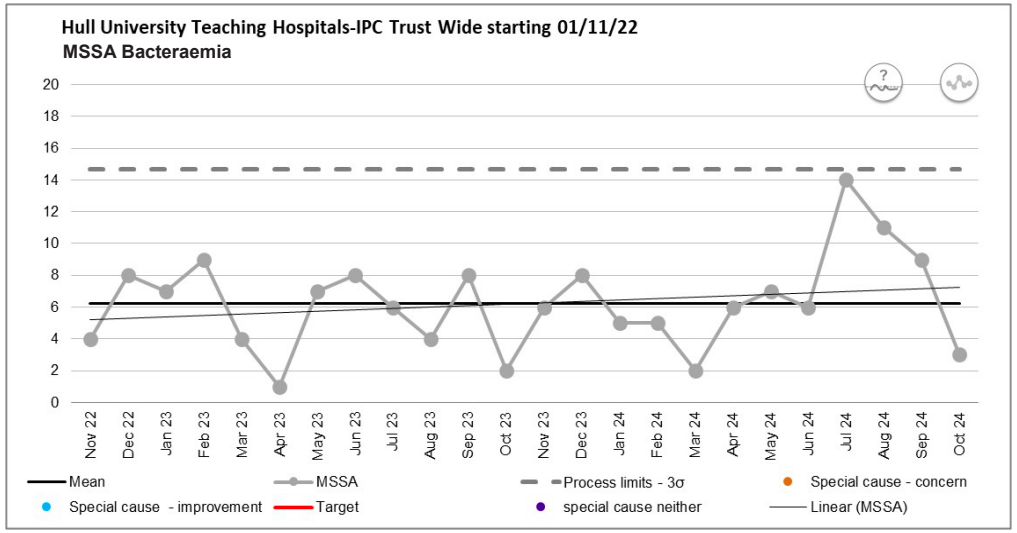
Humber Health Partnership

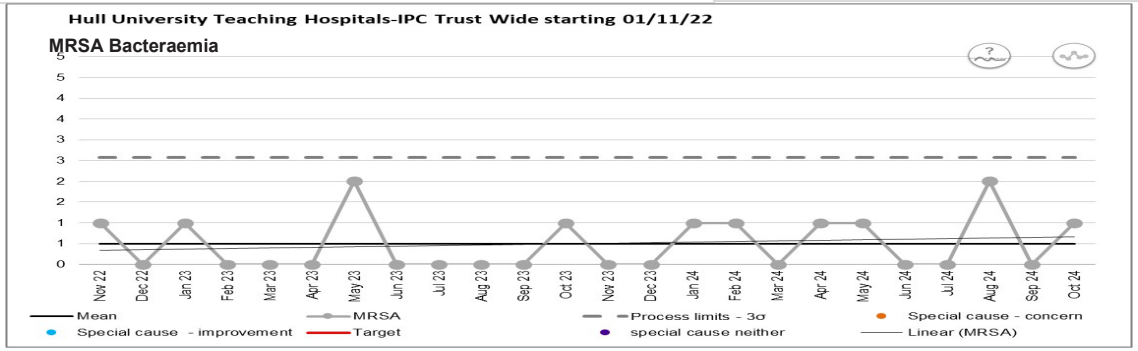












Alert organism	2024 Target	M6	YTD rate	Trajectory RAG
C. Difficile	61	11	65	
E. Coli	216	17	116	
P. Aeruginosa	36	4	18	
Klebsiella spp.	88	7	38	
MRSA bacteraemia	0	1	5	
MSSA bacteraemia	No target	3	56	NA
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory				

- C.difficile – This has now breached the annual target. national increase reported, with further investigation of issues identified in PIR investigation processes.
- MRSA bacteraemia – One case during October 2024, five reported to in the year to date. PIR investigation undertaken to identify concerns in relation to practice and risk factors, IPC and clinical teams meeting to review.
- The other organisms remain below trajectory targets.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)243

