AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 11 April 2024 at 9.00 am to 12.45 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	**Patient Story** Dr Kate Wood, Group Chief Medical Officer	Verbal	Discussion / Assurance	
1.3	**Declarations of Interest** Sean Lyons, Group Chair	Verbal	Assurance	
1.4	**Minutes of the Meeting held on Thursday, 8 February 2024** Sean Lyons, Group Chair	BIC(24)050 Attached	Approval	
1.5	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.6	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(24)051 Attached	Assurance	
1.7	**Group Chief Executive's Briefing including Trust Priorities 2024/25** Jonathan Lofthouse, Group Chief Executive	BIC(24)052 Attached	Assurance / Approval	**09:20**
1.7.1	**Proposal to Adopt the Group Brand** Jonathan Lofthouse, Group Chief Executive			
2.	**GROUP DEVELOPMENT**			
2.1	No items			
3.	**STRATEGY**			
3.1	**Engagement with External Stakeholders** Jonathan Lofthouse, Group Chief Executive	Verbal	Assurance	**09:50**
4.	**BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS**			
4.1	**Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge** Sue Liburd & David Sulch, Non-Executive Directors Committee Chairs	BIC(24)054 Attached	Assurance	**10:00**
4.1.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Stuart Hall & Sue Liburd, NED Maternity & Neonatal Safety Champions	BIC(24)055 Attached	Assurance	**10:20**

4.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Jenny Hinchliffe, Director of Nursing South, Tracy Campbell, Director of Nursing North, Nicky Foster & Rukeya Miah, Heads of Midwifery (NLaG & HUTH)	BIC(24)056 Attached	Assurance	**10:30**
Break – 10:40 – 10:50				
4.2	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Mike Robson & Gill Ponder, Non-Executive Directors Committee Chairs	BIC(24)059 Attached	Assurance	**10:50**
4.3	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Tony Curry & Kate Truscott, Non-Executive Directors Committee Chairs	BIC(24)060 Attached	Assurance	**11:10**
4.3.1	**Staff Survey Results – NLaG and HUTH** Simon Nearney, Group Chief People Officer	BIC(24)062 Attached	Assurance	**11:30**
4.4	**Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge** Gill Ponder & Mike Robson, Non-Executive Directors Committee Chairs	BIC(24)063 Attached	Assurance	**11:40**
4.5	**Health Tree Foundation Trustees' Committee Highlight / Escalation Report & Board Challenge – NLaG** Neil Gammon, Independent Chair	BIC(24)065 Attached	Assurance	**12:00**
4.5.1	**Health Tree Foundation Update – NLaG** Neil Gammon, Independent Chair	BIC(24)066 Attached	Information	
5. GOVERNANCE & ASSURANCE				
5.1	**Board Assurance Framework & Strategic Risk Register – NLaG and HUTH** David Sharif, Group Director of Assurance	BIC(24)067 Attached	Assurance	**12:10**
6. OTHER ITEMS FOR APPROVAL				
6.1	**Fit & Proper Persons Policy** Sean Lyons, Group Chair	BIC(24)068 Attached	Approval	**12:20**
7. ITEMS FOR INFORMATION / SUPPORTING PAPERS				
7.1	**Items for Information / Supporting Papers (as per Appendix A)** Sean Lyons, Group Chair	Verbal	Information / Assurance	**12:25**
8. ANY OTHER URGENT BUSINESS				
8.1	**Any Other Urgent Business** Sean Lyons, Group Chair / All	Verbal		**12:30**
9. QUESTIONS FROM THE PUBLIC AND GOVERNORS				
9.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**12:35**

10. MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON				
10.1	**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	**12:40**
11. DATE OF THE NEXT MEETING				
11.1	**The next meeting of the Boards-in-Common will be held on Thursday, 13 June 2024 at 9.00 am**			

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

APPENDIX A

7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
7.1	**Quality & Safety Committees-in-Common**	
7.1.1	**Quality & Safety Committees-in-Common Minutes – January & February 2024** Sue Liburd & David Sulch, Non-Executive Director Committee Chair	BIC(24)069 Attached
7.2	**Performance, Estates & Finance Committees-in-Common**	
7.2.1	**Finance & Performance Committees-in-Common Minutes – January & February 2024** Gill Ponder & Mike Robson, Non-Executive Director Committee Chair	BIC(24)071 Attached
7.3	**Workforce, Education & Culture Committees in Common**	
7.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – January & February 2024** Kate Truscott & Tony Curry, Non-Executive Director Committee Chair	BIC(24)072 Attached
7.4	**Health Tree Foundation Trustees' Committee**	
7.4.1	**Health Tree Foundation Trustees' Committee Minutes – January 2024 (NLaG)** Committee Chair	BIC(24)073 Attached
7.5	**Other**	
7.5.1	**Integrated Performance Report – NLaG and HUTH** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(24)074 Attached
7.5.2	**Documents Signed Under Seal** David Sharif, Group Director of Assurance	BIC(24)076 Attached
7.5.3	**Guardian of Safe Working Hours** Dr Kate Wood, Group Chief Medical Officer	BIC(24)077 Attached
7.5.4	**Trust Boards & Committees Meeting Cycle** David Sharif, Group Director of Assurance	BIC(24)078 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.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 8 February 2024 at 9.00 am
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Lee Bond	Group Chief Financial Officer
Jenny Hinchliffe	Site Nurse Director (South) (representing Group Chief Nurse)
Shaun Stacey	Group Chief Delivery Officer
Dr Kate Wood	Group Chief Medical Officer
Tony Curry	Non-Executive Director (HUTH)
Stuart Hall	Vice Chair (HUTH)
Linda Jackson	Vice Chair (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Una Macleod	Non-Executive Director (HUTH)
Gill Ponder	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG) (attended virtually)
Mike Robson	Non-Executive Director (HUTH)
Kate Truscott	Non-Executive Director (NLaG)

In Attendance:

Henry Anderson	Health Service Journal
Diana Barnes	Public Governor
Jeremy Baskett	Public Governor
Mike Bateson	Public Governor
Robert Chidlow	Interim Group Director of Quality Governance
Adam Creeggan	Group Director of Performance
Nicky Foster	Associate Chief Nurse Midwifery (NLaG) (for item 4.1.2)
Lesley Heelbeck	NHS Improvement
Myles Howell	Group Director of Communications
Rachel Farmer	NHS Liaison
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Rukeya Miah	Head of Midwifery (HUTH) (for item 4.1.2)
Frances Moverley	Freedom to Speak Up Guardian (HUTH) (for item 4.4.1)
Simon Nearney	Group Chief People Officer
Ashok Pathak	Associate Non-Executive Director (HUTH)
Rebecca Thompson	Head of Corporate Affairs (HUTH) (representing Wendy Booth)
Sarah Meggitt	Personal 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 and Apologies for Absence

Sean Lyons welcomed board members and observers to the first Trust Boards-in-Common meeting and declared it open at 9.00 am.

The following apologies for absence were noted:

Jo Ledger	Interim Chief Nurse (HUTH)
Wendy Booth	Interim Governance Advisor

Sean Lyons wanted to thank everyone for the efforts and support during the first month of the Committees-in-Common meetings. It had been reported they had worked very well over the first month.

Further thanks were noted for the support offered with recent interviews held across the Group. The Boards were reminded that although NLaG and HUTH were now a Group both Trusts sovereignty remained. It was recognised that although challenges would be faced over coming months there was confidence these would be faced together as a group.

1.2 Patients Story – NLaG

Jenny Hinchliffe shared the patient story in respect of a gentleman named Harry and his wife Iris. The story centered around the importance of appropriate conversations with families and patients during end-of-life care as this had affected the family during Harry's care. It was explained the story would also be shared at the End-of-Life Group to support lessons learned. The story had arisen due to Iris raising a complaint regarding the lack of communication during this time. She had felt robbed of her opportunity to discuss his life and death before he sadly passed away as felt this had not been communicated in enough time. The team had thanked Iris for sharing her experience in respect of improvements that should be made for others in the future. It had been recognised the care and compassion at the time had indeed been very good, however, it was the communication that had sadly not been.

Jenny Hinchliffe advised the end-of-life team had been working with colleagues regarding improvements and had created a survey to support this which would be circulated to medical staff for comment. It was noted a training session would be held in the future to focus on end-of-life care and this would include the communication to families and patients. It was recognised this had been a difficult story to listen to and that it was important improvements were made in this area to ensure this did not occur again.

Dr Kate Wood expressed thanks for sharing the story and wanted to pass on condolences to the family for the experience they had encountered. NLaG still had some inadequate ratings within this area from the Care Quality Commission (CQC) Report shared in 2022 and work to improve this still continued. It was

noted early recognition for end-of-life care had been deemed through structure judgement reviews to be found still wanting as shown in the Integrated Performance Report (IPR). Training would continue in this area through the division, this would also remain a quality priority on the South Bank.

Sean Lyons advised patient stories at the board would be provided from both organisations on a rotating basis.

Una Macleod felt more support with education and training for end-of-life care could be offered through the University at Hull. It was agreed Dr Kate Wood and Jenny Hinchliffe would discuss this with Una Macleod outside the meeting.

Sean Lyons recognised this kind of experience would be edged in the memories of families, so it was important improvements were made.

Jonathan Lofthouse queried whether the training was different on the North and South Banks. Dr Kate Wood advised she would review processes in place. It was noted work would need to continue across both Trusts to ensure improvements.

Linda Jackson recognised conversations around this issue were difficult for staff and families, unfortunately, on this occasion it had impacted on Iris. It was important to have this included in future training.

Dr Kate Wood highlighted HUTH had last been inspected in 2017 on end-of-life care, it was noted this had been rated good at the time. Kate Truscott queried whether Hospices in the area could be contacted to support joint training. Dr Kate Wood advised this option had been explored in the past and had worked well on the South Bank. It was agreed this could be reviewed for both organisations.

Sean Lyons felt this had been a very moving story to share to the boards.

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 meeting held on Tuesday, 14 November 2023 (HUTH) – BIC(24)004**

The minutes of the meetings held on the 14 November 2023 were accepted as a true and accurate record and would be duly signed by the Chair.

1.5 **To approve the minutes of the meeting held on Tuesday, 5 December 2023 (NLaG) – BIC(24)005**

The minutes of the meetings held on the 5 December 2023 were accepted as a true and accurate record and would be duly signed by the Chair.

1.6 **To approve the minutes of the Boards-in-Common meeting held on Tuesday, 12 December 2023 – BIC(24)006**

The minutes of the meetings held on the 12 December 2023 were accepted as a true and accurate record and would be duly signed by the Chair.

1.7 **To approve the minutes of the Boards-in-Common meeting held on Tuesday, 23 January 2024 – BIC(24)007**

The minutes of the meetings held on the 23 January 2024 were accepted as a true and accurate record and would be duly signed by the Chair.

Sean Lyons thanked Stuart Hall for chairing the meeting held on the 23 January 2024.

1.8 **Matters Arising**

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

1.9 **Action Tracker - Public**

The following updates to the Action Tracker were noted:

HUTH

- Item 09.03, 12 September 2023 – Workforce, Disability Equality Standards Report. Simon Nearney confirmed the Chair of the Disabled Network was happy to attend a board session including attending the Workforce, Education & Culture Committees-in-Common meeting. It was reported the Equality & Diversity Improvement (EDI) Teams from both Trusts were working closely together to make improvements across the organisations. Decisions had not been made to join the teams as yet, however, this was under consideration.

NLaG

- Item 9.1, 5 December 2023 – Escalation from the Quality & Safety Committee (NLaG) – Lack of equipment. Jonathan Lofthouse advised that as the Trust moved into the end of the operating year decisions around investments were being made regarding equipment. This was being worked through with executive colleagues, a wider piece of work was being undertaken through the Capital Investment portfolio. There were opportunities to bring forward some of the work within areas of concern on the South Bank. A full plan of investment would be shared with boards over coming weeks. Sean Lyons queried whether this programme would include improvements to the environment that staff were currently working in. Jonathan Lofthouse advised this would be undertaken in order of prioritisation.

- Item 9.2, 5 December 2023 – Escalation Report from the Finance & Performance Committee (NLaG) – MADE Events. Jonathan Lofthouse and Shaun Stacey had met to discuss the events. It was reported these would continue to be held throughout the year linked to seasonal change and bank

holidays. It was confirmed the flow teams would lead on this piece of work. Partners had also agreed to support this.

- Item 9.3, 5 December 2023 – Escalation Report from the Workforce Committee – Retention Update. Simon Nearney reported the Workforce, Education & Culture Committees-in-Common had oversight of this issue. It was confirmed turnover had reduced on the South Bank including a reduction in vacancies and sickness. It was recognised there was still work required on the North and South Bank, however, deep dives would be undertaken as part of the Committees-in-Common in relation to staff leavers. Stuart Hall queried whether leaver interviews were in place on the South Bank. Simon Nearney confirmed this was in place, however, from the 1 April 2024 an Integrated Care Board (ICB) wide approach would be in place in respect of leavers. This would enable the ICB to analyse data for the region. Simon Nearney advised a report would be shared at the Workforce, Education & Culture Committees-in-Common every six months to be discussed. Sean Lyons referred to stay vacations and queried whether the organisations would introduce this. Simon Nearney explained this had been undertaken in some areas at HUTH and would be progressed moving forward. Jenny Hinchliffe advised this had been discussed on the South Bank in career clinics that were held.

- Item 9.4, 5 December 2023 – Escalation Report from the Audit, Risk & Governance Committee (NLaG) - Staff working in outside employment. Jonathan Lofthouse confirmed that any staff member undertaking outside employment whilst registered as off sick would be considered as fraud by the Trust and NHS Counter Fraud Services. There were several investigations regarding this at both Trusts currently being undertaken, it was noted the policy was clear in stating this was fraudulent. Simon Nearney advised this issue was robustly dealt with if a member of staff was off sick due to team stress, it was noted this would be investigated in those circumstances. Ashok Pathak queried whether members of staff were made aware that working whilst off sick was fraudulent. Simon Nearney advised this was within the employment framework and was part of individual contracts, it was also part of an individual's professional responsibility to be aware of contractual responsibilities. Sue Liburd raised concern in respect of how grey areas around sickness would be determined. Following further discussion Simon Nearney agreed to speak with Sue Liburd and Kate Truscott outside of the meeting regarding this issue. Sean Lyons felt there was an expectation staff should not work elsewhere whilst off work with sickness. Kate Truscott referred to the fraud awareness training as this included this issue. It was noted this was mandatory training for NLaG staff.

- Item 10.1, 5 December 2023 - Maternity & Neonatal Oversight Report – Maternity Safety Champions Action Log. Jenny Hinchliffe advised actions were being progressed. In respect of the facilities action work was expected to be completed by early March 2024. It was reported there were no concerns to be raised.

1.10 **Chief Executive's Briefing – BIC(24)009**

Jonathan Lofthouse reported substantial progress had been made in appointing tier one, tier two and the site-based leadership teams as detailed within the report. Myles Howell, Group Director of Communications and Adam Creeggan, Group Director of Performance had also been appointed since writing the report. Interviews had taken place for the Interim Group Chief Nurse; details of the individual would be shared following appointment. Jenny Hinchliffe in attendance at the meeting had been appointed as Site Nurse Director for the South Bank. Ashy Shanker had been appointed as Site Managing Director for the South Bank and Dr Nick Cross as Site Medical Director for the South Bank. Shaun Stacey confirmed interviews for the Care Group had been undertaken with 32 out of the 47 posts being appointed to. The recruitment process for the other vacancies had also commenced.

Jonathan Lofthouse referred to the report in respect of the first Top 100 Senior Leaders Event that had recently taken place, this had included external speakers. This was the first of four events scheduled for the year with the next one taking place in April on the South Bank.

It was confirmed the Clinical Negligence Scheme for Trusts (CNST) had been signed off by both organisations. Rebates for this had been received by both Trusts from the Care Quality Commission (CQC) in respect of price changes. As a group this was circa £110,000 rebate for CQC services over the past year.

Shaun Stacey referred to the detail in the report and confirmed HUTH had 11 patients that had breached 78 weeks referral to treatment in December 2023. However, the Trust remained on track to have no patients waiting more than 65 weeks by the end of the financial year. There had been some constraints around industrial action which had impacted on services, however, mitigations were in place. In respect of the Emergency Department (ED) there had been pressures on both the North and South Bank, it was important to note this was due to the acuity of patients along with the exit flow at both Trusts. It was reported work continued with partners to support this. Work was being undertaken at both Trusts to encourage medical teams to access services outside the organisation for chronic care management of conditions. It was reported the Urgent Treatment Centre (UTC) had opened on the North Bank that week.

Sean Lyons had recently visited the UTC and had received positive feedback form patients within that area. It was felt improvements should be seen in respect of patient displacement from ED due to the UTC being in place. Jonathan Lofthouse agreed and felt this should also have a positive reflection on collective performance. This would also improve system performance by around 14%.

Stuart Hall queried whether the boards in future could introduce visits particularly on Trust Boards-in-Common meeting days as this would be received well by staff. Sean Lyons agreed this process needed to be reviewed to be introduced in the future. Mike Robson referred to the opening of the UTC and queried whether this had reduced the pressure within ED. Shaun Stacey advised it was too early to identify this, but it was hoped this would be positive over the next few weeks. Ashok Pathok queried whether the appointment of the management consultant had

impacted and made improvements in that area. Jonathan Lofthouse agreed the appointment of Michael Keizer, Winter Director had brought some overall stabilisation particularly on the North Bank. Further improvements would be made as there had been success in moving clinical viewpoint including the model of opportunity that clinical teams now had. It was agreed those improvements would be shared through the Performance, Estates and Finance Committees-in-Common with an option to review this as a deep dive to highlight performance.

Jonathan Lofthouse explained there had been some debate within the system in respect of the ICB becoming ICB light, this would mean having the correct people in the ICB undertaking the right contributory and supportive functions for the system. This would mean over a period there would be a reduction in staff and recalibration to aid systems and providers. As the organisations were both acute providers the way in working would need to be amended. There was expectation that in the future collaboratives would have a greater level of delegated authority and a greater level of strategic contribution to the ICB. This information would be shared at a future board development session with a view Sue Symington, Integrated Care System (ICS) Designate Chair and Stephen Eames, ICS Designate Chief Executive would attend to share this.

Jonathan Lofthouse confirmed Dr Peter Reading had been appointed as Chief Executive at Yorkshire Ambulance Service (YAS). Discussions had taken place to form a wholesome partnership with YAS.

Ivan McConnell advised the Humber Acute Services (HAS) consultation that had closed on the 5 January 2024 had received 3,900 responses with two petitions from the public received by the ICB board. This was predicated on the closure of ED at Scunthorpe General Hospital (SGH) which had been incorrect. Events had been held within various areas including Focus Groups with protected characteristics, this included sessions for people whose first language was not English. The evaluation process was now being undertaken with the ICB to make a decision in May 2024.

Sean Lyons referred to the ambulance service protocols previously mentioned and queried whether they had been put in place. Jonathan Lofthouse advised they had been handed over and were live to allow ambulances to communicate with ED in circumstances when there was a requirement for an immediate release of a vehicle. This had been working well on the South Bank and was now being introduced on the North Bank.

Jonathan Lofthouse wanted to highlight the organisations had moved into a national reset for finance and performance in December 2023 with the authority given by the boards to the Group Chair and Group Chief Executive to sign off the package of commitments and measures. This was providing there was no further industrial action, however, there had been some after that point. It was noted the Group had held position in terms of this, but it was unfortunately the system wide position had changed remarkably which had impacted on this. It was noted the success of this was of course system first and sovereign second.

Lee Bond referred to the revenue position and reported that whilst there had been some variance from planning, he was confident the target would be met for month 12 with the exception of strike costs which would be incurred for December, January and any further action. In respect of the Capital programme work

continued to accelerate this to close the programme as per the plan by the end of the financial year, the forecast for this may under slightly.

In respect of the Reinforced Autoclaved Aerated Concrete (RAAC) identified within an area at Castle Hill Hospital (CHH) the area had now been closed and the building would be demolished. This had caused major operational issues as this had meant there was no training function at CHH. Following on from this £1 million had been secured from NHS England (NHSE) to support relocation and demolition costs of the building. Sean Lyons queried whether there was confidence no more RAAC would be identified. Lee Bond did not believe there would be, however, a request for further checks had been made.

Simon Nearney referred to the report in respect of the celebration of the apprenticeship programme. This had benefited both Trusts as the programme offered entry to master's level in all areas. It was recognised many awards had been achieved with several staff being successful in substantial roles on completion of the programme. Also in place was a good volunteer programme which enabled volunteers to access the apprenticeship programme before moving into employment. Sean Lyons felt this was a fantastic opportunity. Gill Ponder referred to NLaG as historically it had not spent the apprenticeship levy, a query was raised as to whether this would improve moving forward. Simon Nearney advised the apprenticeship levy provided the funding for learning, unfortunately, this did not support the salary for individuals. This had been a challenge and it was recognised that on the South Bank it had not been as successful, this would continue to be discussed in the future as it was recognised the investment in salaries would support the programme. It was noted the levy would not be lost as it could be transferred to other organisations within the region. Ashok Pathak referred to previous discussions where it had been raised some areas struggled to recruit and queried whether the apprenticeship programme could support those areas. Simon Nearney agreed discussions had been undertaken between managers within those areas and the People team to support those areas and this would continue to be discussed. Lee Bond advised there has been some investment in those posts, however, some areas had redefined roles to accommodate apprentices in those roles.

Jonathan Lofthouse reported the start of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) history month where celebration events were being held.

It was reported the Same Day Emergency Care (SDEC) area had opened at the Diana, Princess of Wales Hospital (DPoWH) which provided a superb patient environment.

Jonathan Lofthouse advised of a future visit by Sir David Sloman. Also Sarah Jane Marsh, Group Chief Operating Officer Lead for Emergency would be visiting SDEC at DPoWH over coming weeks. A further visit would be by Dame Ruth May who would be visiting the North Bank in May.

Ashok Pathak referred to the Community Diagnostic Centre (CDC) point within the report and queried who would be managing this and how patients would be referred to that area. A second query related to patients accessing personal records and how this would be supported for those patients who may struggle with this technically. Jonathan Lofthouse advised in respect of the CDC query this would be nationally funded with HUTH taking on the parenthood responsibility for

the capital environment. The employment of staff would rotate through both the main hospital and the CDC. Funding for the centre and staff would be provided nationally and would then be picked up through the payment tariff. The referral of patients would largely be from a primary source for diagnostic pathways rather than from acute clinicians. In respect of the maternity query, Jonathan Lofthouse advised badgernet would be used nationwide, however, this would not be used exclusively as paperbased folders would still be available for mothers.

1.11 **Matters for Escalation from the NLaG Council of Governors January 2024 Business Meeting – BIC(24)010**

Linda Jackson referred to the report and advised papers had been shared at the meeting for consideration as detailed within the report. The papers had been agreed by the Council of Governors (CoG) in respect of the CoG Business Meeting being the primary forum for holding NEDs to account at NLaG. Also agreed was the status of Governors attending Committees-in-Common meetings as the attendance would now be as observers with no speaking rights due to joint working. It was noted a protocol had been tabled at the meeting on how this would progress and this had been agreed. Support was being offered to Governors in respect of member engagement as this had been identified as a weakness in the annual review. Sean Lyons felt there was a lot to be gained by the new implementations for Governors.

2. GROUP DEVELOPMENT

2.1 **Group Development: Latest Update**

Jonathan Lofthouse advised there was two forms of Group Development in place, one referred to the Boards-in-Common and the other was in relation to the Group Executives that attended a half-day session each month facilitated by Mike Farrar. The wider board development would include improvements in the wider reframing of the Board Assurance Framework (BAF) and Risk Registers in line with executive assurance of the Risk and Governance meeting held. It was noted Stuart Hall was the NED representative at this meeting. The current BAF would be recalibrated to form a joint BAF for both Trusts. There was also a need to update the board on Equality, Diversity and Inclusion (EDI) awareness and development. Sean Lyons wanted the board to collectively think about how the organisations would develop strategic ambitions. There would be several issues to follow up on with regard to this going forward.

2.2 **Group Operating Model / Care Group Structure – BIC(24)011**

Shaun Stacey shared the paper and advised this was the final version. The names of individuals would be included once this had been confirmed. He was pleased to report that no staff member had been placed outside of the three choices with 23 gaining their first choice, six their second choice and no staff member being put into their third-choice role. It was confirmed there were still some vacancies following this process and a programme had commenced to recruit into those roles. Shaun Stacey wanted to thank everyone that had supported this process including candidates for taking part as it was noted this had been a stressful time for those individuals. Sean Lyons endorsed this point. Linda Jackson was pleased to hear candidates had gained roles within their first and second choices and queried whether any analysis had been undertaken in respect of the number of

NLaG and HUTH staff that had been appointed. Shaun Stacey confirmed this had been undertaken and explained that out of the 14 care groups there would be six of them where there would be a mixed team in terms of skills. Linda Jackson had highlighted this as felt it was important this was balanced between the two Trusts. Gill Ponder queried when the full structure would be shared with individual names populated. Shaun Stacey explained this would be shared after the 20 February 2024.

Jonathan Lofthouse advised the vacancy for the Director of Midwifery for the Group was live, there had been some interest in the vacancy. It was reported the Group Deputy Director of Finance and Ivan McConnell's Deputy roles had been shortlisted. The Group Director of Estates and Facilities role had also been advertised.

The Group Operating Model / Care Group Structure was approved by the Trust Boards-in-Common.

2.3 **Group Data Sharing Agreement & Privacy Notice – BIC(24)012**

Ivan McConnell referred to the report and noted this would be updated as required. It was confirmed the proposals complied with General Data Protection Regulation (GDPR) Guidelines and the Data Protection Act 2018. Approval was sought from the Boards. Jane Hawkard queried whether the Information Governance (IG) Group at NLaG had approved the proposal. It was confirmed this had been approved, HUTH approval would be sought at the end of the month. Tony Curry queried how the practicalities would work from a legal perspective as the organisations moved forward. Ivan McConnell confirmed the agreement would ensure the alignment of policies and principles as both Trusts moved forward with shared systems. It was advised this would be governed by each of the Trusts going forward.

The Group Data Sharing Agreement & Privacy Notice was approved by the Trust Boards-in-Common. It was agreed this would be signed by Sean Lyons as Group Chair and Jonathan Lofthouse as Group Chief Executive.

3. STRATEGY

3.1 **Engagement with External Stakeholders**

Jonathan Lofthouse advised ICB colleagues were to update Trusts on their future structure pieces. The relationship with Place would remain unchanged in terms of involvement, however, as they evolved further updates would be shared. Sean Lyons felt more engagement should be encouraged going forward with external stakeholders as a Group. Ivan McConnell felt it was important to recognise Executive colleagues were currently supporting multiple pieces of work across the system. The Place Boards had also requested Executive and NED support on specific pieces of work, this was something that should be considered in terms of individual skills.