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 December 2024**
Director Lead	**Sue Liburd, Non-Executive Director NLaG and David Sulch, Non-Executive Director HUTH**
Contact Officer / Author	**Rebecca Thompson**
Title of Report	**Quality & Safety Committees-in-Common Minutes – August 2024**
Executive Summary	**The Quality & Safety Committees-in-Common minutes from the meeting held in August 2024**
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
Prior Approval Process	**Quality & Safety Committees-in-Common**
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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

QUALITY AND SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 29 August 2024 at 09:00 to 12:30 at Nightingale Suite, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director (NLAG), Chair
David Sulch	Non-Executive Director (HUTH), Co-Chair
Tony Curry	Non-Executive Director (HUTH)
Pete Sedman	Deputy Chief Medical Officer (for Kate Wood)
Mel Sharp	Deputy Chief Nurse (for Amanda Stanford)
Paul Bytheway	Group Chief Delivery Officer

In Attendance:

Sean Lyons	Group Chairman
Stuart Hall	Vice Chair
Ashok Pathak	Associate Non-Executive Director (HUTH)
Marie Stern	Patient Representative (HUTH)
David Sharif	Director of Assurance
Michela Littlewood	Associate Director of Quality Governance (HUTH)
Rob Chidlow	Interim Group Director of Quality Governance
Richard Dickinson	Associate Director of Quality Governance (NLAG)
Jo Palmer	PA Support
Rebecca Thompson	Deputy Director of Assurance (Minutes)

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:

Amanda Stanford, Group Chief Nurse, Kate Wood, Group Chief Medical Officer.

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 31 July 2024.

The minutes of the meetings held on the 31 July 2024 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. No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

There were no actions for review.

1.6 **Operational Pressures/Industrial Action Update**

Mel Sharpe advised the CIC of the maternity industrial action planned for w/c 2 September 2024 and the discussions taking place to resolve the issues.

Pete Sedman added that there had been a national resolution for the Junior Doctors but there were GP pay issues evolving which would impact on the Group.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

There were no matters referred.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

David Sharif presented the report and advised that there had been no changes to the Quality BAF risk ratings since last month. He advised that the high level risks are now included in the report in some detail although this is still challenged due to the Trusts working from different systems.

There was ongoing work planned to refresh the BAF and this would take place on 13 September 2024 at the Executive Team strategy session.

There were a number of high level risks overdue for review but this was due to the Care Groups refreshing the risks in the background.

Ashok Pathak asked what was being done about the crowding in ED risk at HUTH as well as the no criteria to reside patients. Paul Bytheway advised that the Trust was working with a private company who had picked up all the long waits and medical management of Paediatrics.

The new UTC at Hull Royal Infirmary was now open and was helping with flow through the ED as it was seeing a reduction of around 70 patients per day. No criteria to reside patient performance was sitting at 100 but the teams were working to reduce this to 75 in preparation for winter.

Patients with a GP letter was a new initiative to get them straight to the assessment area, keeping ED free for emergencies.

Tony Curry asked when a clearer idea of the mitigations would be seen and David advised that work was ongoing with the Care Groups regarding clarity around the primary controls and what actions are being taken.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Integrated Performance Report**
Rob Chidlow presented the report and advised that it was still evolving with support from Business Intelligence.

FFT patient responses for HUTH were showing improvements with 94.3% in July 2024 against over 1000 patients. A&E FFT data was also on an upward trend and live data was available on a daily basis.

FFT for NLAG was above the national target although some was still paper based.

VTE rates at HUTH remained uncompliant but was showing an upward trajectory. VTE compliance rates at NLAG had reduced and it was thought that this was linked to the Lorenzo issues.

NLAG SHMI data was the lowest it has been on record and Pete Sedman advised that this was testament to the work that had been carried out. HUTH had seen a decrease in the SHMI, but there had been some coding amendments and this was set to improve.