3.1.1 **Formal Submission to Public Consultation – Humber Acute Services (HAS): Your Health, Your Hospitals – BIC(24)013**

Ivan McConnnell referred to the paper and advised this provided the letter submitted in terms of the HAS public consultation. It was important to highlight all statutory consultees had responded to the consultation. An extension had been given to one due to the Health & Wellbeing Board meeting timescale for North Lincolnshire Council. That Board had now agreed that should the proposals post the decision not be in the best interest of the population they reserved the right to refer to the Secretary of State under the new guidelines.

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

4.1 **Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)014**

Una Macleod referred to the report and explained it included those matters for escalation to the Trust Boards-in-Common. It was noted there had been agreement at the meeting to reduce the BAF risk 3.2 from 25 to 20. Concerns had been raised in respect of the Summary Hospital-Level Indicator Mortality (SHMI) at HUTH as there had been an increase during the previous three months those areas had been noted within the report. The highlight report also noted areas where the Committees-in-Common had been assured.

Sue Liburd referred to the report in respect of the NLaG Staffing issues in Maternity Services although this had been raised there were no major concerns. Dr Kate Wood referred to the SHMI figure and advised a robust process had been introduced at NLaG six years ago, following this improvements had been made. It was recognised SHMI at HUTH had been increasing and were now sitting on the as expected range. Over the next few months processes would be reviewed to introduce a similar structure across the Trusts. It was noted the Quality & Safety Committees-in-Common would undertake deep dives in various areas over coming months.

Linda Jackson requested that reports shared at the Trust Boards-in-Common were clearer in terms of which Trust was being referred to. This would make it clearer when regulators where reviewing services in the future. It was felt the Committees-in-Common had worked very well during the first month. Quoracy had been an issue, however, it was felt this would become more robust once roles had been appointed and deputies were identified. It was agreed discussion would take place at the NED meeting to ensure those points were clearer within highlight reports going forward. Stuart Hall felt there had been positive progress with the Committees-in-Common and this should be commended to those involved.

Stuart Hall referred to the assurance received in respect of Transcatheter Aortic Valve Implantation or Replacement (TAVI) actions in respect of progress. Dr Kate Wood advised the report for HUTH had been received into the organisation early January, this had now been shared with the cardiologists and the wider team. This had now been returned following a factual accuracy process, relevant governance processes would be in place once the final version was received by HUTH. As there had been developments and progress from the action plan it had

been determined that NHSE and the ICB monthly review meetings would cease, routine updates would, therefore, be shared through the Quality & Improvement Group. It was noted this showed the progress made by the team in respect of TAVI.

Sean Lyons sought approval in respect of the reduction of the Board Assurance Framework (BAF) risk. This was approved by both Boards.

Sean Lyons sought comments in respect of confidence that all recommendations from the Committees-in-Common would be followed up appropriately. The Trust Boards-in-Common were content this would be in place.

4.1.2 **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(24)015**

Jenny Hinchliffe advised the Trusts reports would be aligned more in the future. Rukeya Miah referred to the HUTH Report and highlighted key actions. It was noted HUTH had fully completed 11 of the actions in respect of the Section 31 received from the CQC. A further eight had been delivered with pending evidence of sustained improvement. In respect of the remaining 25 actions, 21 were on track with overall delivery to be completed by April 2024. Rukeya Miah continued to report on other actions within the report.

Mike Robson referred to the shortage of midwives and queried whether this related to HUTH in particular, if so would there be a solution to resolve this due to the costs of employing the additional midwives. Rukeya Miah advised this was a national area of concern, this also included diversifying the workforce to ensure the correct leaders were in place. It was noted the equivalent of 15.8 newly qualified midwives had been appointed and it was important to ensure they were now supported in those roles. This also included the recruitment of national midwives who would need to be supported. Recruitment and retention were key across the organisations when supporting those roles. Ashok Pathak referred to fundal height monitoring detailed within the report as this had previously been raised as an issue, a query was raised as to whether this had been resolved. Rukeya Miah explained that once results were recorded on the Day Unit a Senior Registrar would review this and would raise issues at that point, she was not currently aware of any issues being raised. It was noted the process in place was quite rigorous.

Jonathan Lofthouse queried whether the current whole-time equivalents (wte) were against the current birth rate plus profile and whether they related to 20 full midwives or if the roles were enhanced leadership roles. Rukeya Miah advised those roles were clinical senior leadership positions.

Dr Kate Wood thanked Rukeya Miah for presenting the report. In respect of the CQC Improvement Plan and Section 31 there had been intense progress made and tangible differences were being seen, particularly with the triage and metrics that were presented on a fortnightly basis. Thanks were also noted to Lesley Heelbeck for the support being provided during the HUTH improvement journey. Work continued with the process of completing diagnostics to move this further forward.

Stuart Hall referred to the supported offered to newly recruited staff in this area and queried whether this detracted from other areas. The second query related to what

support was being given to those staff that approached retirement age. Rukeya Miah advised one of her key priorities was nurturing and supporting staff. A maternity specific training package had been introduced for those staff to enhance support. Stuart Hall felt current skills needed to be built on when recruiting nationally. Rukeya Miah recognised the points made and advised ongoing support would be provided. It was noted support aligned to the national model and was a priority for the team. Further support was also being provided by the newly appointed international midwife.

Sean Lyons sought comments from Lesley Heelbeck on the points made. Lesley Heelbeck wanted to highlight that since September 2023 there had been large improvements. Check and challenge needed to be built in from Board to ward to ensure those improvements were maintained. There was opportunities to build in processes especially as the Trusts started to work together. Links to other Trusts in the area would also provide assurance and guidance in the future. It was important time was provided to put the quality improvement work in place. The teams also needed to be clear on feedback being provided including what the Board were being asked to support. Lesley Heelbeck wanted to thank those that had supported this work, the teams had been very positive and passionate about implementing improvements.

Lee Bond referred to the CQC actions that were still on track to be completed by April 2024, a query was raised as to whether the Board needed to be aware of any concerns in respect of the four that remained. Rukeya Miah confirmed the teams were ensuring comprehensive evidence would be provided by the deadline.

Nicky Foster referred to the report and noted key highlights. It was reported all ten actions had been completed for the CNST submission. The formal report following the inspection of Maternity Services in Goole was still awaited, however, positive feedback had been received at the time.

Linda Jackson requested that the reports included key summaries to ensure concerns for both Trusts were clearer. She had found it difficult to identify key issues that the Boards needed to be sighted on. Lesley Heelbeck agreed to support this being included in future reports. It was noted a minimum data set was required and would be included within the report, however, it was recognised this needed to be more clearer. Sean Lyons highlighted Rob Chidlow would be the point of contact for any improvements to the report. Stuart Hall felt the points raised by Linda Jackson were important to ensure the Trust Boards-in-Common were sighted on concerns being raised to provide assurance. Sue Liburd noted that although the Quality & Safety Committees-in-Common required more detailed reports to provide assurance this was not a requirement for the Boards.

4.1.3 **Maternity & Neonatal Safety: NED Safety Champions' Reports – NLaG and HUTH – BIC(24)016**

Sue Liburd advised it was important to share the information with the Boards-in-Common to ensure evidence was sighted by the Boards. In respect of NLaG the report included areas that had been highlighted to the Quality & Safety Committees-in-Common regarding midwifery services, this related to the non-appointment of the Director of Maternity Services and Group Chief Nurse along with other Care Group related roles. It was noted those issues were being addressed. Those issues had also been raised through the Workforce, Education

& Culture Committees-in-Common and it was felt they would be addressed in the short term. The importance of the Pastoral Care Midwife had been recognised as this supported internationally employed midwives.

Stuart Hall reported both Trusts continued to strengthen relationships to make improvements with joint visits due to be undertaken to support this. A recent walkaround had revealed an area of concern in respect of Badgernet training and whether this would include the recording female genital mutilisation. Rukeya Miah advised this work was in hand and would be migrated across, issues raised in respect of this would be addressed to ensure robust assurance was in place.

Sean Lyons sought assurance from the Trust Boards-in-Common that this item had been discussed adequately to provide assurance, this was agreed by the Boards.

4.2 **Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)017**

Jane Hawkard referred to the report and highlighted HUTH had received an Internal Audit Report for Discharge Management. It was noted that although a Reasonable Assurance opinion had been received there had been four indicator recommendations. Within those there had been many points, the Audit, Risk & Governance Committees-in-Common had wanted to make the Executive team aware of them. In terms of overdue actions from the previous meeting those had reduced. It was noted in terms of Data Security & Protection (DSP) Toolkit both Trusts had achieved high compliance, however, this required 95% compliance. It was important this was achieved moving forward.

It was reported a tendering process for external auditors at HUTH was being undertaken, the Terms of Reference had been updated to reflect this. Fraud Awareness training at NLaG was mandatory, compliance for this had been noted at 93%. It had been recognised this training was not mandatory at HUTH, however, the Local Counter Fraud Specialist (LCFS) was applying to put this in place through the Workforce Committees-in-Common. It was noted 40% of the Subject Access Requests (SARS) at HUTH had not met the 30-day response deadline and concern had been raised in respect of this. In comparison this was not an issue at NLaG where all requests had been met within this timescale. Sean Lyons requested both Boards ensured all mandatory training was completed within required deadlines.

4.3 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)018**

Gill Ponder referred to report and advised the Committees-in-Common had focused on emergency care and ambulance handovers. It had been recognised there had been winter pressures and a request had been made for a performance trajectory against the reset targets for the remainder of the year. A deep dive was also due to be shared for emergency care. One issue raised was around no criteria to reside (NCR), this had been raised due to the loss of bed days at HUTH. The industrial action had impacted on some areas as detailed within the report. It was reported the committee had considered contract approvals and it had been agreed that both Trusts would be aligned in respect of expiry dates in the future. Both contracts considered had been approved with one awaiting the Boards

approval. The Boards attention was drawn to NLaGs cash flow forecast as some support may be required in Quarter One of the next financial year. Capital had been discussed in respect of the risk of underspending, some items due to be purchased in the next financial year had been brought forward to try and support this. The Finance and Performance Committee at NLaG in December 2023 had raised concerns regarding patient and staff safety issues and clinical risks arising from items on the action log received. It was advised those actions would be reviewed further.

Stuart Hall referred to the deep dive on ambulance handovers in respect of 60 plus minutes and queried whether there was sufficient resilience in the system to achieve this. Shaun Stacey explained the single point of access went live at the beginning of January 2024 and was showing some progress in the intervening of category three, four and five work. There was some avoidance in respect of patients being brought to hospital who did not require the intervention of the ED that could have gone straight to the UTC, referrals into community services was also being seen. Teams across both Trusts were working together to make improvements and learn from one another.

Kate Truscott referred to the NCR December figures and queries whether this was due to seasonal pressures or if this was due to an issue with supporting patients for discharge. Shaun Stacey explained this had commenced around a year ago when the numbers had been much higher, this had meant significant improvements were made through joint working. However, as expected this had struggled through the winter period. Focus on improvements would continue in this area.

Ashok Pathok queried whether providers other than City Health Care Partnership CIC (CHCP) would support the UTC. A further query was raised as to whether they were monitored for patient care and if there were any records on how many patients discharged to CHCP were then readmitted back to HUTH. Jonathan Lofthouse explained CHCP was a partner of HUTH and Humber and North Yorkshire (H&NY). They had grown due to the quality of output and had a high level of good patient experience. They would also be monitored for patient care as any other provider would be in terms of CQC. In terms of readmission, data would be included within the IPR. Shaun Stacey confirmed CHCP were working together with the South Bank community team in partnership.

Linda Jackson referred to the cash support issue at NLaG and queried whether this would mean loans would be required. Lee Bond confirmed this would be the case. A further query was raised as to where the call bell issue at NLaG had been closed and whether the committee had been assured. Gill Ponder advised this had been appended to a report that was shared at the meeting. It was felt the action had been closed due to no funding being available, instead of the action remaining open to be reviewed further. Discussion at the committee had highlighted there had been pressure to close the risk. Linda Jackson felt this should have been escalated appropriately. Gill Ponder advised an action to follow this up had been requested by the Committees-in-Common.

Mike Robson referred to the NCR point as it had previously been recognised that estimated dates for discharge (EDDs) were not being set for patients. Shaun Stacey explained this would be part of the ward round and would include EDDs on all HUTH inpatient sites from the following week. The aim would be to reach 89%

which should increase to 95% going forward. Shaun Stacey advised that since December 2023 the approach for NCR patients had been an integrated approach across all sectors and that he led a group with Primary Care Networks (PCNs) colleagues who were fully engaged in this becoming more joined up. It was felt a further session on this may be beneficial to provide more oversight.

4.4 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)019**

Tony Curry highlighted issues around non completion of training had been raised during the meeting. Some issues for staff at HUTH had related to insufficient time due to completing work around actions relating to CQC improvements. Training space issues had been discussed particularly with the loss of Suite 22 at Castle Hill Hospital (CHH), it was reported this would be addressed going forward. The lack of diversity emerging around the senior leadership structure had been noted. Particular areas of additional assurance being sought were noted in respect of retention and the turnover of staff within 12 months. Deep dive analysis had been requested by the Committees-in-Common to be shared in due course. In respect of the BAF the HUTH BAF Risk 2 had been reduced to reflect the improved nursing establishment and vacancy position. However, the NLaG BAF Strategic Objective 5 had been increased due to the ongoing senior leadership changes relating to the new Group transition.

Linda Jackson referred to the Advanced Clinical Practitioners (ACP) point raised within the report and explained that NLaG had trained those staff, however, in some areas clinical staff had not been willing to accept them as trained individuals. Concerns had been raised that trained staff were, therefore, not being utilised as they should be. In respect of staff training at NLaG, 30% of those booked to attend did not attend the sessions. Sean Lyons requested this was focussed on within teams to ensure attendance. A query was raised as to whether some of the targets set were not achievable and whether this was being addressed.

Simon Nearney referred to the point in respect of training accommodation and confirmed this was an issue on both the North and South bank. A commitment had been made to ensure the accommodation at CHH was to be addressed, it was reported the issues with the Lecture Theatre at the Scunthorpe was also being addressed. In terms of the training issue this was now being addressed by the People team who would liaise with the Care Groups to ensure improvements were made. It was confirmed this was 25% on the South Bank which was not acceptable. The compliance figures were currently 85% for the North Bank with the South Bank at 90%. Sean Lyons felt this issue should continue to be focussed on.

Kate Truscott wanted to note thanks to Rebecca Thompson and Amy Slaughter for supporting the first meeting of the Workforce Committees-in-Common.

Jonathan Lofthouse confirmed that staff at a band 8d and above were monitored through the Group CEO office, this included an email to individuals to request training was completed. It was confirmed compliance for senior staff on the South Bank was currently at 91% and on the North Bank this was 89%. On a weekly basis the none completion of training would be focussed on by the senior leadership team with care groups being held to account.

4.4.1 **Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 3) – NLaG & HUTH – BIC(24)020**

Frances Moverley referred to the report and noted there had been an increase in respect of administration staff raising concerns, medical and dental staff concerns had been reduced.

Frances Moverley advised more links were being made with Liz Houchin the FTSUG at NLaG. Changes to reporting would commence from quarter one to ensure consistency across both Trusts. It was noted both Trusts would continue with sovereign guardians. The Strategy for Freedom to Speak Up was due to be updated in August 2024, discussions had commenced as to whether a joint Strategy should be implemented across both organisations. It was felt this would be the way forward to share best practice between the two.

Simon Nearney highlighted key points from the report and advised NLaG had a higher number of staff reporting concerns than HUTH. Kate Truscott queried whether the reports had previously been triangulated with the staff survey results when issues were addressed. Simon Nearney advised both guardians would be reviewing this when the results were shared. It was reported the guardians were also part of other forums where concerns were highlighted. Both guardians were also attending nurse inductions to highlight how concerns could be raised.

Sean Lyons queried whether the guardians felt supported in respect of some of the issues that were raised by staff. Frances Moverley advised both herself and Liz Houchin supported each other and had support through the National Guardian Office when required.

4.5 **Health Tree Foundation Trustees' Committee Highlight / Escalation Report & Board Challenge – NLaG – BIC(24)021**

Gill Ponder referred to the report and noted key highlights. It was noted the Committee had not been quorate for some of the meeting. The Annual Accounts had been approved and submitted to the charity commission.

4.5.1 **Chair of Health Tree Foundation Trustees' Committee – Extension of Tenure – BIC(24)022**

The NLaG Trust Board were asked to approve the extension of Neil Gammon as Chair of the Committee. It was noted the Foundation Patron was due to stand down at some point during 2024. Following some discussion it was agreed Sue Liburd would seek more understanding of what would be required to fulfil this role once Sir Reginald Sheffield had stood down.

Action: Sue Liburd to seek more understanding on what was required of the role

The NLaG Trust Board approved the extension of Neil Gammon as Chair of the Committee for a further three years until the end of March 2027.

4.6 **Charitable Funds Committee Highlight / Escalation Report & Board Challenge – HUTH – BIC(24)046**

Tony Curry referred to the report and confirmed the committee had received and approved the annual accounts. The committee were still in the process of formally moving the funds to the Wish Charity.

5. GOVERNANCE & ASSURANCE

5.1 **Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(24)023**

Rebecca Thompson referred to the report and took this as read. It was noted the reduced risks within the report had been covered within the Committees-in-Common highlight reports. The BAF format would further change going forward, a board development session would be held in March to support this.

The Boards in Common approved the changes.

5.2 **Trust Boards' Aligned Business Reporting Framework – BIC(24)024**

Rebecca Thompson sought approval of the updated framework in light of minor changes. Una Macleod queried whether research would be discussed once in three years at the Boards-in-Common as detailed within the report. After further discussion it was agreed this would be reviewed further.

Lee Bond referred to the Security LSMS Annual Report and Workplan as it currently had no Committees-in-Common oversight aligned to the report. It was confirmed oversight would be from the Performance, Estates and Finance Committees-in-Common. Following discussion it was agreed the paper should be reviewed to ensure the sharing of reports was correct. This included ensuring the relevant person was assigned to reports.

5.3 **Trust Boards & Committees Meeting Cycle – BIC(24)025**

Rebecca Thompson advised this would be updated in the future to include the Performance Management Accounting Framework.

6. OTHER ITEMS FOR APPROVAL

There were no other items for approval.

7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

7.1 **Items for Information / Supporting Papers**

- Quality & Safety Committee – December 2023 (NLaG)
- Quality – December 2023 (HUTH)
- Audit, Risk & Governance – November & December 2023 (NLaG)
- Audit Committee – October 2023 (HUTH)
- NLaG ARG Committee Annual Self-Assessment Exercise
- HUTH Audit Committee Annual Self-Assessment Exercise
- Finance & Performance – December 2023 (NLaG)

- Performance & Finance – December 2023 (HUTH)
- Workforce – November 2023 (NLaG)
- Workforce, Education & Culture – December 2023 (HUTH)
- Health Tree Foundation Trustees' – November 2023 (NLaG)
- Charitable Funds (HUTH)
- Integrated Performance Report (IPR)

8. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

Sean Lyons asked for reflections on the first Boards in Common meeting and requested feedback on anything to be included in future meetings. Nothing was raised in respect of this.

9. QUESTIONS FROM THE PUBLIC AND GOVERNORS

No questions from the public or governors were received.

10. MATTERS FOR REFERRAL TO BOARD-IN-COMMON

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

11. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 11 April 2024 at 9.00 am in the Main Boardroom, Diana, Princess of Wales Hospital

The committee chair closed the meeting at 12.42 hours.

Cumulative Record of Board Director's Attendance 2024

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	2	1	Ivan McConnell	2	1
Jonathan Lofthouse	2	2	Simon Nearney	2	2
Lee Bond	2	2	Ashok Pathak	2	2
Tony Curry	2	2	Simon Parkes	2	2
Stuart Hall	2	2	Gill Ponder	2	2
Linda Jackson	2	2	Mike Robson	2	2
Jane Hawkard	2	2	Shaun Stacey	2	2
Jo Ledger	2	1	Kate Truscott	2	1
Sue Liburd	2	2	Kate Wood	2	1
Una Macleod	2	2			

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(24)051

BOARDS-IN-COMMON ACTION TRACKER

2024

ACTION TRACKER - CURRENT ACTIONS - 11 APRIL 2024

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

Key:

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

ACTION TRACKER - CLOSED ACTIONS

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence

Key:

Green	Completed - can be closed following meeting

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda Item No: BIC(24)052

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 April 2024
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer/Author	Jonathan Lofthouse, Group Chief Executive
Title of the Report	Group Chief Executive's briefing
Executive Summary	This report updates the Trust Boards in Common on progress in senior appointments; strategic direction updates and the headlines of patient safety, quality, finance and performance
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Group Chief Executive Officer

Briefing to the Trust Boards in Common
Thursday 11 April 2024

1. Introduction

1.1 I am privileged to provide this first update to the Trust Boards in the new operating year.

1.2 I am very pleased to update the Trust Boards that the following colleagues have joined us since our last public board meeting:

- Andy Haywood, Group Chief Digital Officer, who started 26 February 2024.
- David Sharif, Group Director of Assurance, who started on 4 March 2024 and joins his first public Trust Boards in Common meeting today.
- Anita Jackson, Group Director of Transformation, who also started 4 March 2024.
- Neil Rogers, who joined as Managing Director for our North site triumvirate team, on 15 March 2024.
- Tracy Campbell, our Nurse Director for our North site triumvirate team, who started with us on 1 April 2024.
- Nick Cross started with us on 1 April 2024 as Medical Director for our South site triumvirate team.

1.3 I am delighted that we are joined today by Amanda Stanford, Group Chief Nurse. She formally starts on 22 April 2024 from Airedale NHS Foundation Trust, however, she has been able to join us in attendance at today's meeting as part of her induction to our Group.

1.4 Monday 1 April 2024 marked the Go Live of the new Care Group structure. I am extremely grateful to Shaun Stacey and a number of colleagues who have worked very hard to get our teams aligned for this start date. There is a significant journey to go on to embed the teams with their full range of support and I would like to acknowledge the efforts of so many colleagues to get us in to this position. We are starting on a solid foundation for our new Group operating structure, which is a bold and innovative structure. I make no apology for being ambitious for our patients and our staff, to start to harness our potential through this new structure.

1.5 There has been very good progress with making appointments to our Care Group vacancies. All posts have been to internal and external advert and a number of applications have been received for all posts. Interviews commenced on 28 March 2024 and are due to conclude on 18 April 2024. I have enjoyed the pre-interview discussions I have had with a number of candidates and look forward to welcoming colleagues in to these new roles.

1.6 We are due to hold our next senior leadership event on 16 April 2024. Our 100 most senior managers are due to spend time on developing their leadership skills with the input of Professor Michael West, who is an international leader in compassionate leadership. The focus of the day will be on our leaders' engagement with developing our Group strategy, and the Chairman and I are looking forward to spending time with colleagues on this crucial area of work.

1.7 I would also give our thanks to the staff who have worked tirelessly on the Lorenzo migration on our south bank sites, supported by colleagues from the north bank, and also those staff who have been part of the launch of Badgernet on our sites, with a roll-

out plan being completed at this present time. This has taken a great deal of expertise to deliver, with risks being anticipated and well managed. The time and support to our staff for these projects has been significant and I am really proud of how our teams have been working together to share resources and support through challenging project delivery requirements.

1.8 I am also very pleased to report to the Trust Boards in Common that we have a proposed Group branding name: the NHS Humber Health Partnership. We proposed four potential names that were in line with NHS England branding requirements, and engaged across our workforce to vote on their preferred one. I am recommending that the Trust Boards in Common adopt the branding name of the NHS Humber Health Partnership following the staff engagement piece, and I ask for the Boards' approval for this.

2. Patient Safety, Quality Governance and Patient Experience

2.1 As Board members are aware, there was an incident in our Grimsby mortuary site on 17 March 2024. I cannot comment publically on the details of what is an active police investigation. I am profoundly sorry to all the families of loved ones who have been affected by this incident. I am extremely grateful for the professionalism and dedication of our staff who have dealt with the immediate aftermath, as well as to those staff who have communicated with those families affected. This has been done with a great deal of compassion and care, and I send my sincere thanks to those staff. I have sent Duty of Candour letters to these families.

2.2 The basis of our Group strategy will be to focus on health inequalities. As I presented at our last senior leadership conference, the health inequalities that our patients, and our staff, are affected by are profound. We have such an opportunity to use our capabilities, our public funding and our position as an anchor institution, to significantly improve the health outcomes for our local population. I look forward to this period of engagement with the Trust Board, our Governors, our staff and our stakeholders, to put together an ambitious strategy to better meet our patients' needs and concentrate our collective efforts on improving quality of life years for as many people as possible.

3. Elective Care and Urgent and Emergency Care

3.1 The year-end position is subject to data validation, however I can share the headlines of what we are expecting to see.

3.2 The headline position for Hull University Teaching Hospitals NHS Trust is that there has been an improvement in meeting the four-hour standard for Urgent and Emergency care, with a positive impact seen from the establishment of the walk-in urgent care centre on the Hull Royal Infirmary site. Our Urgent and Emergency four-hour performance as a Hull and East Riding system has been circa 61% for the last two months, which is a consistent improvement on previous months' performance. Our underlying Type 1 Emergency Department performance remains significantly impacted by patient flow and daily performance remains too variable from a patient experience perspective. We have not met the 76% requirement for 31 March 2024 and, while our ambulance handover position has improved in the last two months, our 30-minute handover performance improvement remains below trajectory. We anticipate continuing to meet the faster diagnosis standard for cancer however will not have met the improvement requirements in 104 day referral to treatment standards nor the 62-day target. The number of 78-week breaches has been maintained and not worsened; at

the time of writing this report, there are fewer than 120 patients over 65-weeks on RTT pathways.

3.3 The headline position for Northern Lincolnshire and Goole (NLAG) NHS Foundation Trust is the focus remained on the zero 65-week waits by year-end however at the time of writing this report, there were circa 30 patients over 65-weeks at year end. We anticipate reporting that we have continued to meet the requirements on cancer two-week wait referrals and on the faster diagnosis of cancer standard, however is not achieving against the 62-day referral-to-treatment cancer target. Our Emergency Department performance for remains around 61% on average, which is below trajectory. There has been increased demand on both our south bank sites for urgent and emergency care in the last three months, which has impacted on four-hour performance and ambulance handover times.

4. Strategy and partnership developments

4.1 The Chairman and I have spent considerable time with regional and national colleagues in the last two months on next year's operating framework and financial planning requirements. I provide more detail about the specific requirements further on in this report.

4.2 I am pleased to have been accepted as Chief Executive lead in our ICB for our Collaboration of Acute Providers (CAP) and also to be the acute provider partner member on the ICB board. This will enable a number of actions that we can take in partnership to make more efficient use of our system capacity, particularly on elective care, and improve access and waiting times for our patients across our system.

4.3 The 2024-25 Priorities and Operational Planning guidance was published on 28 March 2024 by NHS England. The key requirements are as expected: focus on quality and safety, particularly maternity, neonates and health inequalities; improve ambulance response times and Emergency Department four-hour performance; reduce long elective waiting times and improve performance in diagnostic standards; improve access to community and primary care services, as well as mental health services; improve staff experience, retention and attendance. This is against a financial position of stand-still; the £2.45 billion budget increase for the NHS in 2024-25 will cover the cost of the consolidated pay deal and cost increases from 2023-24; the NHS otherwise needs to absorb inflationary costs and increasing demand within its funding envelope. A more detailed report on the Operating Plan and our Group's response will be received at the next Trust Boards in Common Committees and the Trust Boards in Common meetings.

4.4 Our key steps will be to produce our Group strategy, the engagement for which has already commenced and is being led by Ivan McConnell, Group Chief Strategy and Partnership's Officer, with my full support and that of his very able team. There will be extensive stakeholder engagement to produce our Group strategy, which will be published by the end of July 2024, and set our clear priorities for achievement over the next five years.

5. Financial Performance and Estates and Facilities updates

5.1 The headline position for Hull University Teaching Hospitals NHS Trust is that the Trust is anticipating closing year-end at financial plan. The deficit going in to next financial year will place particular pressure on our Group and our ICB system.

5.2 The headline position for Northern Lincolnshire and Goole NHS Foundation Trust is the same, anticipating being at financial plan at year-end.

5.3 In advance of the operational planning guidance publication, there had been detailed discussions with the ICB Executive team particularly around each organisation's financial plan. Our Group organisation is required to deliver a cost improvement plan of £84 million in 2024-25, against our turnover of circa £1.3 million.

5.4 To deliver this, a Group-wide financial improvement plan is being drawn together, which will include: operational efficiencies, workforce efficiency opportunities, income generation opportunities and efficiencies from service transformation. The sign-off and delivery of this plan will be subject to a Group Financial Improvement Board, which I am chairing, the first meeting of which is on Friday 12 April 2024. This has Cabinet and Director-level membership as well as our two Site Triumvirate teams. We have to take every opportunity to work smarter with every pound of public funding we have. This will require difficult choices, so we will include a risk assessment process to understand any impact of decision-making on service delivery before it is taken. The Boards and Committees in Common will be kept fully appraised of this.

5.5 From an estates point of view, a Group-wide bulletin is circulated on the number of capital development and digital schemes we have in progress at the moment. I am particularly pleased to report to the Trust Boards in Common that all of the Community Diagnostic Centres for which we are responsible are making good process. The steel structure for the Scunthorpe site continues at pace; the strip down and fit-out of the Grimsby site is on schedule; the East Riding scheme space has been confirmed and will accommodate all requirements; the Hull scheme is being worked through in partnership with Hull City Council as part of the city regeneration plan.

5.6 I am pleased to report that the official opening of the Scunthorpe General Hospital SDEC/IAAU scheme is planned for 16 April 2024. The investment in urgent and emergency care in our Group has been considerable. I am delighted that our patients are being seen in settings that are best-in-class in respect of estates and facilities, and know that our staff are keen to work on improving the efficiency and performance in our urgent and emergency care pathways, with these key estates enablers now in place.

6. Workforce Update

6.1 I am proud that we have attracted a record number of applicants during our most recent round of recruitment for nurse apprenticeship roles in Hull and the East Riding. This follows a campaign undertaken by the Widening Participation Team and Corporate Nursing Team (Apprenticeships) to target schools, colleges and the wider community to promote the Trust's autumn intake for nursing apprenticeships. A combination of in-school/college promotion and career engagement activities, social media activity, staff communication and ward visits to promote apprenticeship options has resulted in the biggest response to apprenticeship vacancies to date. An open event on 5th February attracted over 150 prospective candidates and their families/friends, and in total, some 628 applications have been received for roles at all levels, broken down by trainee nursing associates (416 applications); registered nurse degree apprenticeships (125); and apprentice healthcare support workers (87). Our north bank sites are the biggest investor in apprenticeships within the Humber and North Yorkshire Health and Care Partnership area, spending over £1m of apprenticeship levy in 2023/24, and more than £600k of this being used for nursing apprenticeships.

6.2 Our workforce figures continue to show improvement in respect of recruitment against vacancies and the number of staff absent from work.

6.3 The National Staff Survey results have been published since my last report to the Trust Boards in Common. The overall engagement scores for both our organisations have improved compared with last year, and there are some real achievements to celebrate. A more detailed analysis of the results has been shared with the Workforce, Education and Culture Committees in Common.

6.4 Clearly there is work to do to make further improvements in staff culture and staff morale. I share my colleagues' concern that the 2024-25 operational year is going to be one of the most challenging we will have to manage. The way in which we lead our organisation and work with our staff to focus on improving service delivery at a time of increasing demand and static resources is paramount. I will be investing our organisation's considerable talents and resource to meeting this challenge.

6.5 I am delighted to inform the Trust Boards that Hull University Teaching Hospitals NHS Trust has been successful with its Veterans Covenant Healthcare Alliance first year review. This is a wonderful achievement and great recognition of the work that our staff have put in to this scheme, many of whom are veterans or come from families of armed forces personnel.

7. Equality, Diversity and Inclusion (EDI)

7.1 Our annual Workforce returns (equalities and disabilities) are due for submission shortly and will be subject to scrutiny by the Workforce, Education and Culture Committee before sign off at the Trust Boards in Common.

7.2 Our three staff networks are starting to take a pan-Group approach, which I welcome. I give my full commitment to improving the work-place and life experiences of our staff, and creating a positive Group culture of inclusion and compassion.

7.3 Our staff engagement over the last few months to create our vision and values, as well as the feedback from the staff surveys, compel us to use the opportunity we have in creating a culture for a new Group organisation. We need to have compassion and inclusion at our core to make the greatest difference to all of our staff. We need to work on narrowing the gap that we, and all workplaces have, when considering the different experiences of staff with protected characteristics.

8. Good News Stories and Communications Updates

8.1 Maternity services at Goole and District Hospital have been rated 'good' by the Care Quality Commission (CQC). The service was praised for having a positive culture where staff felt supported and valued, with CQC inspectors noting staff were patient focused.

8.2 The portering service working across Hull Royal Infirmary and Castle Hill Hospital has been named 'Portering Team of the Year' at the National MyPorter Awards in London. The team was praised in particular for its introduction of the 'Ready to Go?' model, a simple checklist for wards and clinical areas to complete before booking a portering job; in turn, this has helped to reduce transfer delays and improve patient experience.

8.3 Following a stringent audit process, Hull and East Yorkshire Endometriosis Centre has received its 2024 accreditation from the British Society for Gynaecological Endoscopy (BSGE). The national accreditation process is designed to enhance the

delivery of care for women suffering with severe endometriosis. As well as providing assurance in this respect, accreditation is important insofar as it enables valuable research into the disease alongside the University of Hull to continue.

Jonathan Lofthouse
Group Chief Executive
Updated 10 April 2024

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)054

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Sue Liburd & Una Macleod, Non-Executive Directors and Chairs of the Quality and Safety Committees-in-Common
Contact Officer/Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Quality and Safety Committees-in-Common Highlight / Escalation Report
Executive Summary	The attached highlight / escalation report highlights matters considered by the Quality and Safety Committees-in-Common at its meetings held on 29 February 2024 and 28 March 2024, matters for escalation to the Boards, any additional assurance required, confirm and challenge of the BAF and any action required of the boards
Background Information and/or Supporting Document(s) (if applicable)	Quality & Safety Committees-in-Common Terms of Reference for NLaG & HUTH
Prior Approval Process	The report has been approved by the committee Chairs
Financial implication(s) **(if applicable)**	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐Review ✓ Assurance ☐ Other – please detail below:

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

Report for meeting of the Trust Boards to be held on:	11 April 2024
Report from:	Quality and Safety Committees-in-Common
Report from meetings held on:	29 February 2024 28 March 2024
Quoracy requirements met:	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 meetings held on 29 February 2024 and 28 March 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

29 February 2024

- Board Assurance Framework HUTH/NLAG
- Integrated Performance Report HUTH/NLAG
- HUTH CQC Improvement Plan
- HUTH Maternity CQC Improvement Plan and Section 31 Update
- NLAG CQC Improvement Plan
- HUTH Maternity and Neonatal Assurance Report
- NLAG Maternity and Neonatal Assurance Report
- Children and Young People Assurance NLAG
- PSIRF/Serious Incidents (including Duty of Candour and lessons learned) HUTH/NLAG
- Mortality and Learning from Deaths HUTH/NLAG
- CQUINS HUTH/NLAG
- IPC BAF HUTH
- CNST Action Plan HUTH/NLAG
- Deep Dive – Falls prevention

28 March 2024

- PSIRF/Serious Incidents

- Board Assurance Framework HUTH/NLAG
- Integrated Performance Report HUTH/NLAG
- HUTH CQC Improvement Plan
- HUTH Maternity CQC Improvement Plan
- NLAG CQC Improvement Plan
- NLAG Nursing Assurance Report
- Maternity and Neonatal Assurance Report
- Mortality including Learning from Deaths
- Research, Innovation and Development Quarterly Update
- Deep dive – Tissue viability
- Deep dive – Theatres Workstream

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:

29 February 2024

HUTH

a. Maternity triage overnight. The Trust has sustained achievement of the 95% performance KPI to see women in the required risk based times during the day in January and February 2024. However, The CIC was not assured over arrangements in place at night and further assurance was requested.

b. The Committee-in-Common was not assured and further assurance was requested.

c. CQC Maternity actions. The Committee-in-Common wanted further assurance regarding how the completed actions would be sustained. It was agreed that regular updates would be received until the Committee-in-Common was assured that the actions are embedded and being sustained.

d. Mortality – A further update will be received in March 2024. Governance work streams are being developed and work is ongoing to review how mortality is triangulated and reported.

28 March 2024

HUTH

a. The trust had seen its highest NCTR discharge rate in March 2024 with 34 patients being discharged in one day.

b. Sepsis. Further assurance required, however the Coroner is now engaged with the Trust and satisfied with the direction of travel.

NLAG

a. CDifficile performance at year-end was 17 cases against a threshold of 20.

b. Goole Maternity services had been rated as “Good” following the CQC inspection.

c. Antenatal triage phone call recording issues have been added to the risk register. A number of issues have been raised due to storage, information governance and the ability to link patient identification.

d. CNST compliance was confirmed as 10 out of 10 with the standards.

4.0 Matters on which the committees received assurance

4.1 The committees received assurance on the following items of business:

29 February 2024

NLAG

a. Infection Prevention and Control relating to the measles issue. Reasonable assurance was received for the management and containment.

b. CQC. Significant progress has been made regarding the action plan. The Goole Midwifery report had been received and factual accuracy checks are being carried out.

c. Reasonable assurance was received regarding Maternity and the Trust was awaiting exit notification from the Maternity Safety Support Programme.

d. PSIRF work was ongoing and being aligned across the Group.

e. CQUINs – good assurance was received regarding the compliance around antibiotics, medicines on discharge and pressure ulcers.

HUTH

a. Infection Prevention and Control relating to the measles issue. Reasonable assurance was received for the management and containment.

b. PSIRF - reasonable assurance was received regarding the maturing processes and ongoing after action reviews and tabletop exercises.

c. Positive assurance was received from the Falls Lead Nurse. A deep dive into falls improvements was received. The improvements will be monitored through the IPR and further updates.

28 March 2024

Group

a. Nursing reports detailing care hours per patient day were presented from both organisations.

b. A Research and Development Strategy is being developed in conjunction with the University of Hull.

c. An operational update was received and the CIC discussed the Lorenzo outage and restoration time, ED, Ambulance handovers, 65 and 78 week delays.

NLAG

a. The Quality priorities were discussed and further reports with progress would be received.

b. CQC action completion and escalation was received. A quarterly review of actions would be completed.

c. CNST compliance was confirmed as 10/10 with the standards.

HUTH

a. Maternity CQC action plan was received. There was further work to complete regarding closure, but good progress had been made against the actions.

b. Deep dive into Tissue Viability with a focus on training figures and the restructuring of the team.

c. Deep dive into Theatres. There was more work to do regarding mental capacity and consent.

5.0 Matters on which the committees have requested additional assurance:

5.1 The committee requested additional assurance on the following items of business:

29 February 2024

NLAG

a. Integrated Performance Report – Sepsis and ePMA waits were highlighted as requiring more assurance. A revised sepsis tool and improvement plan is being developed.

HUTH

a. Mortality – a verbal update was requested at the next meeting in March 2024.

b. CQUIN – the Committee-in-Common was not assured with the CQUIN relating to nutrition. Further updates would be received.

c. Duty of Candour – further assurance was requested. Work would be expedited and measured through the IPR.

28 March 2024

Group

a. Challenge to all medical and nursing staff to ensure bare below the elbows.

HUTH

a. The committee asked for further assurance in respect of nutrition particularly relating to documentation issues.

b. The CICs received a verbal update on the proposed North Bank strategy to co-ordinate improved focused on initiatives to challenge and improve mortality data as requested at the February 2024 meeting. This addressed some initial high level drivers across site activities and services across the Group/region. A detailed update, incorporating these and the Group Mortality approach would be received at the May 2024 meeting.

NLAG

a. Midwifery vacancy rate remains a challenge. There are now 11 international midwives and the final 4 are due in clinical areas in the coming weeks.

b. There has been an Increase in pressure ulcers for both Community and Acute.

6.0 Confirm or challenge of the Board Assurance Framework (BAF):

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

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- note the issues for escalation.

Sue Liburd

Quality & Safety Committee-in-Common Chair (for the meetings held on 29 February and 28 March 2024)

2 April 2024

NHS
Hull University Teaching Hospitals
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Northern Lincolnshire and Goole
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)055

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 April 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 Champions for both Trusts are pleased to note the appointment of a Group Director of Midwifery who will commence in Q1 24/25 and bring leadership across the Group's sites. Both Trusts have identified priority funding requirements to principally meet Birthrate+ requirements (HUTH) and sustain Ockenden funded posts (NLAG) which are being worked through with the ICB and LMNS.
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: • 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.
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 February and March 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 February and March have included the standard programme of walk rounds, service level meetings, and meetings with service leaders including the Head of Midwifery.

In addition, across both organisations the Champions have attended the following:

HUTH

- 5 Feb - Badgernet implementation meeting;
- 6 Feb Humber and North Yorkshire Local Maternity and Neonatal System (LMNS) Perinatal Quality and Safety Assurance Group;
- 8 Mar Maternity assurance visit;
- 8 Mar Maternity and neonatal champions meeting;
- 20 Mar Maternity Safety Support Programme (MSSP) Maternity Improvement Advisor (MIA).

NLAG

- 13 Feb Humber and North Yorkshire Local Maternity and Neonatal System;
- 20 Feb Maternity Transformation & Improvement Board;
- 28 Feb Maternity and Neonatal Champion walk around Diana Princess of Wales Hospital.

- In March, the planned Maternity Transformation Improvement Group was stood down due to staff availability.
- It was separately noted that Goole maintained its "Good" rating for CQC, with an improvement in the Well Led domain and NLAG during this time from the work the group has overseen.

Learning Lessons:		**Staff Experience & Feedback:**
The importance of training our staff to give them the skills to perform their roles safely and to the best of their ability is where there is some variability across the Trusts particularly with regards to safeguarding. The Champion for HUTH welcomes the marked improvement in training compliance above target in the majority of specialties and is championing the need to ensure we have long term planned and sustainable provision and facilitate	Service User feedback remains largely positive, although it is felt that there is more work to do on the North Bank to capture compliments and wider feedback. This will be important to understand the BadgerNet implementation. Both trusts have received the 2023 Maternity Survey results and are putting actions in place to learn and improve for future surveys, which Champions will be a part of with other stakeholders.	The Safety Champion for HUTH reports a positive response in relation to the BadgerNet role out and for the training received as part of implementation in February. The Safety Champion for NLAG has drawn out the feedback in respect of pastoral support which appears to be working well.

staff having enough time to fulfil their responsibilities. The Safety Champion for NLAG is keen to see we address the feedback from CQC in respect of our reporting at site specific level from our CQC report published in March as we transition to our Group model.		

Good practice, improvements & innovation to share:

The Safety Champion for NLAG has been engaged with the Quality Improvement work in respect of thermoregulation and is pleased to report this QIP has been successfully concluded in February 2024.

The Champions have reported a reduction in midwifery vacancies across the group, although still high, in addition to turnover markedly reducing.

Risks & concerns to escalate:

The Champions for both Trusts are pleased to note the appointment of a Group Director of Midwifery who will commence in Q1 24/25 and bring leadership across the Group's sites.

In the interim, this has created some uncertainty for staff and leadership particularly at HUTH and has been flagged as a risk at the Quality and Safety Committees-in-Common. It is noted there is Improvement Support now in place on the North Bank (HUTH).

The Champions are conscious that both HUTH and NLAG have attended an ICB meeting in March to review and prioritise planned investments for 2024/25 given the funding pressures and are keen to see progression with the HUTH requirement for prioritise in respect of sustaining triage and leadership, and at NLAG to embed roles funding non-recurrently through Ockenden funding.

Activities planned next month:

The following activities are planned during the month:

HUTH
11 April – HNY LMNS meeting
12 April – Maternity and neonatal safety champions
17 April – MSSP MIA Monthly meeting
23 April – Maternity Safety Support Sharing Event

In addition, the Safety Champion for HUTH is committed to undertaking a walk around of the departments outside of core daytime hours to understand the progress being made in respect of handover arrangements and triage from previous regulatory reviews.

NLAG
11 April - HNY LMNS meeting
12 April - NHSE Midlands Maternity NED Network
16 April - Maternity Transformation & Improvement Board
24 April - Maternity and Neonatal safety champions walk around.

The Champions are keen to introduce a joint visit within Q1 of 24/25 to further the opportunities available to the Group.

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

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

2 April 2024

NHS
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)56

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 April 2024
Director Lead	Group Chief Nurse
Contact Officer/Author	Rukeya Miah, Acting Head of Midwifery & Neonatal Services Nicky Foster, Head of Midwifery
Title of the Report	Maternity & Neonatal Oversight Report
Executive Summary	**HUTH** **1. Workforce** Midwifery workforce remains challenging. The service appointed 10wte internationally educated midwives that require a lengthy supernumerary period. In addition there are 14 (11.99 WTE) midwives that are still on maternity leave and are due to return June and July 2024. The service has recently undertaken a recruitment process for student who qualify in September 2024 they were 26.6wte students that were successful through this process. There is a new proposed Establishment / Leadership structure that is going through internal executive approval. **2. Clinical Negligence Scheme for Trust (CNST) year 5** NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. HUTH declared 5/10 standards for year 5 and are currently working towards year 6 standards which was published on 2 April 2024. The Saving Babies lives submission (Appendix V) has demonstrated significant progress against Elements 2 (fetal Growth Restriction) and 6 (management of Diabetes in pregnancy). **3. Quality Improvements** **Maternity** - The leadership structure is under review and the service is focusing on clinical pathway for induction of labour. **Neonates** - The service was successful in securing a funding bid to expand the number of neonatal intensive care and high dependency cots. The building work is now completed, the expansion has provided an additional 2 intensive care cots and an additional 3 high dependency cots. **4. Patient Experience** Service user feedback from FFT/complaints/PALS highlights themes in relation to treatment in care, staff attitude and discharge process. The service will ensure this feedback is captured in future quality improvement work. The service does also receive a high number of compliments and thank you cards which are not always captured through data which is an additional area for improvement. **5. Maternity Safety Support Programme** The service continues to work closely with the maternity and obstetric MIAs on a number of improvements which include, patient pathways,

workforce, maternity triage and improvement sustainability.

6. **Maternity Safety Champions**
   Safety Champions undertake a monthly walk round across the maternity and neonatal services alternating the venue each time. This provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication. There are close links to the Maternity and Neonatal Voices Partnership (MNVP) to ensure the voices of birthing people are represented.

7. **External Visits**
   There have been no external visits on the HUTH site. The Trust's monthly assurance visit programme was supported by external colleagues from the ICB, and Healthwatch East Riding of Yorkshire.

NLAG

1. **Workforce**
   Midwifery vacancy rate remains a challenge. There are now 11 international midwives who have joined the maternity service, the final 4 are due in clinical areas in a supernumerary capacity in coming weeks. Newly qualified midwives recently recruited and positively impacting on midwifery vacancies.

2. **Clinical Negligence Scheme for Trusts (CNST) V5**
   Full compliance will be reported for year 5.

3. **Quality Improvement**
   Current ongoing Quality Improvement (QI) projects within maternity services include Neonatal Thermoregulation; Antenatal clinic/Antenatal Day Unit and the Maternity Triage Service. Capacity and Demand modelling has for ANC/Day Units has taken place by the operational team and has highlighted there are 246 slots per Trust wide short.

4. **Patient Experience and Service User Feedback**
   The Maternity Service continues to receive relatively low numbers of new complaints and PALS concerns. Maternity and Neonatal Maternity Voices Partnership (MNVP) Lead in post and maternity services have commenced co-production of maternity services with the MNVP. Service user feedback through FFT highlights a theme of dissatisfaction around long waiting times. A capacity and demand review is underway within the division.

5. **Maternity Safety Support Programme**
   The Trust has confirmation that the Maternity Safety Support Programme will be exited will be exited once there is stability of the care groups, following governance agreement at local, regional and national levels.

6. **Maternity Safety Champions**
   Locally there are embedded monthly walk arounds across the maternity and neonatal services by the Safety Champions alternating the site venue each time is also a Shout Out Wednesday event each month which enables escalation by all staff of any safety concerns as well as the safety mailboxes open to all. An action log is collated ensuring learning and improvement opportunities are captured and progress monitored.

7. **External Visits**
   CQC inspection of Maternity Services (Goole) 21 November 2023. Report received into the Trust on the 11th March 2024, an action plan will be produced and submitted to the CQC within 28 days.

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 ☐ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other – please detail below:

Maternity & Neonatal Oversight Report – March 2024 (Dec - Feb data)

1. Workforce/Staffing

Midwifery

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.

Currently, the executive management is reviewing the proposed midwifery establishment and leadership model, comprising of key priorities. Recommendations from the Birth Rate Plus (November 2023) Review and the RCM manifesto informed the proposal and excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services. https://www.rcm.org.uk/media/3527/strengthening-midwifery-leadership-a4-12pp_7-online-3.pdf

The refreshed report considered the implementation of the new maternity triage service and recommended a total clinical whole time equivalent of **197.48wte** registered midwives and band 3/4 maternity support workers this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.

The final refreshed report identified a total budget of **221.17wte** for clinical/managerial/specialist roles.

Birthrate Plus	**Total WTE Clinical Requirement**	**Specialist Roles/Managerial**	**Recommended overall Budget**	**Current Budget**
Results 2021	187.89wte	Uplift of 9.29wte	204.80wte	201.04wte
Birthrate Plus	**Total WTE Clinical Requirement**	**Specialist Roles/Managerial**	**Recommended overall Budget**	**Budget GAP**
Refresh December 2023	197.48wte	Uplift of 13.46wte	221.17wte	20.13wte

The service has a number of key priorities for investment for 2024/25 planning together with measures to address capacity and demand issues in respect of theatre provision (growth in C-section rates) which include:

- Maternity Triage
- Specialist midwifery roles and leadership roles including (Head of Midwifery post, Operational Matrons and Governance Leads
- Staff training

The plan was presented to ICB and LMNS on Monday 25 March 2024 at a meeting facilitated by the Executive Director of Nursing and Quality of Humber and North Yorkshire ICB, incorporating Executive Directors of Nursing and Midwifery or equivalent. The purpose of the meeting was to establish a system based approach to identify the key financial

requirements/priorities for 24/25.

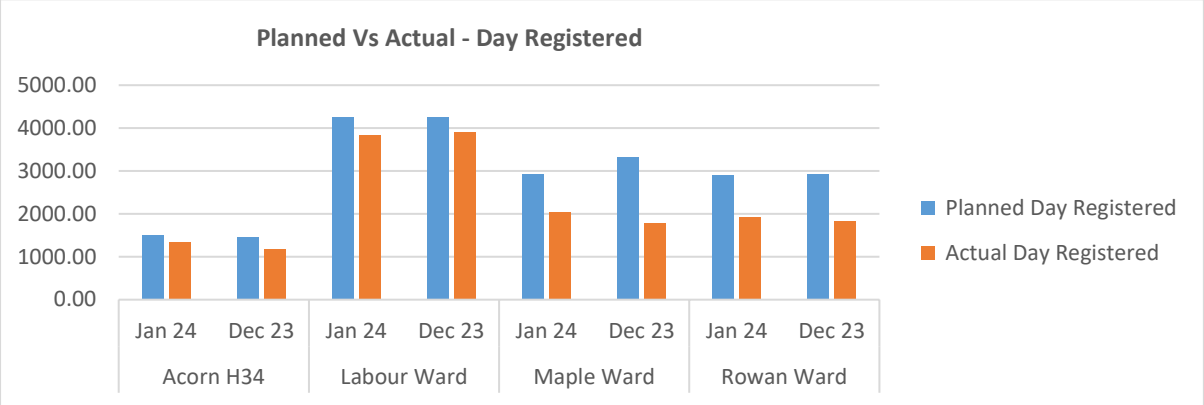
Safe midwifery staffing is reviewed and maintained by the operational matron 7 days a week in line with the regional Opel escalation framework and any issues escalated to the Head of Midwifery. Any staffing shortfalls are managed through the Safe Care meetings and through staff redeployment across the service to ensure safety is maintained. During periods of high acuity/activity requests are made regionally for mutual aid e.g. transfers out to other units as required maintaining safety.