There had been a national safety alert regarding medical beds and this was being managed Group wide and with ICB input.

Mel Sharp advised that the IPC teams for the Group were working well together and were sharing good practice.

Ashok Pathak asked about the FNOF bottlenecks and getting to theatres at HUTH and Pete Sedman advised that HUTH were in the process of moving Paediatric Day Surgery to Castle Hill Hospital freeing up theatre space at HRI. There was also work to improve the availability of urgent geriatricians.

Tony Curry expressed his concern regarding HUTH performance relating to Complaints and Duty of Candour. Rob Chidlow advised that 49 complaints were outstanding over 40 day response time. Work was ongoing across the Group as the average days to close a complaint was 56. Rob also explained that Amanda Stanford was taking Duty of Candour metrics to Cabinet and the revised reporting would be seen from September onwards.

Paul Bytheway advised that there was a lot of pressure on the BI team from a number of areas and he asked that consideration of this be taken when requesting reporting changes and timescales realistic.

4.2 This item was taken as part of 5.1.

4.3 **Maternity and Neonatal Assurance Reports**

Yvonne McGrath presented the report and advised that weekly CNST meetings are in place and work was ongoing relating to Badgernet and Standard 2 for the coming year.

Long term leave had been stripped out of the CNST training figures which were now showing good improvements with an overall compliance of 90%.

There were still staffing issues within the service to meet the capacity, with 36 consultants required. There were national shortages which was compounding the recruitment issues.

The Head of Midwifery was due to start at HRI in November 2024 but there was still a gap as a Clinical Director had not yet been appointed. There were also neonatal surgical out of hours issues but a pathway had been agreed with Sheffield and Leeds for any emergencies.

The CIC discussed the staffing issues in maternity and the focus on the Anti-natal Day Unit due to the CQC must do recommendations. Yvonne advised that the Clinical Director of Maternity scope was 2 PAs only and there was a view amongst clinicians that it would be difficult to make a difference because of this.

It was agreed that the Clinical Director recruitment would be escalated to the Cabinet and the Boards in Common.

Yvonne advised that the Maternity Healthcare Support workers had all been part of the Industrial Action, however safety had been maintained and conversations were ongoing. Sue Liburd and Yvonne had met with them and taken away a number of actions to address some of the issues raised.

HUTH assurance was limited as although the service was safe, there were major issues regarding the sustainability of the service.

The CIC gave NLAG reasonable assurance.

4.3.1 **Maternity Positioning Paper**

Yvonne presented the HUTH maternity positioning paper which highlighted the significant investment of £2.5m to right size maternity services and the leadership structures within it. The paper had been received at Cabinet previously.

The management team and the ICB had worked together to try to manage the financial position but this had resulted in a number of interim roles and created a dissatisfied culture. The investment was a good opportunity to get the governance and staffing right and reduce the CNST premiums.

Tony Curry suggested it would be useful to determine the expenditure breakdown into external and internal and what the offset might be if the Trust achieved it plans. He added that making clear how staff morale would be tackled and how the CNST payments would be reduced would help with the case. Rob Chidlow advised that Theresa Fenwick was very supportive and working with the ICB would be advantageous to the Trust.

Action: The CIC approved the direction of travel and advised that the revised document should be presented to the Board in October 2024.

PSIRF/Serious Incidents

4.4 Michela Littlewood presented the Group report which highlighted the after action reviews and any learning from them.

There was a discussion around dissemination of the learning to Care Groups. Michela advised that the revised medical processes and principles would be shared with relevant groups to ensure they had stopped and thought about what had happened rather than information sharing on Bridget or emails. Richard Dickenson added that embedded learning would be re-checked at 6 months to ensure there is no slippage. Proportional learning responses were required particularly regarding Never Events and deaths that may have been caused.