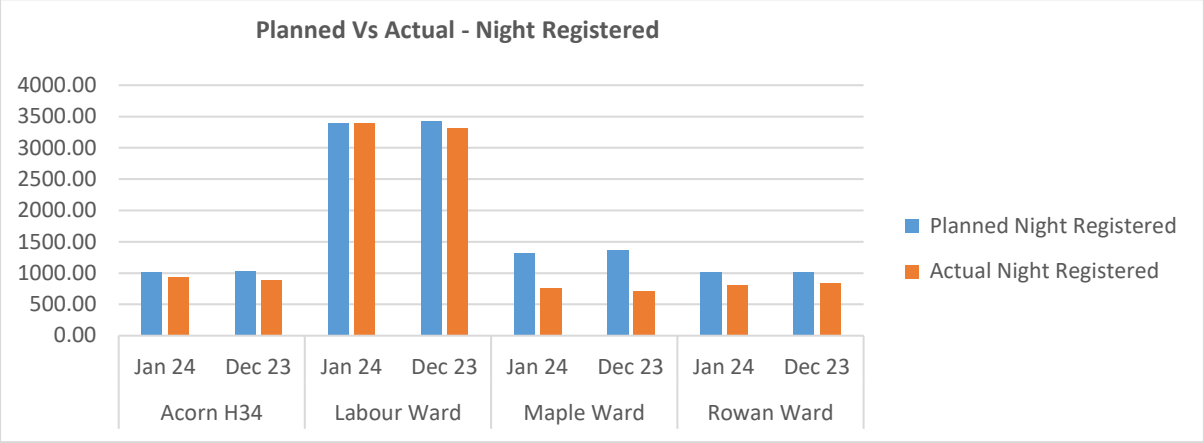
Financial approval is key to supporting safe staffing levels in line with NICE and RCOG guidance this will support the service in sustainable service improvements.

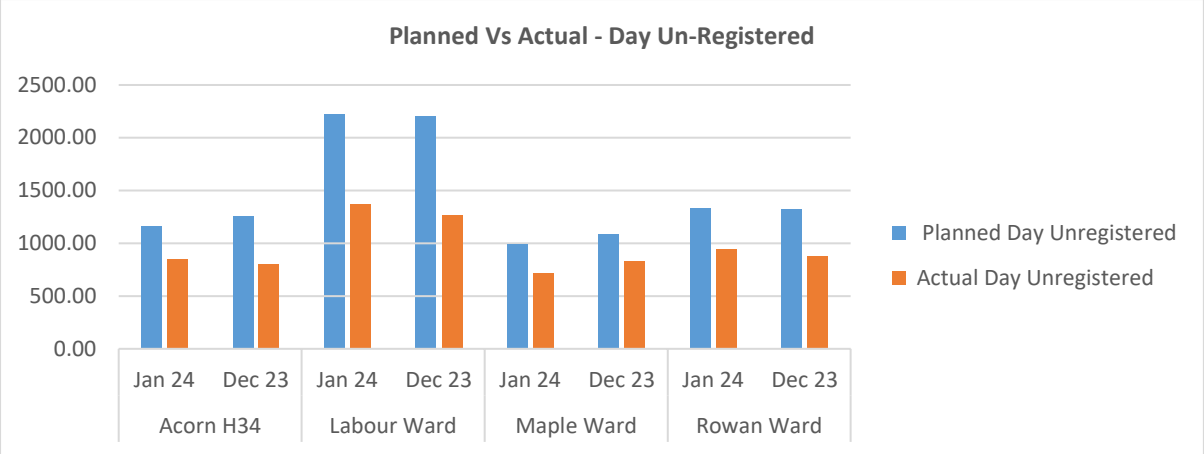
Midwifery as at 31st January 2024

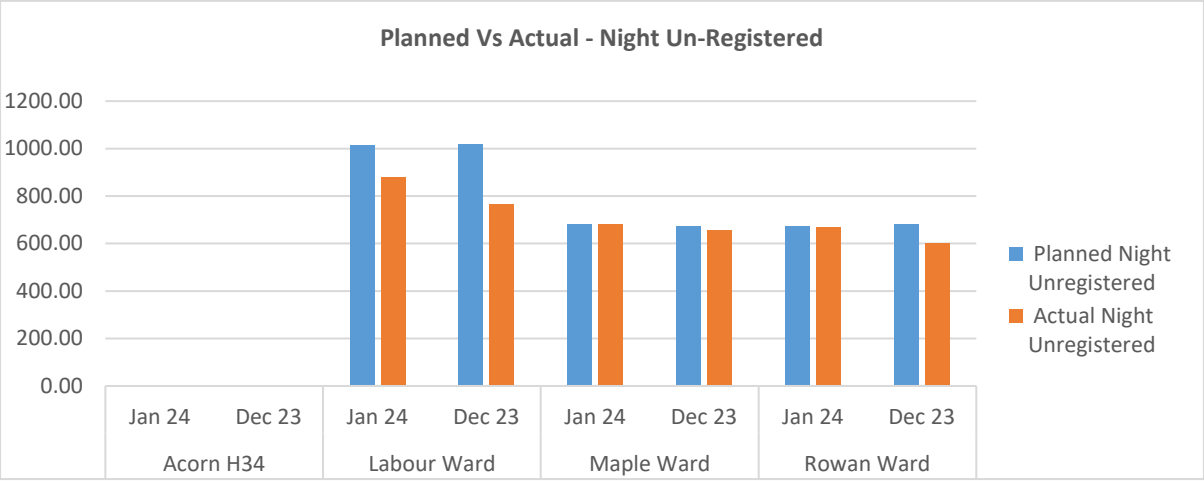
Care Hours per Patient Day (CHPPD)

In the context of the high level of midwives on maternity leave who are due to return to work in June and July 2024, the service has taken steps to ensure there is sufficient qualified staffing within the Labour ward. At times, this dictates that staffing is reallocated subject to demand and acuity from Maple and Rowan Ward.









Neonates

The neonatal workforce remains stable, the neonatal matron post is currently out to advert and any successful recruitment will enable greater neonatal operational leadership.

Current roster fill rates and ratios of nurses to babies achieved.

- Vacant matron post
- Vacancy of 3.29wte, with the uplift to 24.14 WTE.
- Recruitment plans are in place to close address uplift.
- Qualified in Speciality (QIS) compliance is currently at 54% with a positive trajectory for releasing staff allowing compliance in 2025.
- Expectation - Dec 2025 70%
- Need against activity 85%

Next steps

- Recruit to matron vacant post
- Recruit to the neonatal breastfeeding lead nurse post
- Working towards the Go-Live date for expansion of the additional cot capacity as;
- 7 intensive care cots (increase of 2 cots)
- 10 high dependency cots (increases of 3 cots)
- 12 Special cots (decreased to 2 cots)

Avoiding Term Admissions into NICU Q3 Data (MIS Safety Action 3)

The Aim of the ATAIN program is designed to reduce the avoidable causes of harm that can lead to infants born at term (at or over 37 weeks' gestation) being admitted to the Neonatal Unit. Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the ATAIN work to date.

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

HUTH - Current position

Table 1 shows a decrease in Term Admissions to NNU since 2016

Year	Total Term Admissions to NNU	% of total NNU admissions	% of Term admissions to NNU
2016	191	39.6%	4.1%
2017	186	37.7%	3.9%
2018	154	35.2%	3.3%
2019	175	35.5%	3.1%
2020	159	33.3%	3.2%
2021	187	39.9%	2.6%
2022	186	41%	2.3%
2023	198	41%	2.8%

All unexpected term admissions to NNU reported through the DATIX system and investigated through weekly Maternity ATAIN multi-disciplinary meeting. CNST approved ATAIN proforma completed for data collection purposes. Themes, trends and learning points shared amongst multidisciplinary teams. Online training packages via HEY 24/7 educational platform informs learning for the team.

Table 2 demonstrates term admissions into NICU in Q1, Q2 Q3, and Q4 (2023-2024).

Table 2

Duration	Total Babies Born	Total Admissions to NNU	% of total NNU admissions (that were Term)	Total number of Term admission to NNU	% of term admissions to NNU
Quarter 1 2023	1236	202	24.2%	49	3.9%
Quarter 2 2023	1258	194	24.7%	48	3.8%
Quarter 3 2023	1208	189	26.7%	53	4.8%
Quarter 4 2023	1205	179	29.0%	52	4.3%

Unexpected Term Admissions to NICU cases, reviewed through Maternity ATAIN review equated to 52 cases in Quarter 4. Themes identified presented below. The average gestation at admission to NICU was 37 weeks – 37+6 weeks. The primary reason for admission to NNU was for respiratory support requiring Continuous positive airway pressure (CPAP). As stated in CNST year 5 all reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet.

2. Patient Experience/Service User Feedback

The following section details the feedback via formal complaints, Patient Advice Liaison Service (PALS), compliments and Friends and Family Test (FFT).

Formal Complaints and PALS data

Obstetrics	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Number of complaints open and ongoing	8	7	9	9	9	7	12	9
Number of complaints overdue	2	1	4	6	4	3	5	3
Number of complaints closed this month	2	1	1	3	5	4	4	3
Number of new complaints this month	6	3	2	5	2	3	4	1
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Number of PALS open							5	8
Number of PALS overdue							3	6
Number of PALS closed this month	5	16	7	16	22	19	11	8
Number of new PALS	10	15	12	16	21	19	14	3
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
% of complaints closed within 40 working days (KPI 80%)							25%	50%
Average length of time to respond to complaints closed (working days)							76	57
% of PALS closed within 5 working days							54.50%	58.10%
Children and Young People including Neonates	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**
Number of complaints open and ongoing	4	1	1	2	4	3	2	1
Number of complaints overdue	0	0	0	0	2	0	0	1
Number of complaints closed this month	3	3	0	1	2	0	2	1
Number of new complaints this month	3	0	2	0	1	1	3	0
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Number of PALS open							2	0
Number of PALS overdue							2	0

Since January 2024, data has been collated to reflect a consistent reporting basis across the Group. As such, data for historic PALs monitoring was not monitored in this format.

Obstetrics

The Maternity Service at HUTH received four new complaints in January 2024 and one in February, bringing their total open and ongoing complaints to nine; three of which, are overdue the 40 working day target. The main themes of the open and ongoing complaints are treatment, care, and comfort including privacy and dignity. Three complaints closed, three were overdue and one closed within the 40 working day target.

Three new PALS cases opened in February 2024 and eight PALS closed, leaving eight remaining open and ongoing PALS cases. Six cases remain overdue the 5 working day target. The main themes for the open cases are treatment, discharge and attitude.

Children and Young People (including Neonates)

The Children and Young People Services at HUTH received no new complaints in February 2024. One complaint closed, leaving one open and overdue. The main themes of the open and ongoing complaints are communication, care, and comfort including privacy and dignity.

There are no PALS open for Neonates.

Summary

The Patient Experience Team continues to support the clinical teams with the management of their PALS and Complaints. An element of this, is separate weekly complaint meetings with Maternity, Children and Young People, ED, Medicine and Surgery (areas with more complaints received) to manage their open and overdue PALs, Complaints and actions. Focussed support provided to the Medicine Health every Tuesday from a Patient Experience

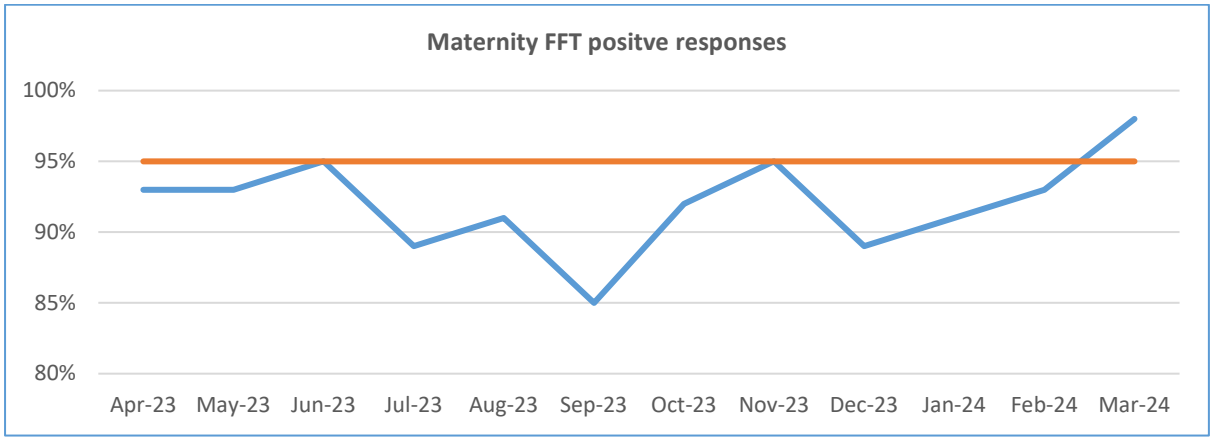
Officer, who is working with the clinical teams to draft complaint responses due to a slight increase in the number overdue late last year.

Compliments

Five compliments received for the Maternity Service in February 2024.

Friends and Family Test (FFT)

The Maternity Service had a response rate of 31% (90 responses) in February 2024; 93.33% was positive and 4.44% was negative.



The periods of lower attainment (July, Sept and Dec 23) relate to our Rowan Ward (Postnatal) and attributable to staff attitude themes, predominantly borne out of staffing pressures.

Children and Young People Services results are not currently collated as no one is on Envoy (system used to collate and report FFT results); therefore, the following is a breakdown of results per area for February 2024: H20 Woodlands – 12% response rate with 84.62% positive feedback receive. Paediatric Assessment Unit – 10% response rate with 82.76% positive and 13.79% negative. Paediatric High Dependency Unit and NICU – 20% response rate with 100% positive feedback The Trust is striving to get to 95% and above positive feedback in maternity overall so recognise there remains work to do.

National Maternity Survey 2023

The Maternity survey results were published on the 9th February 2024; the Trust had 214 responses, which were gathered between April – August 2023 – response rates of 46% which is considered a good response rate. There has been little change from the 2022 results with results against 49 questions remaining very similar. It is worth noting that the 2023 survey was undertaken at the same time of the March 2023 Maternity inspection and results did not deteriorate.

The Maternity Service has remained the same in 49 questions, somewhat worse than expected in one question and worse than expected in four questions.

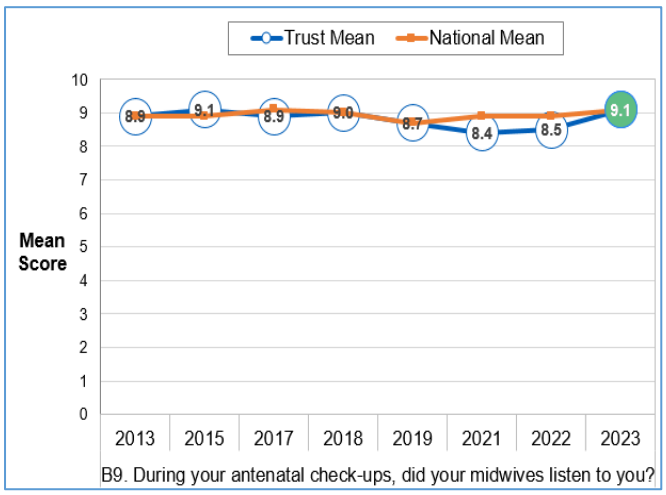
Worse than expected

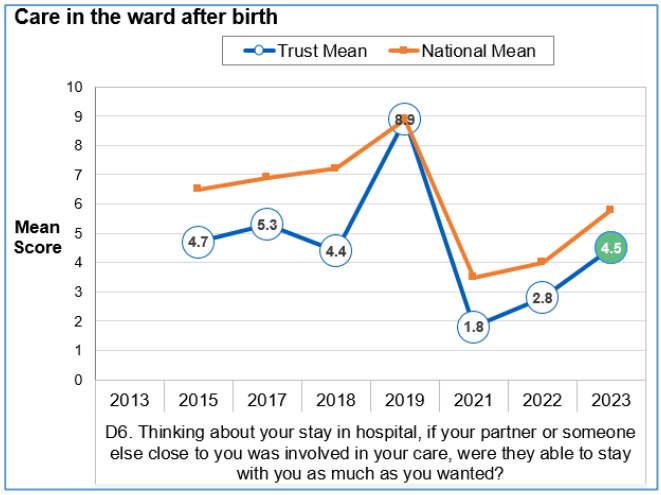
- B3. Were you offered a choice about where to have your baby?
- B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
- C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Somewhat worse than expected

- B14. Thinking about your antenatal care, were you involved in decisions about your care?

The service has significantly statically increased in two questions as follows.



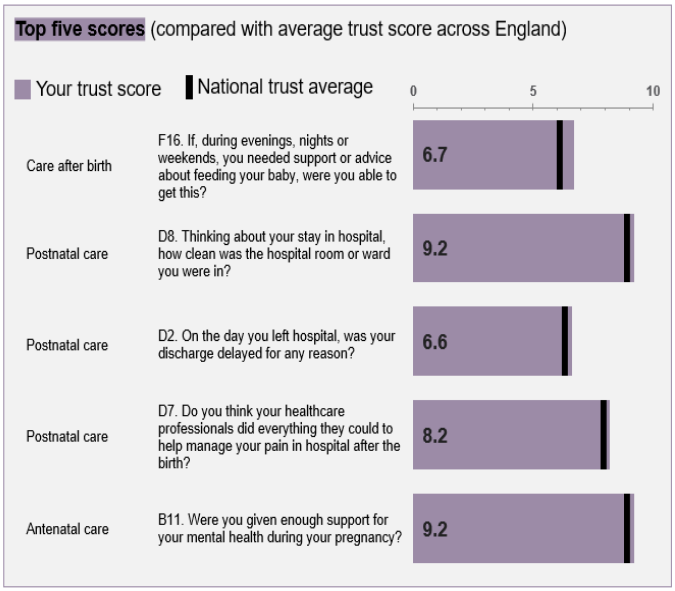


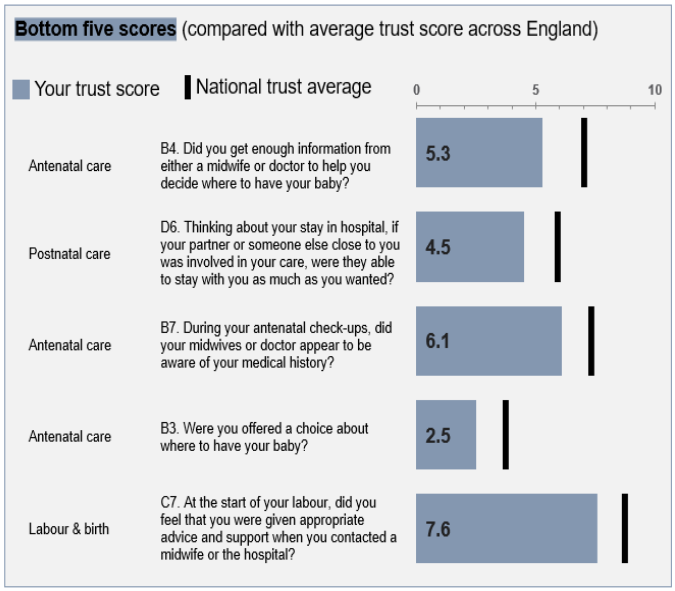
Below are the maternity service top five and bottom five score:

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.





The Patient Experience Team are currently working with the Maternity Service, ICB and LMNS to develop a coordinated improvement plan in response to the latest Maternity survey results. The action plan will Incorporate all key areas identified from the recent survey and will align with our CQC action plan.

Hull University Teaching Hospitals NHS Trust (HUTH) showed improvements during antenatal check-ups, with respondents saying they were:

- Given enough time to ask questions/discuss about their pregnancy;
- Midwives listened to them;
- They were given support for mental health during pregnancy;
- Had confidence in and trust in staff
- Treated with respect and dignity

Responders also felt there were improvements during labour and birth, highlighting:

- They felt their partner or someone close to them was involved as much as they wanted, and could stay as long as you wanted;
- That they were spoken to in a way they understood; and
- That decisions about how you want to feed your baby were respected by midwives.

HUTH also had positive outcomes in the following areas, with people saying:

- They were given support and advice during evening, nights and at weekends about feeding;
- The hospital room or ward they stayed in was clean;
- Healthcare professionals did everything they could to help manage pain in hospital after birth; and
- They were given enough support for mental health during their pregnancy

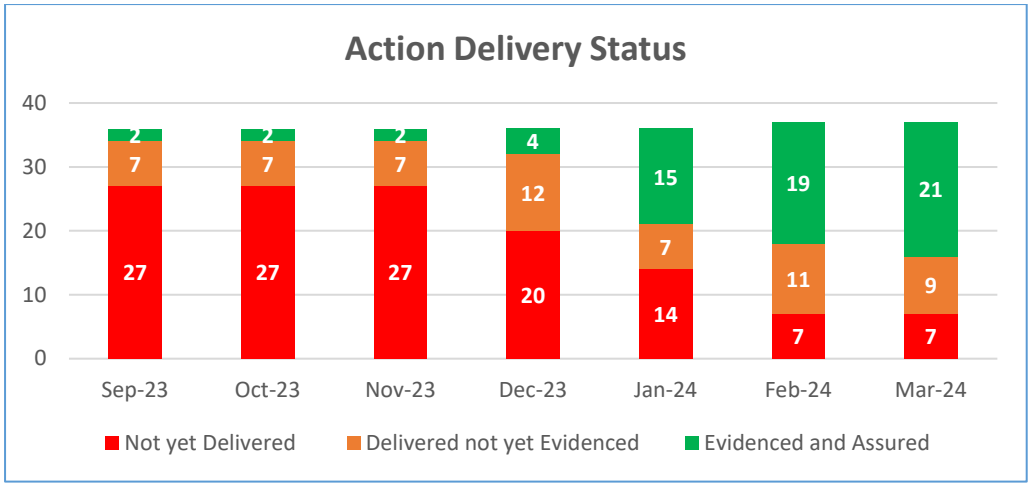
3. Assurance

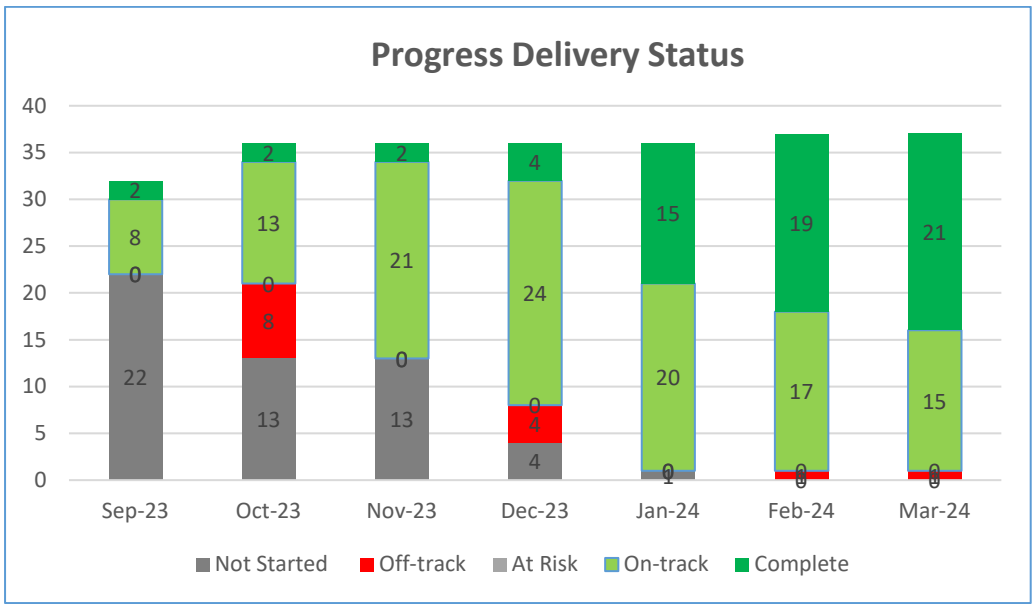
Maternity Transformation Assurance Committee (MTAC) was established to provide the executive management assurances of CQC progress and provide a robust evidence base for maternity Improvements.

MTAC is responsible for the oversight, monitoring and governance of the Maternity Transformation Programme (MTP), with the first element of this being the delivery of the Care Quality Commission (CQC) Action Plan (2023). Over time, this meeting will evolve to oversee the governance and assurance of the Maternity Transformation Programme, as it evolves. MTAC will ensure continuous and sustained improvements in the quality of care (safety, effectiveness and experience) of women and families.

The Maternity Transformation Programme Group (MTPG) will report and account to this committee. MTAC meetings are fortnightly and below is an update of CQC action delivery status. The service has:

- 37 actions in total on the Maternity CQC action plan
- Delivery of actions between October 2023 and April 2024 (evidenced and assured, turning them to green-green)
- MTAC meetings continue to be held fortnightly
- 21 actions to green and 9 actions to amber, following review of the evidence supplied
- 16 actions reviewed and reported as on-track





4. Feedback

Maternity & Neonatal Safety Champions

Maternity & Neonatal Safety Champions The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal) service users, LMNS (Local Maternity & Neonatal System) leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes. The Maternity and Neonatal Safety Champions have completed an assurance visit and the feedback is captured below within the report.

Positive feedback

- **Maternity triage**:
  Calm atmosphere in the unit, some good feedback from women on the day. Staff able to articulate risk assessments. Maternity Incident Review board (MIRIM) purpose / knowledge articulated well by staff;
  BadgerNet digital system now live;
  Good multi-language signage;

- Labour ward: Visible Triage dashboard, staff awareness of KPIs;
- Good FFT posters displayed;
- Staff reported appraisals were completed and effective ;

Recommendations:

- Teams could use QI approaches as PDSA cycles across service areas for drive service improvements ;
- Areas to review notice boards are up to date and other languages displayed across all areas;

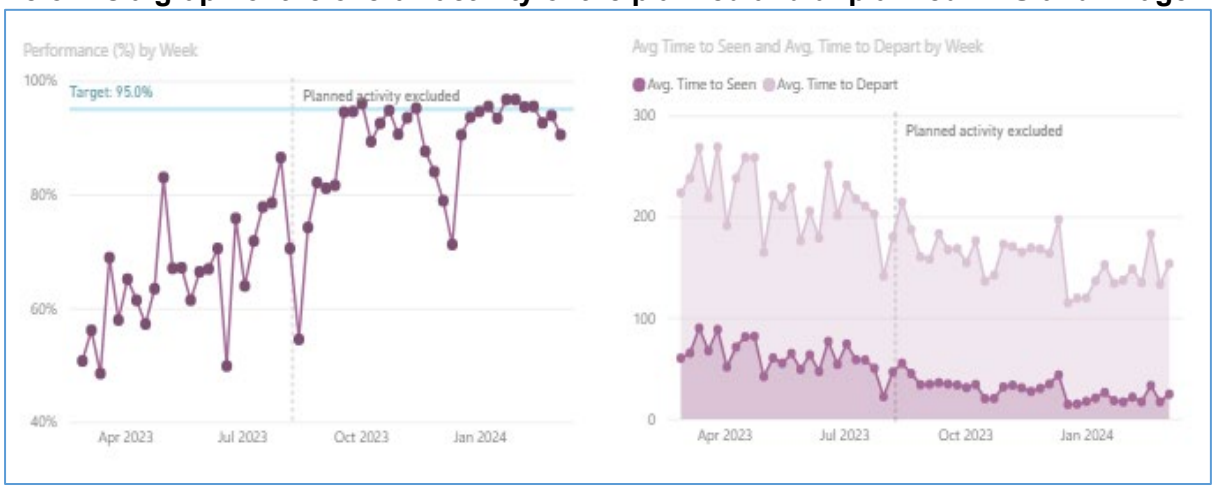
Escalated Issues:

No issues escalated

5. Quality Improvement

Maternity Triage Services
The recent CQC inspection identified Systems, processes, and risk in the antenatal day unit / triage department were not well managed which led to long delays in women and birthing people being seen and a chaotic environment which was not fit for purpose. In order for the service to understand the activity profile through antenatal day unit /triage the digital team have supported with the development of a live dashboard. This has enabled accurate data collection on 'planned/unplanned' activity from April 2023 which has supported the case for a dedicated triage to separate planned and unplanned activity. The service has worked closely with the Interim Chief Nurse and the Executive team to secure a dedicated space within the Family and Women's Hospital for triage and it opened on the 20 November 2023 with a phased approach to opening times.

Below is a graph of the overall activity of the planned and unplanned ADU and Triage



The overall time to be seen reduced from > 3 hours to an average of 25 minutes with the overall time in department has reduced from over 6 hours to an average of 2hrs 30 minutes creating a safer environment and improved patient experience.

6. Serious Incident (SI) Reporting (MIS SA9)

Patient Safety Incidents (PSII)

The purpose of the information is to inform the Board of the patient safety incident investigations that have been declared and investigations concluded in January 2024 – March 2024 for Maternity Services. This forms part of the assurance process set out in the Trust's response in December 2020 to the Ockenden Report. In addition, the report forms part of the assurance in response to the Care Quality Commission March inspection 2023.

Patient Safety Incident Investigations

The service have declared 0 PSIIs in Quarter 4

PSIIs - completed

There was one internal PSII for Maternity closed January 2024 (2023-15178). Immediate learning response **Appendix II**

ACTIVE INVESTIGATIONS

At the time this report there are currently 5 active investigations, three are being supported by the Patient Safety Team and 2 are external investigations being undertaken by Maternity and Neonatal safety Investigations (MNSI) 2 have been ongoing for over 100 days.

Maternity services have a Maternity Incident Overview Group meeting (MIROG) in place which all Maternity Investigation are presented for review of the incidents and agreement on action plans prior to them being presented at the Trust Learning from Patient Safety Events (LFPSE).

Ongoing - Internal Investigations

Investigation approach	Ref	Incident Date	Date Declared on Steis	Number of days open for investigation	Date Due at MIROG	Date Due to LFPSE	Family Involvement
Comprehensive	PSII/2024/1363	28/11/2023	29/11/2023	**113**	TBC	TBC	Currently out of the country for 6 months. Have had bereavement support. awaiting PMRT report
Comprehensive	PSII/2023/16089	10/08/2023	11/08/2023	**223**	April 2024	April 2024	The family are being supported by the bereavement team and have contributed to the Perinatal mortality review meeting.
Comprehensive	PSII/2023/19595	14/10/2023	16/10/2023	**157**	April 2024	April 2024	The family are being supported by the bereavement team and have contributed to the Perinatal mortality review meeting

7. Sustainability Plan

Ongoing Maternity Sustainability

Key areas of work

- Governance and PMRT arrangements (ongoing external support required). MSSP programme supporting the service
- Regional Chief Midwives supporting.
- Following opening if new Maternity Triage in November 2023, working on the phased 24-hr service model.
- Working underway with the Obstetrics workforce business case (5 year plan previously approved and updated)
- Birthrate plus staffing proposal under executive review, includes band 3 maternity Support Worker roles
- BadgerNet roll-out commenced 6th February 2024

8. Conclusion

The oversight report highlights the ongoing improvement work within HUTH maternity services.

Workforce/Staffing

Although an improving position, nonetheless vacancies continues to be challenging.

Patient Experience

The Patient Experience Team continues to support the clinical teams with the management of their PALS and Complaints. An element of this, is separate weekly complaint meetings with Maternity, Children and Young People, ED, Medicine and Surgery (areas with more complaints received) to manage their open and overdue PALs, Complaints and actions. Focussed support is being provided to the Medicine Health every Tuesday from a Patient Experience Officer, who is working with the clinical teams to draft complaint responses due to a slight increase in the number overdue late last year.

Assurance

- Local Maternity and Neonatal System (LMNS) assurance visit November 2023

Appendices

For further details, please refer to the narrative below and appendices

Appendix I – Maternity Assurance Visit

Appendix II - Learning

Appendix III - Mandatory Training

Key areas of improvement have been Perinatal Gap e learning, Fetal Monitoring, Newborn Life Support, Mandatory Training Day 2, Pool evacuation and K2 training. There has been slight deterioration in Safeguarding Children level 3, Conflict Resolution and PROMPT training. Currently the trajectories for the next quarter being reviewed taking into account the impact of the BadgerNet training and staffing levels.

Appendix IV– PQSM Dashboard

In March, there were two Catastrophic cases and 6 moderates cases; one escalated to Weekly Patient Safety Review. A further case in waiting Perinatal Mortality Review.

Appendix V - Saving Babies Lives Version3

The HUTH and HNY LMNS SBLCBV3 Quarterly Review Meeting on 19/03/24 recognised the significant progress made in Elements 2 and 6. There has also been consistent progress made in all the other elements with an increase in the number of interventions now fully implemented. All those involved in the improvement work congratulated on this.

Since the previous review, 5 out of 6 elements partially implemented to CNST MIS Yr5 requirements. Where Elements 3 and 4 remain at 50% and 20%, acknowledged that within the last quarter progress made on updating guidance and establishing the audits needed to meet the requirements within each of those elements.

Next steps

Once additional evidence uploaded, LMNS will finalise the tool. The Trust will receive an email with the finalised tool template and agreed dates for Q1 24-25 Quarterly Review. Trust to submit a summary report of progress to their Board.

Appendix VI - Maternity Dashboard

Dashboard Narrative

The service has reported 0 stillbirths in February 2024. Stillbirth rate in HUTH remains low at 2.3% and below the national average of 3.5%.The service currently reporting the last stillbirth 62 days the average is 18 days. All stillbirths reviewed in line with the national perinatal mortality review tool and learning from rare events cascaded to the workforce.

The service reported 2 cases to Maternity and New-born investigations MNSI in February 2024 which are currently accepted and open by MNSI. One Neonatal death and one baby which had to be cooled. Local learning identified and themes identified from last 3 case reported to MNSI appears to be escalation of the CTG monitoring

The service have 3 fetal monitoring specialist who are implementing the saving babies lives version 3 Element 4 of SBL Effective fetal monitoring during labour- which discusses the buddy system and risk assessment we should be completing 1 hourly 'systematic reviews' .This is a very recent change and recent guideline update. In view of these elements not being fully embedded coupled with high acuity and team fatigue they are a requirements to be extra vigilant to support staff in delivering safe care which has been communicated by the teams.

APPENDIX VII – shared Learning (GAP Presentation)

Our quarter 3 Perinatal Institute data (July - Sept 2023) showed our referral rates for USS based on fundal heights has fallen slightly to 41% (but still above the national GAP average of 39.1%), with a true detection rate for SGA after USS of 46.6% (above the national GAP average of 42.6%)

Hull University Teaching Hospitals NHS Trust

Appendix I

MATERNITY MONTHLY ASSURANCE VISIT REPORT

1. PURPOSE OF REPORT

The purpose of this information is to provide updates to the Maternity Transformation Assurance Committee (MTAC), Maternity Safety Champions and the Quality Committee on the monthly observations within the Maternity Service. The audit requires both observations and conversations with staff in the Antenatal Day Unit (ADU), Maternity Triage, Maple Ward and Labour Ward.

2. ASSURANCE VISIT TEAM

The team undertook the assurance visit to Maternity on 06 February 2024. The team consisted of the following members and visited all areas as planned during the visit (Antenatal Day Unit (ADU), Maternity Triage and Labour Ward):

- Rachel Boulton, Compliance Manager
- Jayne Gregory, Maternity Patient Safety Specialist
- Wendy Page, Interim Deputy Chief Nurse
- Rob Chidlow, Interim Director of Quality Governance
- Rachael Sharpe, Designated Professional for Safeguarding Adults, NHS Humber and North Yorkshire Integrated Care Board (ICB)
- Ann-Marie Robinson, LMNC Safety and Quality Lead, NHS Humber and North Yorkshire Integrated Care Board (ICB)
- Emily Oakshott, Project Officer Secondary Care and Mental Health, Healthwatch East Riding of Yorkshire

3. VISIT FINDINGS

Maternity triage

- The area was very calm and had 6 women in the unit, 4 were rag rated as red and had been reviewed within guideline, 2 were being seen whilst visit underway but had been seen within 15 minutes.
- It was clear there had been a spike of red assessed patients in the morning, which had been absorbed.
- A lot of discussion about triage. The phone system explained and how it works on a “hunt” system if not picked up. Staff were committed to facilitating it during the day when they were able, but appreciative work still needs to be done at night (for 24/7 service). The environment and prominence of the phone (more space, two screens) could be better.
- A patient was very pleased with the organisation of this department and that it much needed. She said when she had her first child not too long ago she had to wait hours in the ADU. However reported that she was not informed how long she would be waiting (it was an empty waiting room though so she assumed it wouldn’t be long)
- Staff able to articulate the risk assessment of the woman arriving to Triage and the out of hours processes.

- The dashboard was visible and all staff aware of the KPIs this was discussed in the huddles and reminders to all staff.
- The MIRM board was visible and members of staff working could articulate the information e.g. they were aware of the maternity risks and Datix themes from that week - feedback was given that they would like the boards to be bigger this has been actioned as new boards have been ordered.
- Staff were aware of the operational matron and how to contact and escalate to them.
- BadgerNet had gone live.
- Staff shared there was challenges to completing online training within working time, some staff appeared reluctant and was explained the importance.
- Good multi-language signage in the department generally.

Labour ward

- The triage dashboard was visible and all staff aware of the KPIs
- A telephone triage observed in which good advice provided and appropriate escalation and discussion with the matron.
- The MIRM board was visible and staff working could articulate the information they were aware of the maternity risk and Datix themes from that week
- The Matron confirmed all the risks assessments had been recently reviewed including Legionella. Aware that there are ligature risks but that patients are given 1:1 care which mitigates the risk
- There were some rooms found unlocked which gave easy access to medicine fridges and contents.
- There were no PAL and Complaints posters on display
- FFT posters were displayed but data was from June and July 2023.
- Staff reported appraisals were given and were effective and mandatory training was scheduled throughout the year.

Other feedback

- BadgerNet was implemented in antenatal and would be live in March for labour.
- Informed that a midwife was planning to do a monthly newsletter Health Watch suggested that this would be a good place to put service feedback from patients for each department.
- Issues with compliance with boards the quality and safety boards or FFT board were not updated, raised following each assurance visit and still not up to date
- Information displayed still only available in English on Labour Ward.
- Within Triage Door FD30S has a key pad on it and a sign that says no patient access / staff only and looks in practice to be a throughfare. Door not locked.
- Staff raised concerns over space, particularly with the urine analysis machine that there is not capacity to house in the sluice.
- Overarching feeling of staff was that stress levels were “Humungous” previously, but it has calmed down significantly.

4. RECOMMENDATIONS

The Maternity Service recommended to:

- Quality Improvement methodologies such as the PDSA cycle maybe used by the team to evidence improvements made and areas, which would benefit from being strengthened. This would also need to include the voice of those using the service
- Consider how the patient safety specialists now in post who could be involved in the assurance work as well as supporting the service in their audit processes
- Request Humber Teaching NHS Foundation Trust to undertake an assessment and provide their expert recommendations on how to address ligature risks within Maternity
- Ensure all notice boards are up to date
- Review the information displayed and use other languages to ensure information is accessible to all.

Hull University Teaching Hospitals NHS Trust

Appendix II - Learning

What happened?

PSII 2023 15178

The woman was an English-speaking woman who was un-booked for maternity care with her fifth pregnancy. The woman had had four spontaneous vaginal births, 3 abroad and the last spontaneous vaginal birth at Hull University Teaching Hospital maternity services.

On the 15th July 2023 at 06:00 hrs the woman was at home and awoke with lower abdominal pain, vomiting and vaginal spotting. At 08:30 the woman went to the toilet and had heavy vaginal bleeding, the woman collapsed on the bathroom floor, the woman's husband found the woman shortly after and called an ambulance at 09:16.
The ambulance arrived at the woman's address at 09:29 on arrival of crew, the woman was suspected to have lost approx. 500mls of blood vaginally and appeared pale, clammy, dizzy, and had bruising to right side of her head and a bruise to her left arm.

At 10:25, the ambulance arrived at Hull Teaching Hospitals Emergency Department (ED) and the woman admitted to the Majors area of ED. The woman appeared to be in hypovolemic shock. Blood gas confirmed this and Major Haemorrhage Protocol was commenced. Blood products rapidly infused using fluid warrior and pressure bags. The Intensive Care Unit (ICU) team and the Gynaecology Constant were both present. A Sonographer attended and confirmed the woman was approx. 30 weeks pregnant with no signs of life to baby.

Plan made to take the woman for interventional radiology, CT head scan and for theatre for emergency caesarean section. Following the caesarean section the woman's total blood loss was 4710mls, the woman had a cardiac arrest and was successfully resuscitated .The woman continued care on Intensive care until the 18 July 2023 when discharged back to Midwifery care.

What we learnt

The investigation found that

- The woman was high risk in pregnancy
- The woman and Maternity services were unaware of the woman's pregnancy. Until the point of confirmation of pregnancy via ultrasound in Emergency department.
- They was a reported delay from the woman reporting to vaginal bleeding to her husband to an ambulance being called

How we will improve

- The investigation found evidence of effective team work between Emergency Department and Maternity services
- The investigation found evidence of well-coordinated team work with all services
- The investigation found that even though they was a 28 minute delay of transferring from the ambulance to the major are of Emergency Department this did not contribute to the cardiac arrest.

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Appendix III Trust Mandatory Training Compliance – March 2024
Maternity Specific Mandatory Training

Competency	21.12.23	23.1.24	22.2.24	25.3.24
Information Governance	88.8%	88.1%	92.1%	96.3%
Resuscitation	84.0%	85.3%	87.5%	90.1%
Health, Safety and Welfare	90.5%	90.9%	91.3%	94.9%
Moving and Handling	83.4%	83.3%	88.2%	93.7%
Fire Safety (clinical)	81.4%	81.9%	88.2%	92.9%
Mental Capacity Act	80.5%	82.2%	85.7%	90.6%
Deprivation of Liberty	85.7%	86.7%	90.7%	95.1%
Infection Control	88.8%	88.4%	89.6%	94.6%
Equality, Diversity and Human Rights	90.0%	88.4%	89.9%	92.6%
Safeguarding Children Level 2	89.5%	93.3%	98.7%	100.0%
Safeguarding Children Level 3	77.0%	74.3%	82.7%	89.5%
Safeguarding Adults Level 2	87.0%	92.2%	94.8%	98.7%
Safeguarding Adults Level 3	77.9%	70.7%	85.1%	91.6%
Conflict Resolution	87.4%	87.8%	91.6%	97.1%
Perinatal Gap E-learning	67.2%	70.1%	77.6%	86.2%
Fetal Monitoring	75.9%	78.4%	74.4%	75.4%
Fundal Height Measurement	69.1%	85.3%	84.5%	90.2%
Newborn Life Support	63.0%	64.1%	64.6%	68.4%
PROMPT	77.1%	73.9%	75.3%	81.4%
Pool Evacuation	57.1%	68.3%	78.1%	94.3%
K2	82.4%	83.1%	95.2%	91.1%

- ✓ 18 competencies are now compliant with Trust target (*85% with exception of Information Governance) which is an improvement of a further four since February 2024.
- ✓ Of these, 16 competencies exceed 90%, which given the number of midwifery staff currently on maternity leave and unavailable to work or train is close to delivering full training compliance in these areas. Also noteworthy this is across a growing workforce (including 10 international recruits).
- ✓ Perinatal Gap E-learning (cited in Section 31 Notice) is now compliant.

For those areas not fully compliant, the Trust has facilitated extra sessions in April 2024. Establishment changes and delivery plans will embed and sustain achievement for 2024/25.

Hull University Teaching Hospitals NHS Trust

Appendix IV - PQSM
Revised Perinatal Quality Surveillance Tool

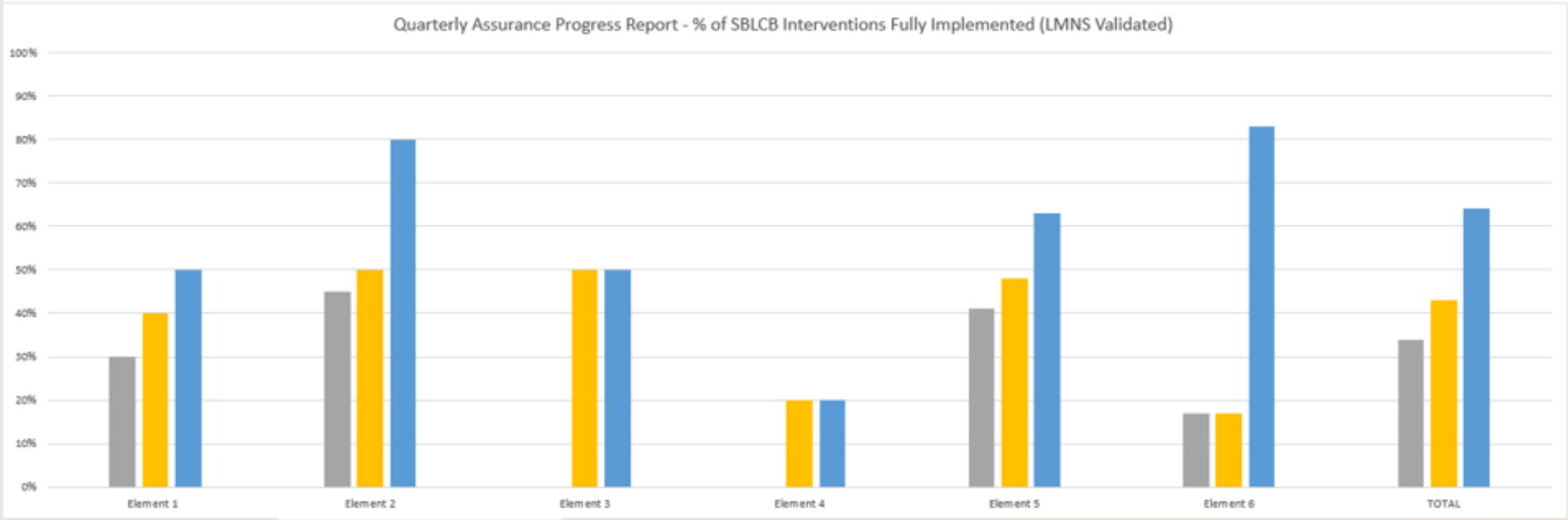
CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
	Inadequate					
Maternity Safety Support Programme	Yes	Yes Lesley Heelbeck (NHSE) and Ruwan Wimalasundera				

	Jan	Feb
1.Findings of review of all perinatal deaths using the real time data monitoring tool	Interpretation of fetal monitoring	Risk assessment at every contact No fresh eyes completed online with SBL element 4
1a Number of cases referred to MNSI/ENSR	Early Neonatal Death , RFM fetal bradycardia on CTG in correct classification	twin birth Twin 1 cooled in correct classification of CTG
1c Number of family's informed of referral to MNSI/ENSR	1	1
2. Findings of review of all cases eligible for referral to MNSI	Awaiting completed report	Awaiting completed report
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	2 Catastrophic 4 moderate Escalated to WPSS 1 MNSI and PMRT	0 Catastrophic 4 Moderates Escalated to WPSS 1 MNSI
4.Staff feedback from frontline champion and walk-about	Generally positive and helpful	Non Exec Director walkabout for safety champions in January. Overall very positive findings noted across the service and staff well engaged. Quality improvement ideas discussed with NED and Safety lead in MTU to display digital waiting times Postnatal ward discussed office space and working conditions. All ideas fed back to staff on the wards

Appendix V - Saving Babies' Lives Care Bundle v3 Progress Report

Implementation progress

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10	Assessment 11
Review Quarter		Q2 23/24	Q3 23/24	Q4 23/24								
Assurance Review Date		13/10/23	18/12/23	19/03/24								
Element 1		30%	40%	50%								
Element 2		45%	50%	80%								
Element 3		0%	50%	50%								
Element 4		0%	20%	20%								
Element 5		41%	48%	63%								
Element 6		17%	17%	83%								
TOTAL		34%	43%	64%								



Q4 - Progress

Humber and North Yorkshire Health and Care Partnership

Element 1

- Comprehensive audit report with conclusion and action plan
- 1.1 & 1.2 Maintained standard
- 1.3 All performance indicators now part of Element 1 Audit
- 1.6 All performance indicators now part of Element 1 Audit
- 1.8 Plan in place for CO monitoring training for staff

Element 2

- Guideline compliant with SBLCBv3
- 2.2 Process in place via Badgernet self referral
- 2.6 procurement of digital BP monitors
- 2.7 Audit in place
- 2.18 (2d) Standard met
- 2.19 (2e) standard met

Element 3

- 3.2 Audits now in place for indicators 3b and 3d

Element 4

- Guideline compliant with SBLCBv3
- Audits now in place – comprehensive audit report with conclusion and action plan

Element 5

- 5.11 Audit in place – standard met
- 5.21 5.22 5.23 5.24 Standard met

Element 6

- Guideline compliant with SBLCBv3
- 6.1 Plan in place for Diabetes Maternal Medicine clinic
- 6.2 Fully implemented
- 6.3 Fully implemented – to clarify blood glucose results recorded in diabetes pregnancy record?
- 6.4 Fully implemented

Improvement work to be undertaken

Humber and North Yorkshire Health and Care Partnership

Element 1

- Monitor data capture on Badgernet
- Focused QI work where standards not met
- 1.7 Further development of pathway to improve adherence
- 1.8 Continue plan to meet standard for training compliance

Element 2

- 2.2 Undertake audit to provide evidence
- 2.4 Undertake audit
- 2.10 Undertake audit
- 2.19 2b - include in GAP audit ensuring SBL numerator/denominator are used

Element 3

- Focused QI work to improve standards for 3b and 3d – target to be set for next quarterly review.

Element 4

- Improve training compliance
- Focused QI work to improve standards

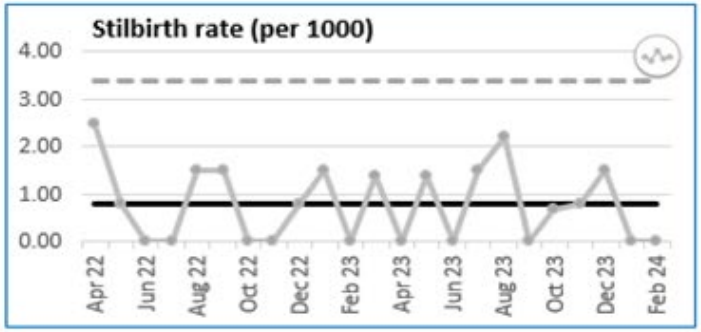
Element 5

- 5.2 Submit audit evidence for 5i
- 5.3 All women to have a risk assessment for PTB completed at booking – audit of this process.
- 5.9 Undertake audit
- 5.16 Undertake audit
- 5.21 Submit audit evidence for 5j

Element 6

- 6.1 Monitor implementation and adherence to appointment criteria
- 6.2 (6d) Clarify % of MDT staff who have undertaken training

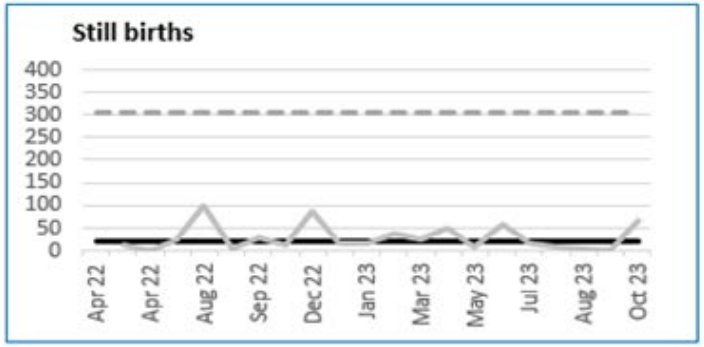
Appendix VI – Maternity Dashboarh

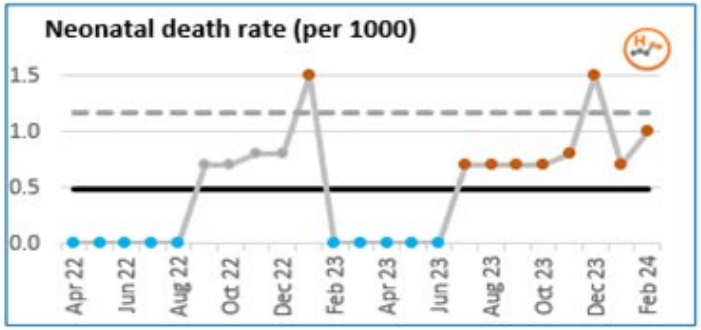


Date of last stillbirth 14/10/23

Average days between stillbirths **18.0**

No significant change

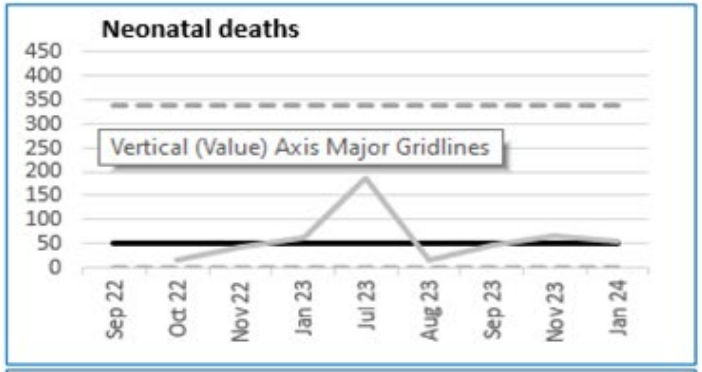


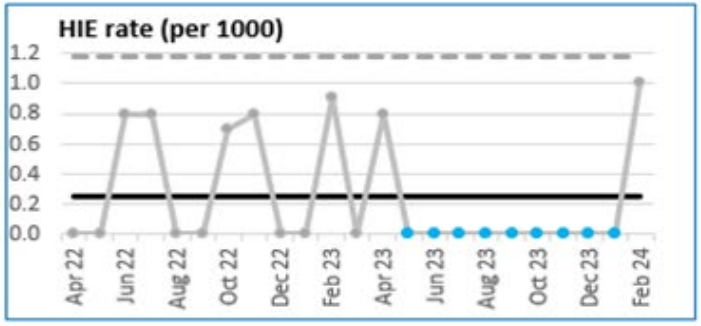


Date of last neonatal death 22/01/24

Average days between deaths **50.0**

No significant change

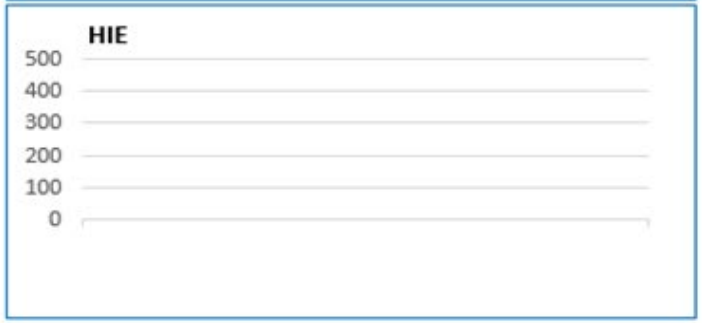




Date of last HIE

Average days between HIE

No significant change



Maternity & Neonatal Oversight Report – February 2024 (January 2024 data)

1 Workforce/Staffing

Midwifery

	Registered	Unregistered
DPOW	10.0 WTE	4.12 WTE
SGH	6.9 WTE	1.77 WTE

Midwifery staffing is reviewed daily (weekdays) and a weekend plan cascaded widely. Maternity OPEL (Operational Pressures Escalation Levels) are reported internally and regionally, ensuring escalation as per the Staffing Escalation policy and to request or support with regional mutual aid as required to maintain safety. Mutual aid, escalation and provision currently under review by the Local Maternity and Neonatal System (LMNS) and the regional maternity team.