The agenda was taken out of order at this point

5.1/ **IPC Annual Report and IPC BAF Update**

4.2 The IPC Team (HUTH/NLAG) presented the report and highlighted the Bacteraemia rates in HUTH and Surgical Site infections as being areas of concern. Infection rates were also increasing in the Vascular service at HUTH.

Other issues included ward areas not achieving the IPC gold standard (across the Group) and only 20% of wards were scoring green at HUTH, basic hand hygiene and environmental challenges.

CDifficile rates were also challenging and there was a piece of work regarding training, education and IPC basics being carried out. Both Trusts were working to ensure Anti-microbial stewardship processes were in place and that there were no cross transmission of cases at any of the hospitals.

The CIC discussed hygiene enforcement policies, but the process was re-setting expectations in the first instance with consequences following for repeat offences.

The IPC BAF had been in place for a few years at HUTH and this would be reflected at NLAG. The new strategic IPC Committees would also be live from September 2024.

The IPC Annual report was received by the CIC.

The CIC agreed that the assurance should be limited due to the concerns raised.

The agenda returned to order at this point.

4.5 **CLIP Report (Including triangulation of incidents, complaints/PALs, claims and lessons learned**

Richard Dickenson presented the report which highlighted themes and risks triangulated from complaints/PALs and the Friends and Family Test.

Richard reported that claims linking to maternity were being reviewed against incidents that had occurred and the financial impact was being shared. Rob

Chidlow added that NHS Resolution also review claims linked to inadequate nursing care to FFT and staff attitudes.

David Sulch asked how information was shared if an incident or claim was raised in York and Rob Chidlow advised that there was no formal route but the ICB would review and share where this was appropriate.

4.6 **Mortality including Learning from deaths**

Pete Sedman presented the report and advised that the SHMI rate for HUTH remained high but the NLAG SHMI was at expected levels.

There were still three areas of concern and they were; Sepsis, Fractured Neck of Femur and Secondary Malignancies. A Group taskforce had been set up to tackle the issues around Sepsis and the numbers related to Secondary Malignancies were now reducing and the spike was thought to be a coding issue. The Subject Judgement Reviews were showing that poor care had not been reported in any instance. More information regarding FNOF would be received at the November Q&S CIC.

The death certification process was working well on both sites and the teams were working together and sharing best practice. The first Group-wide meeting had taken place and it had shown members were engaged and enthusiastic with a joint benefit culture being displayed.

The assurance rating for HUTH was limited but the CIC acknowledged the amount of work that was being undertaken to address the issues.

The assurance rating for NLAG was reasonable.

4.7 **CQUINS**

Rob Chidlow presented the report and advised that CQUINs were not mandated in 2024/25, however the Governance Team had prioritised resource to work on Sepsis and End of Life. As the Trust's had not met their Flu targets last year this work would also be reviewed.

4.8 **EQIA**

There were no Impact Assessments to review.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The following items for information were noted:

- Infection Control Annual Report

6. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

Sue Liburd thanked Rob Chidlow for his contribution, support, education, information and steadfastness during his time at the Trust and attendance at the CIC. She added that his input had been invaluable and wished him well on behalf of the CIC.

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:

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Quality and Safety CiC meeting:

The September meeting is a time-out, Thursday 26 September 2024, the Board Room at HRI, 09:00 – 12:30

The next official meeting of the CIC: Thursday 24 October 2024, 09:00 – 12:30, The Board Room, Diana Princess of Wales Hospital

The committee chair closed the meeting at 12:30 hours.

Cumulative Record of Attendance at the XXX Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
REQUIRED ATTENDEES													

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

7 - ANY OTHER URGENT BUSINESS

Sean Lyons, Group Chair

8 - QUESTIONS FROM THE PUBLIC & GOVERNORS

Sean Lyons, Group Chair

9 - MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON

Sean Lyons, Group Chair

10 - DATE OF THE NEXT MEETING

Sean Lyons, Group Chair

Thursday, 13 February 2025 at 9.00 am