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data which was 1:21.8 in December 2023 (DPOW 1:22.4 and SGH 1:20.1). Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios. The Midwife to Birth Ratio has throughout the year been below the expected 1:28 for both sites.

Maternity Wards Fill Rates and CHPPD Jan 2024

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**106.1%**	**▲ 12.6%**	**98.3%**	**▲ 16.6%**	**10.9**	**▼ -1.63**
Registered Nurses and Midwives	112.3%	▲ 13.9%	103.1%	▲ 17.9%	7.5	▼ -1.07
Care Staff	94.5%	▲ 10.2%	89.2%	▲ 14.3%	3.4	▼ -0.56
Central Delivery Suite	**85.8%**	**▼ -13.2%**	**57.4%**	**▼ -14.6%**	**23.9**	**▼ -8.63**
Registered Nurses and Midwives	88.7%	▼ -16.1%	55.3%	▼ -17.7%	19.9	▼ -7.84
Care Staff	73.8%	▼ -1.0%	65.9%	▼ -1.8%	4.0	▼ -0.79
Jasmine & Honeysuckle	**94.2%**	**▲ 2.2%**	**84.4%**	**▲ 7.4%**	**13.3**	**▼ -1.74**
Registered Nurses and Midwives	91.1%	▲ 1.6%	82.7%	▲ 9.7%	8.7	▼ -1.19
Care Staff	100.5%	▲ 3.4%	87.8%	▲ 2.7%	4.7	▼ -0.55
Ward 26 SGH	**84.5%**	**▲ 5.2%**	**62.9%**	**▲ 8.6%**	**5.6**	**▼ -0.18**
Registered Nurses and Midwives	82.0%	▲ 5.8%	59.6%	▲ 9.8%	4.0	▼ -0.08
Care Staff	91.2%	▲ 3.5%	72.0%	▲ 5.2%	1.6	▼ -0.09
Total	**93.7%**	**▲ 2.5%**	**77.8%**	**▲ 5.4%**	**10.6**	**▼ -1.58**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	68.8%	▲ 0.4%
Central Delivery Suite	83.2%	▼ -2.0%
Jasmine & Honeysuckle	65.1%	▼ -0.4%
Ward 26 SGH	70.9%	▲ 0.7%
Total	**71.2%**	**▼ -0.9%**

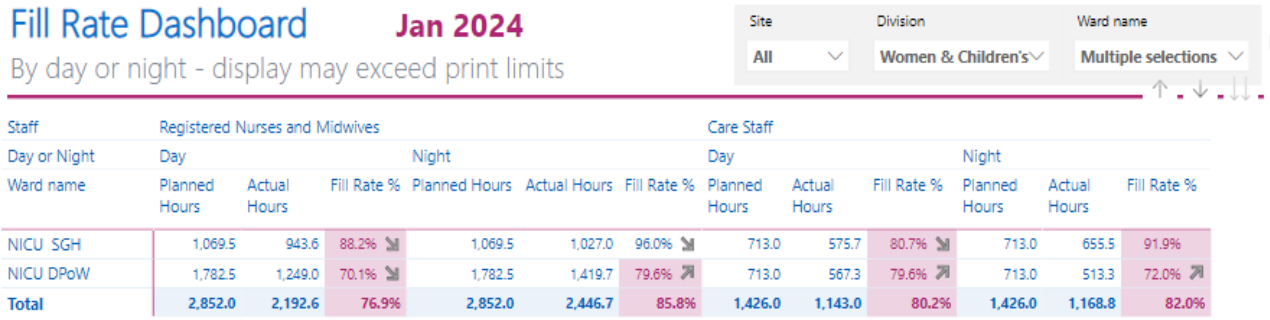
SGH – Scunthorpe General Hospital
DPOW – Diana, Princess of Wales Hospital, Grimsby

There are now 11 internationally educated midwives, all have passed their OSCE. The final 4 are due in clinical areas in a supernumerary capacity in the coming weeks.

The latest **Trust wide Maternity Dashboard** is shown in **Appendix I.**

Neonates

Fill rate and CHPPD data for the two neonatal units is outlined below.



Fill Rate Dashboard Jan 2024

By day or night - display may exceed print limits

Site: All | Division: Women & Children's | Ward name: Multiple selections

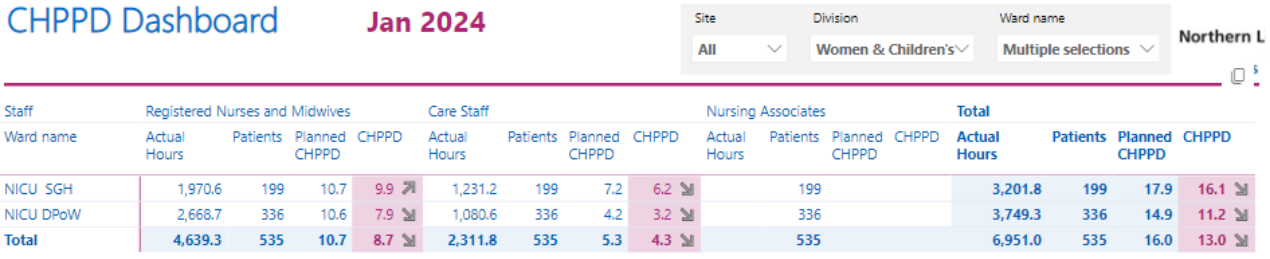
Staff	Registered Nurses and Midwives						Care Staff					
Day or Night	Day			Night			Day			Night		
Ward name	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %
NICU SGH	1,069.5	943.6	88.2%	1,069.5	1,027.0	96.0%	713.0	575.7	80.7%	713.0	655.5	91.9%
NICU DPoW	1,782.5	1,249.0	70.1%	1,782.5	1,419.7	79.6%	713.0	567.3	79.6%	713.0	513.3	72.0%
Total	**2,852.0**	**2,192.6**	**76.9%**	**2,852.0**	**2,446.7**	**85.8%**	**1,426.0**	**1,143.0**	**80.2%**	**1,426.0**	**1,168.8**	**82.0%**

The fill rate for Registered Nurses (RN) at the Scunthorpe site has dipped to slightly under the target of 95% for the day shift and remained above target for the night shift.

At the Grimsby site, there is an improving picture, however the fill rates for both RN and HCA remain below the target of 95% across both shift profiles. This is due to on-going challenges in recruiting to the increase in the establishment, with the improvement associated in month to staff returning from sickness absence. The remaining HCA vacancy is now recruited to and start dates confirmed. Bed occupancy is reviewed daily, and shifts are only covered when necessary if cot occupancy or acuity dictates.

The fill rate for HCAs (Health Care Assistants) on the SGH NICU (Newborn Intensive Care Unit) has shown reasonable improvement due to an improved sickness position, however the current vacancy remains. Recruitment is completed and start dates confirmed.

Any deficit in position is mitigated due to the embedded process of on-going review and movement of staff between Paediatrics and NICU to keep areas safe and the use of bank and agency where mitigation cannot be established form within baseline resource.



CHPPD Dashboard Jan 2024

Site: All | Division: Women & Children's | Ward name: Multiple selections

Staff	Registered Nurses and Midwives				Care Staff				Nursing Associates				Total			
Ward name	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	**Actual Hours**	**Patients**	**Planned CHPPD**	**CHPPD**
NICU SGH	1,970.6	199	10.7	9.9	1,231.2	199	7.2	6.2		199			**3,201.8**	**199**	**17.9**	**16.1**
NICU DPoW	2,668.7	336	10.6	7.9	1,080.6	336	4.2	3.2		336			**3,749.3**	**336**	**14.9**	**11.2**
Total	**4,639.3**	**535**	**10.7**	**8.7**	**2,311.8**	**535**	**5.3**	**4.3**		**535**			**6,951.0**	**535**	**16.0**	**13.0**

The CHHPD continue to fluctuate due to the number of occupied cots and the reviewed staffing levels to ensure patient safety. The care staff CHHPD is lower to a planned higher ratio of RN to HCA.

2 Patient Experience/Service User Feedback

The following section details the feedback received via Formal Complaints, Patient Advice and Liaison Service (PALS) concerns, Compliments and the Friends and Family Test (FFT). The most recent performance data relates to **February 2024.**

Formal Complaints and PALS data

Obstetrics	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23
Number complaints open/ongoing	5	6	2	1	2	2
Number of open complaints out of timescale	1	1	0	1	0	0
Number complaints closed this month	3	0	4	0	1	1
Number of new complaints	3	0	1	0	2	2
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23
Number of PALS open	2	2	2	0	1	0
Number of PALS out of timescale	2	2	0	0	1	0
Number of PALS closed this month	6	4	4	5	5	3
Number of new PALS	5	4	4	3	6	2
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23
% of complaints closed within timescale (KPI 85%)	**33%**	**0**	**75%**	**0**	**0%**	**100%**
Average length of time to respond to compaints closed (working days)	55	0	50	0	62	8
% of PALS closed within timescale (KPI 60%)	**66%**	**25%**	**25%**	**40%**	**0%**	**66%**
Average length of time to respond to PALS closed (working days)	7	12	10	7	16	10

In February 2024 there were 2 new complaints for Obstetrics (1 at DPOW and 1 at SGH). 1 complaint was closed this month within timescale, giving 100% compliance within the 60 day timescale KPI.

There were 2 new PALS received, 3 PALS were closed with 66% achieved within 5 day target in line with the targeted KPI for closure (60%), with an average of 10 days to close a concern. The central team continue their work with the Divisional Medical Director and Associate Chief Nurse for Family Services to address complaints and concerns in a timely and appropriate manner.

Themes from complaints and concerns raised during quarter 3 (Oct - Dec 23) for maternity are communication, delays in a clinical setting.

Children and Young People:

In February 2024, Children and Young People received no new formal complaints. 1 complaint was closed this month within timescale, giving 100% compliance within the 60 day timescale KPI and 0 complaints remaining open.

11 new PALS concerns were logged, 46% of the 11 PALS closed were in timescale (against a KPI of 60%), with an average of 12 days to close a concern.

All complaints and PALS are related to paediatric areas and not neonatal areas. Themes were relating to delays/access to outpatient appointments and communication.

As noted in the previous months report, consideration can be given that Family Service complaints and concerns feedback tends to be complex and emotive which can make timescale delivery challenging, especially for PALS. Weekly meetings remain in place to keep the divisional leads sighted on progress for both these measures.

Children and Young People including Neonates	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Number complaints open/ongoing	5	1	3	3	0	0
Number of open complaints out of timescale	2	0	0	0	0	0
Number complaints closed this month	1	2	0	1	3	1
Number of new complaints	1	0	3	0	1	0
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Number of PALS open	3	2	1	2	5	4
Number of PALS out of timescale	0	2	1	2	4	1
Number of PALS closed this month	9	11	10	8	6	13
Number of new PALS	5	8	9	9	10	11
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
% of complaints closed within timescale (KPI 85%)	**0%**	**0%**	**0**	**100%**	**100%**	**100%**
Average length of time to respond to compaints closed (working days)	64	74	0	0	37	1
% of PALS closed within timescale (KPI 60%)	**33%**	**18%**	**60%**	**75%**	**66%**	**46%**
Average length of time to respond to PALS closed (working days)	17	13	6	5	6	12

Summary:
The Patient Experience Lead has met with the Associate Chief Nurse (ACN) for Neonate, Paediatric & Young Persons (ACN for Maternity was unable to attend) to discuss causes and explore where further support can be offered. It was felt during the meeting that as our Group model was due to be announced, identifying who to develop an action plan and support with would be more beneficial when Senior Group Leads were in post. It was agreed during the interim that the Complaints/Patient Experience Manager and Patient Experience Lead continue to highlight to both ACNs for prompt escalation of identified Complaints/PALS until further arrangements with Senior Group Leads can be made.

Compliments:
One compliment was formally logged on Ulysses in January relating to Obstetrics (SGH). It related to excellent care given. Five compliments were registered for NICU (SGH) relating to caring with kindness and warmth.

Friends and Family Test:
Maternity collected 89 pieces of Friends and Family Test feedback (FFT), with 58 at Diana, Princess of Wales (DPOW) 89.6% positive, 1.69% negative & 3.4% neutral; and 30 at Scunthorpe General Hospital (SGH) 90.0% positive, 6.6% negative and 3.3% neutral. This indicates a slight decrease in responses from the previous month reported across Maternity Services.

A theme identified was related to lengthy waiting times. A capacity and demand review is underway within the division.

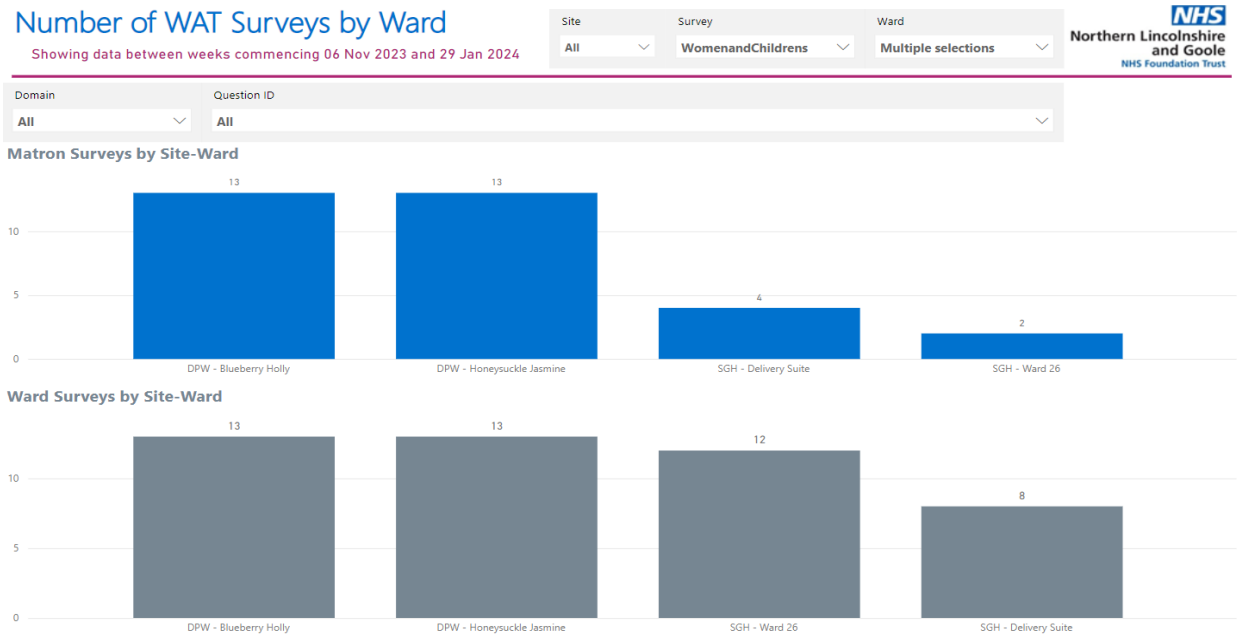
Children and Young people collected 38 FFT responses in January 2024; 2 at SGH and 36 at DPOW. Of those, 2 responses (1 at DPOW and 1 at SGH) related to the neonatal wards – both with a positive rating.

3 Assurance

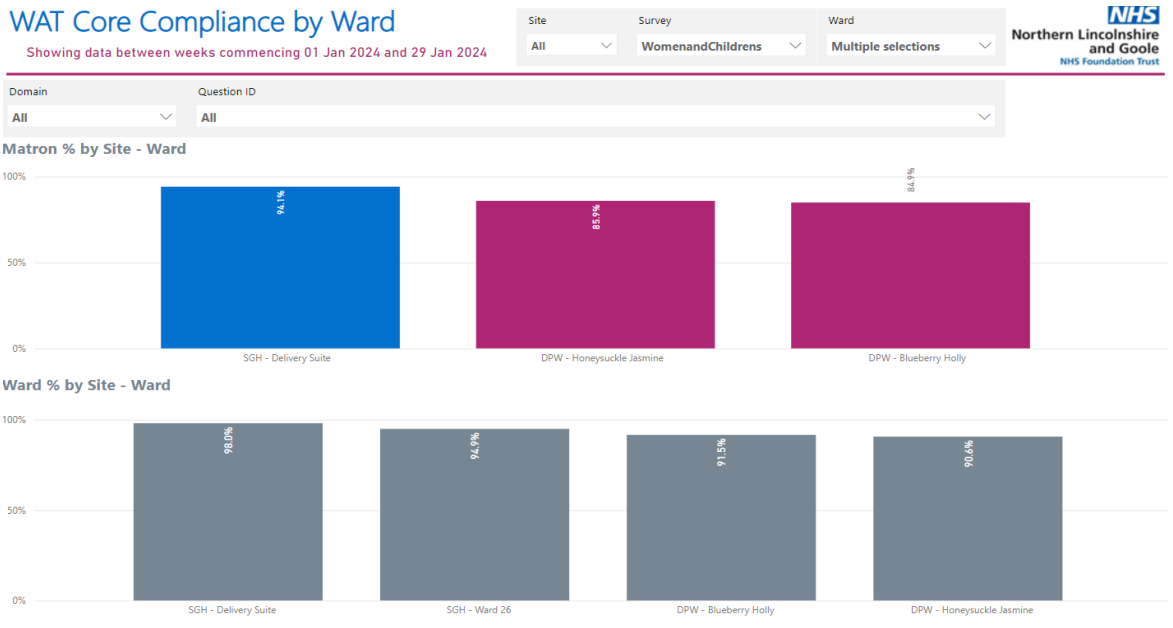
There were no visits planned to Maternity Wards or Neonatal Units throughout January, supportive visits continue to take place reviewing individual 15 Steps improvement plans and gaining further assurance with ongoing actions previously identified. A meeting has also been scheduled for reviewing the 15 Steps Standard 2 toolkit following the introduction of Badger Net to the Maternity Wards.

Ward Assurance Tool (WAT) data, Maternity and Services, January 2024

The table below shows individual number of assurance surveys completed across Maternity Services out of an expected 4 by Manager and 4 by Matron per area, at Diana Princess of Wales (DPOW) and Scunthorpe General Hospital (SGH). Poor completion noted by Matron due to vacancy at SGH however role now filled and we can expect to see an increased compliance from February/ March 2024.



The table below shows the compliance percentage for quality standards across Maternity Services for both Matron and Manager surveys.



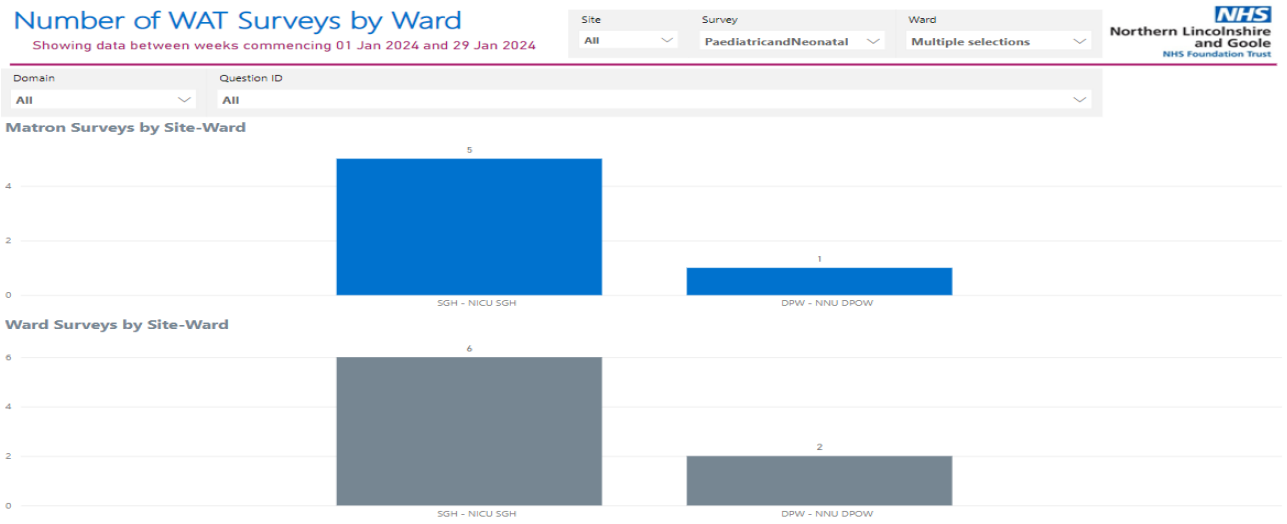
Blueberry, Holly, Jasmine, and Honeysuckle Wards fell below the expected 90% compliance, themes included, reduced staffing numbers, unsafe and unsecure management of medical notes, ‘safe to care’ checklists incomplete and poor medications management, as highlighted in the table.

Questions with less than 100% compliance

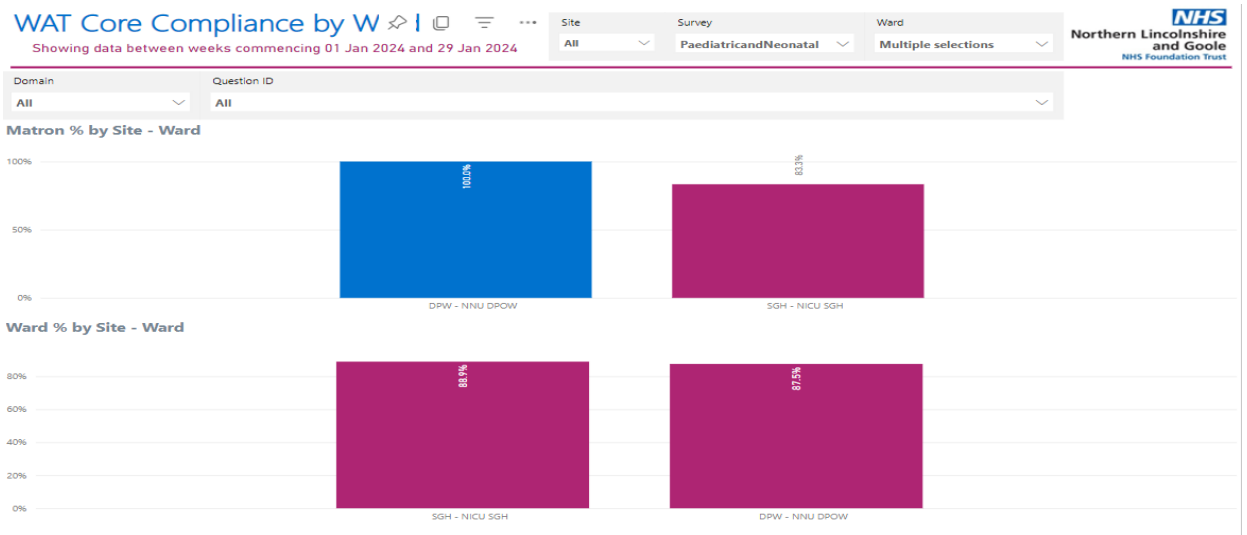
Week Commencing (Reverse)	WC 29/01/2024		WC 22/01/2024		WC 15/01/2024		WC 08/01/2024		WC 01/01/2024		Total
Question ID	Matron	Ward	Matron	Ward	Matron	Ward	Matron	Ward	Matron	Ward	
019. Are staffing levels at agreed planned establishment?	100.0%	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%	25.0%
051. Are all patient medical notes stored securely and computer screens locked when not in use?	0.0%	0.0%	0.0%	50.0%	33.3%	100.0%	100.0%	100.0%	100.0%	50.0%	53.6%
020. Have the safe to care checklists been completed daily check (check for the last 7 days?)	100.0%	50.0%	100.0%	100.0%	33.3%	100.0%	50.0%	100.0%	0.0%	50.0%	67.9%
023. Is the controlled drugs register completed correctly?	50.0%	50.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	50.0%	100.0%	82.1%
024. Are there any medications lying around on the worktops/station?	50.0%	100.0%	100.0%	100.0%	33.3%	100.0%	100.0%	100.0%	100.0%	100.0%	89.3%
007. Is uniform policy adhered to by clinical staff?	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%
050. Is the ward clean, tidy and clutter free including toilets and bathrooms?	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%

Ward Assurance Tool (WAT) data, Neonatal and Services, January 2024

The table below demonstrates individual number of assurance surveys completed across Neonatal Intensive Care units (NICU) out of an expected 4 by Manager, at DPOW and SGH. Poor completion by Matron at DPOW discussed at Nursing Metrics.



The table below shows the compliance percentage for quality standards across Neonatal services, for Manager surveys.



Themes for improvement across both sites for NICU included medications management and gaps in planned establishment.

Questions with less than 100% compliance

Week Commencing (Reverse)	WC 29/01/2024		WC 22/01/2024		WC 15/01/2024		WC 08/01/2024		WC 01/01/2024		Total
Question ID	Matron	Ward	Matron	Ward	Matron	Ward	Matron	Ward	Matron	Ward	
021. Is the treatment room locked?	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	50.0%	0.0%	50.0%	**28.6%**
019. Are staffing levels at agreed planned establishment?	0.0%	100.0%	100.0%	100.0%	50.0%	100.0%	0.0%	50.0%	0.0%	50.0%	**57.1%**
024. Are there any medications lying around on the worktops/station?	100.0%	0.0%	100.0%	50.0%	50.0%	100.0%	100.0%	100.0%	100.0%	50.0%	**71.4%**
007. Is uniform policy adhered to by clinical staff?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	**92.9%**

Perinatal Quality Surveillance Dashboard (PQSM) Dashboard

The latest PQSM dashboard is attached as Appendix II.

4 Feedback

Maternity & Neonatal Safety Champions
The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal) service users, LMNS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes. There are embedded monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the venue each time. It provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication.

A walkaround for January took place at SGH and at DPOW during February 2024. No issues were escalated.

Safety Mailbox and Shout Out Actions
Staff can raise safety concerns through a Safety Mailbox and via Shout Out Wednesday, which occurs monthly cross site. This is a short gathering on the clinical areas where all grades of staff are encouraged to attend to express any safety concerns that they may have. All are progressing and there are no areas for escalation.

The latest **Safety Champions Improvement Plan** is attached as **Appendix III.**

5 Quality Improvement

Transforming Maternity Triage Services

The Ockenden report outlines a number of recommendations in relation to how maternity services should conduct triage for pregnant women with medical related concerns who are 16 week plus. These recommendations outline the need to follow a recognised model of triage to priorities timely assessment, i.e. the Birmingham Symptom Specific Obstetric Triage System (BSOTS).

This Quality Improvement Project aim is to Implement a fully operational Maternity Triage Service across the whole of the Maternity Service in NLAG, that utilises a Nationally recognised Triage Model (BSOTS). In order to enhance the patient experience and care.

Phase 1 – Telephone triage and Phase 2 - face to face triage has now been successful implemented at both SGH and DPOW. Phase 2 went live on October the 16th and have received 1962 calls through the telephone triaged service with 482 women requiring to be seen triaged face to face at DPOW and 327 women been triaged face to face at SGH. Phase 1 Telephone triage has been live for over a year and has received 10436 calls during that time. Challenges remain at both site in relation to staffing levels to consistently man Maternity Triage however this has been actively managed by the service with a contingency process in place where staffing levels are low to maintain patient care, however this falls outside the BSOTs model.

Updated BSOTs best practice guidance advises to record triage calls for training and monitoring has been explored with the digital team. A number of issues were raised re storage, information governance and the ability to link patient identification. Routinely recording of triage calls has therefore not been implemented however matrons will have the ability to listen to calls on an ad hoc basis for training purposes.

Staff training is underway to increase knowledge across the unit in relation to BSOTS / triage. 76% staff at DPOW and 74% of staff at SGH have been trained to date this will allow greater flexibility in utilising staff to cover and maintain the triage service. Badger net implementation is due in the first part of this year this will enable enhanced pathway reporting and evidence of compliance with BSOTS triage criteria metrics.

A closedown report has now been produced and will be sent to the Maternity Transformation Board in March for signoff and this project will then be handed over for Business as usual.

Reducing Thermoregulation

New-born babies following birth are at risk of thermoregulation (loss of body temperature) which can lead to other health related issues requiring admission to NICU. This Quality Improvement projects aim is to have no more than 10% of NICU admissions as a result of babies with a temperature outside of the optimal limits (37 week gestation by 31st March 2023 (based on a baseline mean of >1 Jan 2021 – Jan 2023 equating to 97 babies).

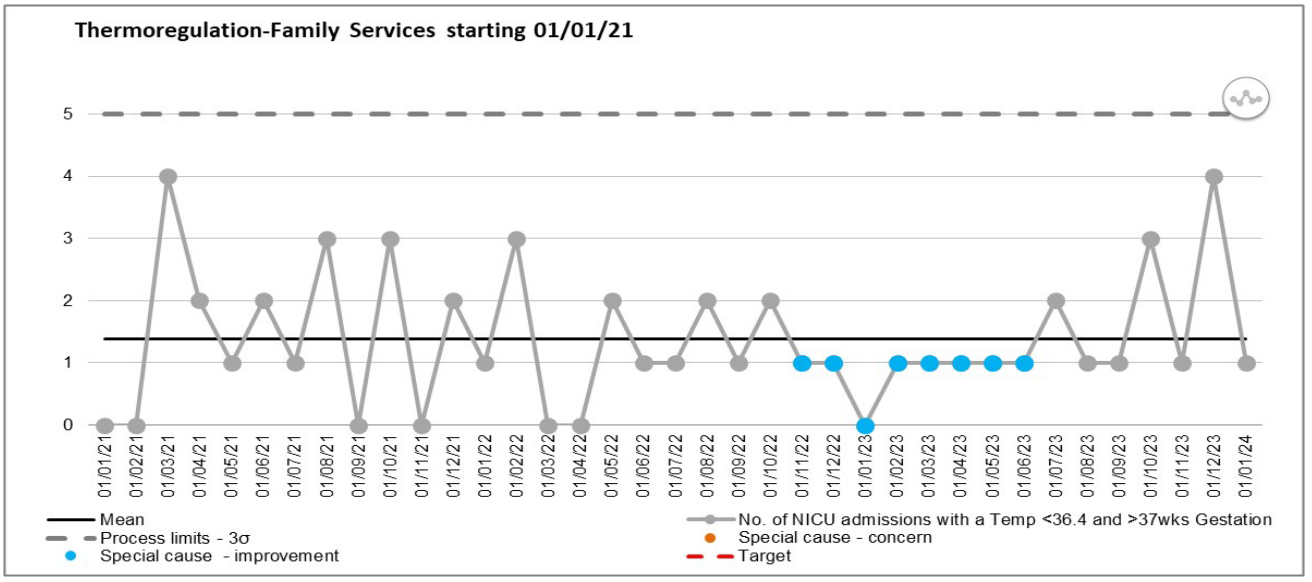
Whilst the baseline (mean) position is >1 the SPC chart below shows the larger variation and impact from 0 to >4 babies over 37 weeks gestation been admitted to NICU with thermoregulation.

The below SPC chart shows an increase to 3 babies attending NICU for Thermoregulation during October before returning to 1 during November, however this is within normal variation and there is no special cause - concern. This is the first time since February 2022

that 3 babies within the criteria have been admitted to NICU for Thermoregulation.

Upon review of these babies in October there were issues with the heating system on the ward due to scheduled maintenance, this was escalated and ultimately resolved, but did result in the ward being difficult to heat for a period. In addition, October saw new Junior Doctors rotate into the department who may not have been aware of the ongoing work to prevent thermoregulation. This has now been communicated via the ward huddles to ensure everyone is aware of the importance of the measures in place to keep the babies warm post birth.

December saw a spike in admissions for thermoregulations and these have been picked up with the Ward Managers for mismanagement of temperature. A closedown report has now been produced and will be sent to the Maternity Transformation Board in March for signoff and this project will then be handed over for Business as usual.



Antenatal Clinic (ANC) Quality Improvement (QI) Project

The divisional Senior Management Team have agreed for the commencement of a new QI project focusing on improving the Antenatal Clinics processes at both DPOW and SGH. This work has been prioritised after initial scoping showed opportunity to improve the service across a number of quality and performance metrics including patient and staff experience, reducing clinic over runs, aligning ANC and scanning capacity and reviewing both midwifery and medical roles within the ANC. Mapping the patient journey through the clinic has taken place during January 2024 with waiting times for patients been collected to identify the largest areas of delay. This data is still be analysed but will inform the focus of the next phase of the improvement project.

Capacity and Demand modelling has taken place by the operational team and has highlighted there are 246 slots per Trust wide short. The roles and responsibilities task is underway with the ANC Managers and is due to be signed off this month.

6 Serious Incident (SI) Reporting

Open Maternity Serious Incident Investigations as at 12 March 2024
There are currently 6 Maternity Serious Incidents open in the Trust. One of these incidents is being investigated by the Maternity and Neonatal Safety Investigations programme (MNSI), formerly HSIB.

Please note that the cases described in this report are also represented in the PSIRF / Serious Incident (including Duty of Candour and learning) report to the Quality & Safety Committees-in-Common in a summary form, tracking the investigation process. The table below provides immediate actions taken during the initial investigation stage to demonstrate response to risks identified; along with deadline dates or updates to the deadline dates where extensions have been agreed.

STEIS Ref	Site	Description	Stage	Immediate Action(s) (as from 72-hour report)	Deadline date
2023 20199	DPOW	Delayed delivery following abnormal CTG reading	Investigation	•Registrar to have 1:1 with the fetal monitoring lead. •Line manager and College Tutor to be informed and discuss with the registrar involved. •Coordinator to have 1:1 with fetal monitoring lead. •Labour Ward Coordinator manager to have discussion with coordinator •Discuss at Obstetric and Gynecology Governance Fetal growth was fluctuating and questions around appropriate management of fetal surveillance – plan.	21.03.2024 (new date - extension agreed)
2023 18396	SGH	NVF shared cremation error	Investigation	• Discussed at Managers weekly meeting and Maternity Safety huddles • Patient Safety Midwives educating unit/ward staff on the appropriate paperwork. • The form has been updated. This was agreed and will be	12.04.2024 (new date - extension agreed)

STEIS Ref	Site	Description	Stage	Immediate Action(s) (as from 72-hour report)	Deadline date
				shared to Family Services Governance team and is part of the education. • Flowcharts to be completed that will aide our staff on the 3 different processes- again this will be shared at Family Services Governance team and is part of the education. • Bereavement Midwives will continue to closely work with our mortuary staff to check all paperwork for accuracy and consistency and will be able to rectify any potential issues- at the beginning of this process. • The Bereavement Midwives will be responsible for scanning all the correct documents directly to the crematorium and will be the point of contact. • Chaplaincy actively support families in their loss when requested to do so. • NL Registrars are assured with our change in process and confirmed that the temporary suspension would be lifted. • Backlog of DPoW cases urgently reviewed on 26.09.23 and DPoW's Mortuary Assistant and DPoW Chaplain supported by Family Services and are assured that each case had been dealt	

STEIS Ref	Site	Description	Stage	Immediate Action(s) (as from 72-hour report)	Deadline date
				appropriately with no concerns raised on consent.	
2023 8658	DPOW	Maternal Cardiac Arrest	Investigation	Reviewing the issues relating to referral and acceptance for Interventional Radiology (HUTH) Investigating the decision making and potential disagreements between staff during the cardiac arrest.	11.04.2024 (new date - extension agreed)
2023 12695	SGH	Lower Segment Caesarean Section (LSCS) admitted to ITU	Investigation	Investigation report being written	22.03.2024 (new date - extension agreed)
2023 13122	DPOW	Maternal death	Investigation	This case was reported to MBRRACE as a maternal death and from the review of the case, there was no immediate learning identified.	15.03.2024 (new date - extension agreed)
2023 13399	DPOW	HSIB - Maternal death	Investigation	Review of the postnatal care due to the large gap between reviews Email sent to all midwives for student midwives not to be given care without supervision Email sent to Consultants and Coordinators to ensure patients with safeguarding concerns to only be considered for transfer out when an absolute must eg <27 weeks gestation	Not applicable due to HSIB investigating.

Maternity Serious Incident Completed Reports – 1

STEIS Ref	Date reported on STEIS	Site	Description	Stage
2023 10062	22/05/23	DPOW	Antepartum Still Birth	ICB now assured (27/02/204); currently ongoing action plan monitoring.

Other Maternity & Neonatal Safety Investigations (MNSI) Investigations – 1

Ulysses Reference	Description	Comments
314161	Unexpected term baby transfer out to Jessops - for additional care cooling.	Referred to MNSI- rejected 30/01/2024 as MRI normal. Rapid review undertaken within NLAG.

Risks and themes
The following 3 risks have been added to the risk register:

Number	Date	Title	What is the Risk?
3301	06/03/2024	Antenatal clinic review capacity	Not enough clinic capacity to accommodate the amount of obstetric patients seen on a weekly basis cross-site
3296	06/03/2024	Resusitaires on Maternity	The Resusitaires are beyond repair and are not able to provide the most up to date technology, this will result in the inability to effectively stabilise a new-born infant.
3158	14/02/2024	Obstetric data transcription	There is a risk of obstetric data transcription error subsequent to implementation of the Badgernet EPR system due to the current Viewpoint v5 being incompatible with a HL7 interface with Badgernet, requiring manual transcription of obstetric data into Badgernet, which may result in the clinical mismanagement of pregnant women.

7 Sustainability Plan

Following a positive visit by the National Maternity Team in September the Trust has confirmation that the Maternity Safety Support Programme will be exited once there is stability of the care groups, following governance agreement at local, regional and national levels.

The **Maternity Sustainability Plan (Appendix IV)** is monitored through the Maternity Quality Improvement meeting and Maternity Transformation & Improvement Board.

Ongoing Maternity Sustainability

Key Areas of Focus

- Leadership/Culture stability and QUAD
- Safety (embedding maternity and neonatal safety champion processes)
- Incident review process (rapid reviews/PSIRP)
- Reviewed and strengthened governance structure
- Learning – identifying and sharing
- Quality Improvement
- Audit Plan

Next Steps

- Safety and Quality – continue to monitor embedded processes and seek opportunities for service improvement
- Co-production with new MNVP Lead (including Maternity Strategy)
- Keep QI high on maternity agenda (identifying new projects)
- Maintain senior leadership team visibility
- Continue supporting and developing our teams/engagement with teams/succession planning
- Culture – repeat SCORE survey March 24
- Maternity and Neonatal Safety Conference – Spring 24
- Professional Midwifery Advocates (PMA)

8 External Visits

CQC inspection of Maternity Services (Goole) took place on 21 November 2023. Report received into the Trust on the 11 March 2024, an action plan will be produced and submitted to the CQC within 28 days.

9 Conclusion

The oversight report highlights all the work being undertaken within the maternity services.

Workforce/Staffing – Although improving position, midwifery vacancies remain challenging.

Patient Experience – complaints and PALS remain low. Friends and Family test (FFT) results show excellent feedback and positive experience. Overall themes (negative and positive) relate to communication and compassionate clinical care.

Assurance

- Local Maternity and Neonatal System (LMNS) assurance visit October 2023
- Positively the Maternity and Neonatal Voices Partnership Lead Role (MNVP) role commenced September 2023. Collaborative working and co production of maternity services has commenced.

Maternity Safety

The Maternity Safety Champions have an embedded walk round programme visiting different areas each time and it provides assurance of a 'floor to board' communication.

There are a number of on-going Quality Improvement projects including maternity triage services, neonatal thermoregulation and the Antenatal day unit/clinic review. All projects have full support from the executive and maternity team and feedback from staff and service users is excellent. A closedown report has now been produced for the neonatal thermoregulation project and will then be handed over for Business as usual once approved by the Maternity Transformation and Improvement Board.

Serious incidents (SI) and Maternity and Neonatal Safety Investigations (MNSI) formally HSIB (Healthcare Safety Investigation Branch) cases remain low with the last reported SI (MNSI) in November 2023. The Trust has moved to Patient Safety Incident Report Framework and at present there are currently 3 after action reviews ongoing.

In relation to complaints and PALS (Patient Advice & Liaison Service) for maternity, themes related to communication and delays in clinic. Themes are reported into the Local Maternity and Neonatal System (LMNS) Perinatal Quality Safety and Assurance Group (PQSAG) and Perinatal Quality Safety Oversight Group (PQSOG) meeting.

Clinical Negligence Scheme for Trusts (CNST)

The Trust declared compliance for all 10 safety actions. Assurance and monitoring provided by:

- Family Service quad oversite and escalation as required
- Quality & Safety Committee and Trust Board oversite
- Introduction of Maternity Audit and Compliance Manager
- Introduction of Saving Babies Lives implementation tool – quarterly ICB/LMNS check and challenge assurance meeting.
- LMNS Check and Challenge meeting 26 January 2024
- Extraordinary Trust Board 23 January 2024

Saving Babies Lives (SBL) V3

80% Compliance achieved for all 6 elements of SBL for quarter 3 2023/24 submission (highlight report attached as **Appendix V)**.

Ockenden Report

Action plan following the initial Ockenden Report is now complete and work is progressing on the immediate and essential actions to improve maternity care, supported by the multidisciplinary team. There are currently 66 green, 19 amber and 0 red actions.

Mandatory Training

As per the request of the LMNS at the CNST check and challenge meeting in January 2024, a new monitoring spreadsheet and recovery plan has been developed detailing actions taken where compliance dips below 90%. Whilst the table below provides compliance rates for PROMPT and fetal monitoring competencies, all other competencies affecting CNST / Saving Babies' Lives compliance are monitored.

Northern Lincolnshire and Goole NHS Foundation Trust																
Core Competency Framework - Compliance Tracker (Trustwide)																
Core Competency Module	Staff Groups												Total Compliance			
	Obstetric Consultant	%	Medical staff on Obs rota	%	Anaesthetic Consultant	%	Anaesthetic staff on Obs rota	%	Midwives	%	Heath Care Assistants	%	Numerator	Denominator	%	
Month: February 2024	Denominator															
	16		33		28		23		230		77					
Fetal Monitoring *(incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).*	15	94%	25	76%					223	97%			263	279	94%	
PROMPT *To include: Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.*	14	88%	23	70%	22	79%	20	87%	211	92%	73	95%	363	407	89%	

Appendix I – Trust wide Maternity Dashboard

Trustwide Maternity Dashboard

Indicator	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
Midwife to Birth Ratio	23.4 ↘	22.2 ↘	22.4 ↗	22.3 ↘	23.0 ↗	23.1 ↗	23.3 ↗	22.8 ↘	22.7 ↘	20.8 ↘	21.8 ↗	
Red Flags	1.0 ↘	4.0 ↗	6.0 ↗	15.0 ↗	25.0 ↗	2.0 ↘	7.0 ↗	14.0 ↗	3.0 ↘	14.0 ↗	9.0 ↘	7.0 ↘
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	0.0	0.0	0.0	2.0 ↗	2.0	0.0 ↘	0.0	3.0 ↗	1.0 ↘	3.0 ↗	1.0 ↘	1.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0 ↘	3.0 ↗	2.0 ↘	3.0 ↗	0.0 ↘	0.0	3.0 ↗	3.0	1.0 ↘	2.0 ↗	2.0	1.0 ↘
(c) Missed medication during an admission to hospital	0.0	0.0	2.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	1.0 ↗	1.0	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	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	1.0	1.0	1.0	3.0 ↗	5.0 ↗	0.0 ↘	1.0 ↗	1.0	1.0	0.0 ↘	1.0 ↗	0.0 ↘
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	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	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	0.0 ↘	0.0	0.0	6.0 ↗	16.0 ↗	2.0 ↘	2.0	5.0 ↗	0.0 ↘	8.0 ↗	3.0 ↘	5.0 ↗
Continuity of Carer %												
In Receipt of %												
CoC In Receipt of %												
Continuity Team Caseload												
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	92.3 ↘	97.2 ↗	97.8 ↗	98.2 ↗	94.8 ↘	94.2 ↘	92.8 ↘	94.5 ↗	93.9 ↘	98.5 ↗	94.3 ↘	
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	99.5 ↘	100.0 ↗	100.0	100.0	100.0	100.0	100.0	99.5 ↘	99.0 ↘	99.4 ↗	99.5 ↗	99.5 ↗
Vacancies	41.7 ↘	34.4 ↘	16.0 ↘	10.5 ↘	14.5 ↗	14.9 ↗	15.5 ↗	15.4 ↘	27.9 ↗	29.4 ↗	28.4 ↘	22.8 ↘
Vacancies - Registered	37.3 ↗	30.5 ↘	17.6 ↘	13.9 ↘	18.0 ↗	17.6 ↘	19.1 ↗	15.9 ↘	27.5 ↗	23.0 ↘	22.4 ↘	16.9 ↘
Vacancies - Unregistered	4.4 ↘	3.9 ↘	-1.6 ↘	-3.4 ↘	-3.5 ↘	-2.7 ↗	-3.6 ↘	-0.4 ↗	0.4 ↗	6.4 ↗	5.9 ↘	5.9 ↘
Serious Incidents	0.0	0.0	1.0 ↗	1.0	1.0	1.0	0.0 ↘	1.0 ↗	1.0	0.0 ↘	0.0	0.0
Complaints	1.0	1.0	2.0 ↗	1.0 ↘	0.0 ↘	3.0 ↗	1.0 ↘	3.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	2.0 ↗
PALS	3.0	4.0 ↗	1.0 ↘	6.0 ↗	6.0	6.0	4.0 ↘	5.0 ↗	4.0 ↘	3.0 ↘	3.0	6.0 ↗
Sickness Absence (Division) %	5.5 ↘	5.9 ↗	6.0 ↗	5.7 ↘	5.2 ↘	5.5 ↗	5.7 ↗	5.4 ↘	5.8 ↗	5.4 ↘	5.7 ↗	

Appendix II – PQSM Dashboard

Maternity Services			
CQC Maternity Ratings	Caring	Well-led	Responsive
	Good	RI	Good
	Good	RI	Good
	Good	RI	Good
Maternity Safety Support Programme			
	Nov-23	Dec-23	Jan-24
Findings of review of all perinatal deaths using the real time data monitoring tool	wed care and completed the PMRT tool for for 1 late fetal loss, 1 neonatal death and 7 s, 1 neonatal death and 7 antepartum stillbirths in the review period. Actions have been nd 1 serious incident investigation is underway.		Report not yet available for Q4
Findings of review of all cases eligible for referral to MNSI	0 referrals to MNSI	1 referral to MNSI (rejected)	0 referrals to MNSI
Report on:			
	Reported (N=2)	Reported (N=1)	Reported (N=0)
The number of incidents logged graded as moderate or above and what actions are being taken	1) Baby born with Anophthalmia (left eye absent), missed screening in pregancy. Action Taken: Screening safety incident (reportable to NHSEI) – currently under investigation 2) Baby admitted to NICU following resuscitation at birth on labour ward. Multiple airway maneuvers made and suction removed a mucous plug under direct vision. Blood gas poor and decision made to commence passive cooling. CFAM attached, baby for transfer to a tertiary centre. Action Taken: Currently being investigated, MNSI rejected case, local rapid review completed.	Baby delivered via ventouse and episiotomy, shoulder dystocia, baby had fractured humerus **Action Taken**: Duty of candour provided to parents. No further action required as recognised complication for shoulder dystocia.	N/A
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training:			
Core competency - S&G Maternity (all staff groups)	81.64%	82.38%	82.50%
Core competency - DPOW Maternity (all staff groups)	90.96%	90.98%	90.92%
Role Specific Training - S&G Maternity (all staff groups)	78.31%	76.84%	78.70%
Role Specific Training - DPOW Maternity (all staff groups)	87.17%	83.68%	85.26%
Other competencies - S&G Maternity (all staff groups)	77.10%	69.61%	65.66%
Other competencies - DPOW Maternity (all staff groups)	81.36%	69.59%	70.17%
K2 Training (Trustwide Maternity Services)	94.68%	88.46%	92.79%
PROMPT (Trustwide Maternity Services)	94.68%	94.55%	88.02%

safe staffing planned cover versus actual cover:			
Midwifery staffing (source: safer staffing dashboard)			
Blueberry/Holly - DPOW	Planned hrs: 2,884.3	Planned hrs: 3,105.9	Planned hrs: 3,105.9
	Actual hrs: 2,517.4	Actual hrs: 3,055.3	Actual hrs: 3,487.8
	Fill Rate: 88.5%	Fill Rate: 98.4%	Fill Rate: 112.3%
Central Delivery Suite - SGH	Planned hrs:2,839.2	Planned hrs:2,933.8	Planned hrs:2,933.8
	Actual hrs: 2,388.0	Actual hrs: 3,075.1	Actual hrs: 2,602.2
	Fill Rate: 84.1%	Fill Rate: 104.8%	Fill Rate: 88.7%
Jasmine and Honeysuckle - DPOW	Planned hrs: 2,839.2	Planned hrs: 2,933.8	Planned hrs: 2,933.8
	Actual hrs: 2,471.8	Actual hrs: 2,624.1	Actual hrs: 2,671.4
	Fill Rate: 87.1%	Fill Rate: 89.4%	Fill Rate: 91.1%
Ward 26 - SGH	Planned hrs: 2,484.3	Planned hrs: 2,567.1	Planned hrs: 2,567.1
	Actual hrs: 1,861.0	Actual hrs: 1,955.3	Actual hrs: 2,104.2
	Fill Rate: 74.9%	Fill Rate: 76.2%	Fill Rate: 82.0%
Obstetrician staffing - cover on the delivery suite, gaps in rotas			
Delivery Suite - SGH	100.0%	100.0%	100%
	0 gaps identified	0 gaps identified	0 gaps identified
Delivery Suite - DPOW	100.0%	100.0%	100%
	0 gaps identified	0 gaps identified	0 gaps identified
Service User Voice Feedback / 15 Steps Feedback	15 Steps - Ward 26 at SGH were visited and achieved a rating of 'requires improvement'. Friends & Family October Results: Not yet available for Nov 23 on Power BI.	No visits to report	Antenatal Outpatients Clinic (DPOW) achieved a rating of requires improvement, with further assurance required within standard 1, and the safe, secure storage of medications within the clinic.
WAT Tool Ward Area Compliance	96.2% (Sept - Nov 23)	93.9% (Oct - Dec 23)	97.0% (Nov - Jan 24)
Staff feedback frontline champions and walk abouts	10 open actions, 4 relate to action required from Estates & Facilities Team with expected completion dates of end of January 24. Action plan in place and monitored (Reported to Board / Q&SC).	10 open actions, 4 relate to action required from Estates & Facilities Team, completion dates extended as action relating to the holes in Theatre floor prioritised. Agreed for final completion date of the end of the financial year. Action plan in place and monitored (Reported to Board / Q&SC).	11 open actions - Themes identified: Estates Capacity & demand / Pathway Equipment / IT Action plan in place and monitored accordingly.

Learning from Feedback (Patient Experience)	**DPOW F&FT Feedback Q3 (Oct - Dec)** Acorn: 20 responses - 85% positive Blueberry: 66 responses - 100% positive Holly: 45 responses - 98% positive Honeysuckle: 22 responses - 100% positive Community DPOW: 4 responses - 100% positive Community Louth: 3 responses - 100% positive **SGH F&FT Feedback Q3 (Oct - Dec)** Midwifery Unit: 3 responses - 67% positive Antenatal dept: 18 responses - 77.8% positive CDS: 14 responses - 93% positive Ward 26: 53 responses - 100% positive Community: 4 responses - 88% positive **Maternity Themes identified:** Distress caused by birth experience, Communication, Staff attitude, Delays in ANC **Action Taken:** Discussion with staff members about inappropriate comments through Just and Learning Fed back through Safety Huddles	**DPOW F&FT Feedback Q3 (Oct - Dec)** Acorn: 20 responses - 85% positive Blueberry: 66 responses - 100% positive Holly: 45 responses - 98% positive Honeysuckle: 22 responses - 100% positive Community DPOW: 4 responses - 100% positive Community Louth: 3 responses - 100% positive **SGH F&FT Feedback Q3 (Oct - Dec)** Midwifery Unit: 3 responses - 67% positive Antenatal dept: 18 responses - 77.8% positive CDS: 14 responses - 93% positive Ward 26: 53 responses - 100% positive Community: 4 responses - 88% positive **Maternity Themes identified:** Distress caused by birth experience, Communication, Staff attitude, Delays in ANC **Action Taken:** Discussion with staff members about inappropriate comments through Just and Learning Fed back through Safety Huddles	**The Friends and Family Test** **89 responses Trustwide (Jan 24)** Positive: 89.8% Negative: 6.7% **DPOW:** Positive: 89.6% Negative: 6.9% Neutral: **SGH & Goole:** Positive: 90.0% Negative: 6.6% **Trustwide Themes:** Lengthy waiting times. **Action taken:** Capacity and demand review underway.
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust	0	0	0
Coroner Reg 28 made directly to the Trust	0	0	0
Progress in acheivement of CNST SA 10	On track	Compliance declared for 10 standards	Compliance declared for 10 standards
Proportion of midwives responding with 'Agree or Strongly Agree'			22 responses (please see sheet 2)
Proportion of specialty trainees in Obstetrics & Gynaecology respc			1 response (please see sheet 2)
Family Services Operational Dashboard - Power BI Safer Staffing - Power BI WAT Women and Childrens - Power BI H:\Service Development & Modernisation\Medical Staffing\1. Master			

Appendix III – Safety Champion Improvement Plan

Overdue or Incomplete
In Progress
Completed

Northern Lincolnshire and Goole NHS Foundation Trust

Date Raised	How concern	Site	Theme	Concern Raised	Action Taken	Responsible Person	Escalation	Plan to close	Action by Date	Status	Comments
19/10/2022		DPOW	Estates	Holes in theatre floor – previously been reported but no action has been taken. Infection control risk.	Reported again to Estates Department and General Manager for Family Services. Visit theatre with Estates and Facilities team.	Vicki Booth	Claire Shipley – Family Services General Manager Keith leech – Estates & Facilities Management Team	Repair flooring via external contractor	31/12/2023		CS met with KL 6/12/23 – to obtain quote for repair and liaise with team around access to theatre CS – work has commenced and will continue throughout February 2024.
21/12/2022		DPOW	Estates	Stores cages left obstructing maternity theatre corridor, not enough room to fit a bed through and dangerous in an emergency situation.	Email sent to Bill Parkinson & Iona Johnson (Iona already aware of situation as previously raised by a coordinator) Funding obtained through Health Tree Foundaton to fit new storage.	Vicki Booth	Claire Shipley – Family Services General Manager Keith leech – Estates & Facilities Management Team	Purchase cupboards for storage	31/01/2024		Cupboards and quote have been approved – awaiting fitting in Dec 23. Dec 23: The fire warden has concerns about storage units in a corridor. Feb 24: VB met with Fire Warden, other options to be explored. NJ to discuss with CS/SL.
18/04/2022		SGH	Estates	The tiles on the wall in the sluice are falling off and have narrowly missed hitting a member of staff.	Highlighted concern to ward manager to ask if it could be followed up for remedial work to be carried out for safety of staff using the area. Estates and Facilities depatment re-secured tiles. Further request submitted to apply for a persex wall covering to replace all remaining tiles.	Natalie Jenkin	Claire Shipley – Family Services General Manager Keith leech – Estates & Facilities Management Team	Replace/repair area in sluice	31/01/2024		Work has commenced, agreed to be completed by the end of the financial year.
17/05/2023		DPOW	IT	Ward mobile phones should be taken into delivery rooms when caring for labourers, co-ordinators are receiving calls other staff members without correct information and sbar.	Email sent to ward managers.	Vicki Booth Carla Siviter	Sonia Last – Assistant General Manager	Link in with the networking project telam to ensure data points in place	30/11/2023		08/11/23 Update from V. Booth, W. Woolridge recommends static phones in the delivery rooms due to the increased demand on the wifi, the mobile phones are not reliable for our needs. He advises linking in with the networking project team to ensure we will have the data points and then IT can sort 15 phones for the delivery rooms. These phones will be locked so no external calls can be made. 13/12/23 Update from V. Booth. Linking in with network project to install devices. Pre-meet taking place 04/03/24 VB, will provide further update following meeting.
19/09/2023	Safety Mailbox	TWD	Pathway	Discrepancies between the Placenta Praevia Guideline, the Fetal Medicine Referral Form and the Pathway to Leeds FMC.	Editable versions of the documents requested	Natalie Jenkin	Head of Midwifery Fetal Medicine Consultant Lead	Review documents and make necessary amendments (where required).	31/12/2023		HoM working with FM Lead to ensure no discrepancies

20/10/2023	Shout out Wednesday	SGH	Estates	The Nurses station desk has become separated and needs fixing in place underneath and the large end of the desk has beome separated and needs either securing or replacing.CDS.	Needs replacing or repairing. Requisiton sent to Estates to assess and repair/ or replace (20/10/23).	Kendra Thomas	Claire Shipley - Family Services General Manager Keith leech - Estates & Facilities	Repairs/replacement to desk	31/01/2024		CS - quote received, delay initially but the E&F team are working with us to ensure this is completed. Holes in the theatre floor work has been prioritised first.
26/10/2023	Safety Champions Walkaround	DPOW	Pathway	Antenatal clinics frequently running over due to overbooking of the clinics.	To be reviewed as part of the QIP for ANC/ADU.	Natalie Jenkin	Sonia Last - Assistant General Manager	Quality improvement project underway (in the early stage), action plan will be devised to address the issues identified	30/11/2023		Increased demand following the implementation of Saving Babies Lives which exceeds capacity. This is a cross site issue. Feb 24: VB / SL have reviewed capacity and demand.
07/12/2023	Safety Champions Walkaround	SGH	Capacity and demand	Scan capacity at weekends and bank holidays is not sufficient for demand.	Discuss with Associate Director of Allied Health Professionals, Clinical Sciences to enquire about potential increase of obstetric scan slots at a weekend and bank holidays.	Natalie Jenkin	N/A	N/A	28/02/2024		2 slots on Saturdays, 2 slots on Sundays and 2 on BHs. VB to confirm in place with Ruth Kent and find when commencing. VB to confirm and then close.
07/12/2023	Safety Champions Walkaround	SGH	Equipment	Pulse oximetry purchased for Edan monitors do not fit in the machines.	Escalated to Fetal Monitoring Lead Midwife to source alternative equipment.	Linda Keech	N/A	N/A	28/02/2024		Feb 24 - HG contacted LK for update. LK to contact managers at SGH to resolve issue 29/02/24.
07/12/2023	Safety Champions Walkaround	SGH	Capacity and demand	Lengthy waits and costly tests being undertaken for SBR.	Explore the possibility of purchasing equipment which gives an instant result.	Natalie Jenkin	N/A	N/A	28/02/2024		Feb 24 - JC to send quote to NJ.
21/02/2024	Shout out Wednesday	SGH	Logistical safety	Theatre equipment stored outside of main theatres at times impedes moving a bed out of delivery suite	Request matron to have a discussion with theatre matron re possibility of making sure the equipment kept outside of main theatres doesn't cause moving issues for CDS	Claire Brothwell	Email to matron 22/02/2024		31/03/2024		27/02 - Concern sent to SGH Maternity Matron I to action.

Appendix IV – Maternity Sustainability Plan

Actio ID	Sustainability Action Pla	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date/ Timeline	Evidence
SAP1	Developed maternity risk management strategy	Periodic review as per document control policy	17/5/23 - Strategy in development 15/6/23 Strategy in governance approval process - currently out for comment 23/6/23 Ratified at O&G Governance meeting June 23	Strategy ratified at Obstetric Governance Meeting and available on the Trust intranet		Chief Nurse	Assocoiate Chief Nurse	Jun-23	Strategy. 10/8/23 To provide further evidence of process for document control ratification and staff engagement 7/9/23 Evidence re Trust - document control process DCP001
SAP2	Benchmarked against maternity self-assessment tool with a QI plan to be reviewed quarterly at the maternity transformation board chaired by Chief Nurse attended by the NED and MVP lead to be reviewed quarterly	Self-assessment tool action plan - monitored at QI and Monitoring Group, Maternity Transformation Board and presented at Trust Board.	9/5/23 Ongoing 15/6/23 Ongoing 23/6/23 Progress continues 14/7/23 Progress on action plan continues	Minutes of QI and Monitoring Group, Maternity Transformation Board and Trust Board. Completion of action plan.		Chief Nurse	Jul-23	Jul-23	10/8/23 Provide minutes of Trust Board meeting (Aug 23) and 3 months of MTIB minutes 5/9/23 - Email from Sarah Meggitt (PA) Trust Board minutes will be available after 3 October (date of Board) 5/9/23 Requested minutes from SM
SAP3	To develop and refine the SMART approach to QI plans in response to learning from incidents and complaints	Incident review meeting - action log, Action plan re Complaints (monitored at QI and Monitoring Group Meeting) Embed process for triangulation of themes and trends for incidents, complaints and claims.	9/5/23 Action log commenced for Incident Review Meeting and Complaints Action plan monitored at the QI and Monitoring Group. Work in progress to embed triangulation of themes. SOP in place. 15/6/23 Work ongoing 14/7/23 Work continues - Quarterly Report will commence July (O&G Governance meeting for information)	Incident Review Action log and Minutes from the QI and Monitoring Group.		Chief Nurse	Associate Chief Nurse	Jul-23	In h/family services/divisional managers/maternity/self assessment tool Incident review action log, minutes QI and monitoring group. QI highlight reports.QI Strategy. 10/8/23 Provide further evidence, including action log, safety bulletin, PMRT newsletter, safety huddles, LMNS (PQSAG/PQSOG)up2date,incident learning lessons Review SOP section 5.0 monitoring compliance and effectiveness 12/9/23 SOPS reviewed and reflect monitoring process
SAP4	Develop a PMA QI plan around A-Equip model	Service reconfiguration re: team model. Consider benchmarking against Birmingham A Equip model	9/5/23 Meeting planned with Lead PMA. Pastoral support , recruitment and retention midwife in post 15/6/23 Gap analysis against the national steering group's 'principles for successful implementation of PMA teams' completed and completion of action plan in progress by PMA team.	Model implemented		Chief Nurse	Associate Chief Nurse	Jul-23	PMA strategy, PMA Guideline DCT168, PMA team implementation gap analysis. 10/8/23 PMA annual report to Trust Board (presented by PMA) Follow up offer from CK to support PMA Evidence of PMA action plan. 9/1/24 Offer from CK followed up by PMA team
SAP5	Develop the Matrons and their role as visible leaders supporting the senior team to implement the quality improvements	QI course completed by Maternity Matron (DPOW) Further Matron post - Gynaecology and Breast to support maternity services.	9/5/23 Matron post - Gynaecology and Breast is currently advertised (planned date for interview 13/6/23) Plans for Matrons and managers within the Division to attend Trust 'Leading with Kindness, Courage and Respect Programme' 15/6/23 Matron - Gynaecology and Breast interview 16/6/23. Plan for matrons and B7 managers to attend the 'Leading with Kindness, Courage and Respect Programme' 26/6/23 Matrons booked onto course for September 2023 26/6/23 Matron posts for maternity and gynaecology and breast both appointed.	Matron for Gynaecology and Breast in post and Matrons booked onto the course.		Chief Nurse	Associate Chief Nurse	Jul-23	Email from Tori Hordon confirming course booking

Actio ID	Sustainability Action Pla	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date/ Timeline	Evidence
SAP6	Support plans to increase establishments of the governance team and reduce portfolios of the senior clinical teams so the maternity services have capacity to have senior oversight and messages to the executive team are not diluted under the umbrella of family services	Work on-going. Review completed - March 2023	9/5/23 Recruitment agreed for Maternity audit and compliance manager and Governance Deputy posts. 15/6/23 Recruited into Maternity audit and compliance manager post 9/6/23 (post will commence from August 23) Deputy Governance Lead post interview planned for July 23	Maternity audit and compliance manager and Governance Deputy in posts.		Chief Nurse	Associate COO	Jul-23	
MSAT1	Leadership development opportunities	Leadership and development programme for potential future talent (talent pipeline programme)	Evidence required. Leadership Development Strategy.15/6/23 Leadership Development Strategy				Tori Hordon, Organisational Development Business Partner	May-23	Leadership Development Strategy.Perinatal culture and leadership (QUAD attending and 2nd cohort booked)
MSAT2	Maternity strategy, vision and values	Maternity strategy in place for minimum 3-5 years	14/4/23 Draft document, awaiting illustration to be added prior to wider circulation for comments. 15/6/23 Strategy written and in governance process - due for ratification O&G Governance June 23. 23/6/23 Ratified T O&G Governance meeting June 23 (CN forward to be added)				Division Tri	Jun-23	Strategy 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned 14/9/23 North and North Lincs MNVP- On line listening events weekly - plan to use this forum for coproduction of Maternity Strategy
MSAT3	Maternity strategy, vision and values	Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children?s chapter of the NHS Long Term Plan	14/4/23 as above 15/6/23 As above.23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned
MSAT4	Maternity strategy, vision and values	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff	14/4/23 as above 15/6/23 As above.23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy. 10/8/23 To provide further evidence of process for document control ratification and staff engagement
MSAT5	Maternity strategy, vision and values	Maternity strategy aligned with trust board LMNS and MVP?s strategies	14/4/23 as above 15/6/23 As above. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy. 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned
MSAT6	Non-executive maternity safety champion	NED appointed as one of the board level maternity safety champions and working to national role descriptor	14/4/23 NED in post, working to national role descriptor. Core member of Safety Champion monthly walk-rounds				Chief Nurse	Apr-23	In h/family services/divisional managers/maternity/self assessment tool. Sharing of Safety Intelligence from floor to board on safety and quality issues standard operating procedure DCR246 10/8/23 Safety champions – Gateshead good board - have emailed TC and CK today to ask for contact from Gateshead. 5/9/23 TEAMs chanel accesible to all staff re: Maternity and Neonatal Safety Champions. 12/9/23 Maternity and Neonatal Safety Conference - planning (minutes of meetings) Safety champion badges ordered.
MSAT7	Multi-professional engagement workshops	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality planned safety days. improvement plans	Evidence required 23/7/23 Proposed date for Maternity Safety Conference (multidisciplinary and cross site) 18/10/23 - followed by quarterly sessions	Maternity and Neonatal Safety Conference			Division Tri	01/06/2023 Amended target date 30/4/24	
MSAT8	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	Evidence required. DS provided evidence				Dave Sprawka	Feb-23	Values based recruitment

Actio ID	Sustainability Action Pla	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Own	Target Date/ Timeline	Evidence
MSAT10	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	Evidence required. Divisional framework in development. 15/6/23 Evidence required from GD 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing change (change management and quality improvement methodology). •Culture work : oteam interventions available including team coaching and Insights training to provide team cohesion through self awareness and open discussions on personal style and preference, ocivility & respect training, building respectful teams team intervention available through OD. •H&WB: stress management risk assessment policies and talking toolkit, wellbeing conversations training for managers in line with our strategic plan p8 •Staff values and charter : Values are available and linked to all written materials and training available in the Trust. p5 of our Trust strategic plan oStaff charter and behavioural framework will be explored in late 2023. •PACT training, civility & respect training programme rolling out in q2 2023 onwards, included in our summer leadership events in August 23				HRBP	Jul-23	Leadership and management behavioural framework 12/9/23 NMC Code Quad attending Perinatal Leadership Course and second cohort planned. SCORE survey to be commenced Feb 2024. Managers all currently completing 'Leading with Courage, Kindness and Respect'
MSAT11	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	Evidence required. In progress at divisional level. 15/6/23 Evidence required from GD. Have maternity behavioural charter 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing change (change management and quality improvement methodology). •Culture work : oteam interventions available including team coaching and Insights training to provide team cohesion through self awareness and open discussions on personal style and preference, ocivility & respect training, building respectful teams team intervention available through OD. •H&WB: stress management risk assessment policies and talking toolkit, wellbeing conversations training for managers in line with our strategic plan p8 •Staff values and charter : Values are available and linked to all written materials and training available in the Trust. p5 of our Trust strategic plan oStaff charter and behavioural framework will be explored in late 2023. •PACT training, civility & respect training programme rolling out in q2 2023 onwards, included in our summer leadership events in August 23				HRBP	Jul-23	12/9/23 Strategic plan for NLaG, Values, Maternity specific behaviour charter, stress/civility,
MSAT12	Maternity governance structure	Maternity governance and leadership team roles review	Review underway supported by MIA. Recruitment in progress for additional leadership roles 15/6/23 Review undertaken. Appointed to Maternity Audit and Compliance Manager role and Deputy Governance Lead post currently out to advert. 22/7/23 Deputy Governance Lead role appointed to.				Division Tri	May-23	

Actio ID	Sustainability Action Pla	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Own	Target Date Timeline	Evidence
MSAT13	Proactive shared learning	Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	Evidence required 15/6/23 Update from RD - Sharing Learning document currently under review 14/7/23 Existing Learning Strategy document reviewed, consulting on through Quality Governance Group and PSIRF implementation Group. Awaiting responses as of 7/7/2023. Annual review date being applied to this version as last version was in 2020 on a 3 year cycle. Relaunch of Trust learning group to follow, with refreshed membership and focus.				Richard Dickinson, Associate Director of Quality Governance	Aug-23	http://nlgnet.nlg.nhs.uk/DocumentControl/Documents/Learning%20Strategy%20(DCP369).pdf#search=learning%20strategy / Learning Strategy 10/8/23 Review action with focus on maternity services
MSAT14	Safety huddles	Audit of compliance against safety huddle guideline/SOP	Evidence required 15/6/23 JL/TM completing SOP and audits. 30/6/23 SOP in governance process (out for comments to governance group)7/7/23 SOP ratified and on HUB - audit regisitered.	SOP ratified and available on the HUB			Division Tri	Jun-23	13/9/23 Plan for MNVP lead coproduction/attendance at maternity study days.
MSAT15	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division
MSAT16	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division
MSAT17	Trust wide Swartz rounds	Broad range of specialties leading sessions	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division. Encourage maternity staff to attend.

Red	Overdue
Amber	On track
Green	Completed

Appendix V

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

FAMILY SERVICES DIVISION

MATERNITY SERVICES

Saving Babies' Lives Care Bundle v3

Progress Report

Nicola Foster

March 2024

Introduction

NHS resolution is operating year five 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 6 of the MIS and as part of the Three Year Delivery Plan for Maternity and Neonatal Services the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To meet the minimum requirement for CNST the Trust must demonstrate implementation of 70% of interventions across all 6 elements overall and implementation of at least 50% of interventions for each element.

In September 2023 the new national implementation tool was released which enables the Trust to track and evidence improvement as well as report on compliance with the requirements set out in the Care Bundle. The implementation tool and supplementary evidence are validated by the Local Maternity and Neonatal Service (LMNS), ensuring a more comprehensive process of assurance and better understanding of where improvement can be made across the LMNS. As part of the process, Maternity Services have been reporting to the local LMNS/ICB at quarterly assurance meetings following submission of evidence via the implementation tool on the NHS Futures platform.

The most recent assurance meeting took place in December 2023 and one of the recommendations was to ensure the Trust Board are sighted on the current position, therefore, the purpose of this report is to provide an overview of the current compliance for the 6 elements of the care bundle following submission of evidence for quarter 3 2023/24.

Current Position – Overall Summary

The tables below provide a breakdown of the current position for all six elements of the Saving Babies Lives Care Bundle Version 3 following Quarter 3 submission along with the overall position for CNST compliance for Safety Action 6.

Intervention Element	Description	Number of Interventions	Minimum benchmark	% of Interventions Fully Implemented Q1 (LMNS Validated)	% of Interventions Fully Implemented Q2 (LMNS Validated)	% of Interventions Fully Implemented Q3 (Unvalidated)	CNST Safety Action 6 Met?
Element 1	Smoking in pregnancy	10	50%	10%	70%	70%	✓
Element 2	Fetal growth restriction	20	50%	70%	70%	90%	✓
Element 3	Reduced fetal movements	2	50%	100%	100%	100%	✓
Element 4	Fetal monitoring in labour	5	50%	80%	80%	80%	✓
Element 5	Preterm birth	27	50%	59%	70%	78%	✓
Element 6	Diabetes	6	50%	17%	67%	67%	✓
ALL	**TOTAL**	**70**	**70%**	**56%**	**71%**	**80%**	✓

CNST Safety Action 6 Requirements		Requirement met?
1)	Provide assurance to the Trust Board and ICB that you are on track to implement all 6 elements of SBLv3 by March 2024.	✓
2)	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.	✓

Areas of non-compliance

The tables below provide a breakdown of the interventions where compliance has NOT yet been achieved for all six elements.

Element 1: Reducing smoking in pregnancy

Quarter 3 data collection demonstrated an improvement in documentation in the case notes and on CMIS (particularly relating to smoking status). However, despite improvement NLAG are not able to declare full compliance for the 3 interventions listed in the table below, therefore compliance for element 1 remains at 70%

LMNS wide meetings are taking place which allows leads to learn from each other, adopt best practice from those already achieving the standards, at present discussions are focused on ensuring the relevant information is captured on BADGERNET Maternity systems for future data collection. Additionally, a collaborative meeting on smoking cessation is due to take place with the local government to discuss pregnancy initiatives and the local NLAG Task and Finish Group continue to meet and to undertake focused quality improvement work.

				Current Compliance		
Ref	**Source**	**Target**	**Measure**	**SGH & Goole**	**DPOW**	**NLAG**
1.3	Snapshot Audit	80%	Smoking status should be recorded for all pregnant women at the 36-week appointment.	75%	71%	73%
	Snapshot Audit	50%	Smoking status should be recorded for pregnant smokers at all routine antenatal appointments excluding booking / 36 weeks).	24%	32%	28%
1.4	Snapshot Audit	95%	An opt-out referral should be instigated for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a TDA within an in-house tobacco dependence treatment service.	88%	84%	86%
1.6	DCRS	60%	Of the pregnant smokers with an opt out referral recorded, 60% should set a quit date.	N/A	N/A	47%
	DCRS	50%	Of the pregnant smokers who have a 4 week smoking status outcome recorded, 50% should be non-smokers at 4-week quit date and 85% of these should be CO verified.	N/A	N/A	10%
	CMIS Delivery Data	50%	Of the pregnant smokers who have 4 week smoking status outcome recorded, 50% should be non-smokers at 4-week quit date and 85% of these should be CO verified.	N/A	N/A	11%

Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

For Q3 submission, a total of **18** interventions were considered fully implemented, demonstrating improvement from 70% to 90% compliance. The **2** remaining interventions with partial implementation are detailed in the table below. Evidence is yet to be validated by the LMNS at the next Quality Assurance Meeting in March 2024.

				Current Compliance
Ref	**Intervention**	**Target**	**Comments / Actions**	**NLAG**
2.7	Women who are designated as high risk for FGR should undergo uterine artery doppler (UAD) assessment between 18+0 and 23+6 weeks gestation.	LMNS to agree local ambition	Clinical audit in progress to assess if women who booked as high risk for FGR had a UAD between the required weeks gestation. ***A delay occurred due to difficulties in identifying a reliable patient sample. This has now been provided by the Perinatal Institute and audit is underway.***	Partial
2.19e	Percentage of babies >3rd centile born <39+0 weeks gestation, where growth restriction was suspected.	<5%	Focused quality improvement work is underway to assess if other indications were present that prompted early delivery.	7.7%

Element 4: Effective fetal monitoring during labour

Following Q3 submission, **4** interventions were considered fully implemented and **1** remains partially implemented at SGH (detailed in the table below).

				Current Compliance	
Ref	**Intervention**	**Target**	**Comments / Actions**	**SGH**	**DPOW**
4.2	Ensure every woman at onset of every labour has a risk assessment undertaken which informs clinicians of the most appropriate fetal monitoring method at the start of labour and then revisited regularly throughout labour.	80%	Issue has been brought to the attention of the Labour Ward Managers and Patient Safety Midwives to undertake QI work.	68%	95%

Element 5: Reducing preterm birth

Following Q2 validation, **21** interventions were considered fully implemented and **8** partially implemented (detailed in the table below).

				Current Compliance	
Ref	**Intervention**	**Target**	**Comments / Actions**	**SGH**	**DPOW**
5.1	Each Trust should have the following in place for preterm birth prevention: a) Obstetric consultant lead b) Preterm birth/perinatal optimisation midwife c) Neonatal consultant lead d) Neonatal nursing lead for preterm perinatal optimisation.	-	Neonatal nurse lead for perinatal optimisation is with Neonatal Ward Manager job descriptions. Maternity Improvement and Transformation Board approved and requested a SOP detailing duties. SOP to be developed and approved by FS quad. ***All other job descriptions sent in Q1 and accepted***	Partial	
5.2	The incidence of women with a singleton pregnancy giving birth between 24+0 to 36+6 weeks (liveborn and stillbirth) as a % of all singleton births.	<6%	Undertake pre-term birth risk assessment and undertake QI work around perinatal prevention/optimisation (including referral to the pre-term birth clinic).	7.2%	6.6%
5.3	Assessment of all women at booking for the risk of pre-term birth *(Full compliance achieved in Q1 and Q2)*	80%	Standard not achieved at SGH & Goole due to old antenatal summary record in use. Managers made aware and asked to replace with correct version.	72%	96%
5.16	The neonatal team should be involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with the parents prior to birth.	95%	A continuation sheet/form has been developed to evidence retrospective discussions with the neonatal team prior to maternity BADGERNET introduction.	60%	70%
5.24	Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5-37.5°C and measured within one hour of birth.	85%	Thermoregulation quality improvement project underway. Improvement required at SGH.	67%	88%
5.25	Percentage of babies born below 34 weeks gestation who receive their own mother's milk within 24 hours of birth.	52%	Mothers are supported and encouraged to breast feed/express early after birth. Continue to loan pumps to mothers and provide support.	44%	55%

Element 6: Management of pre-existing diabetes in pregnancy

Following Q3 submission, no further progress has been made as **4** interventions were considered fully implemented, **1** partial and **1** not implemented (detailed in the table below).

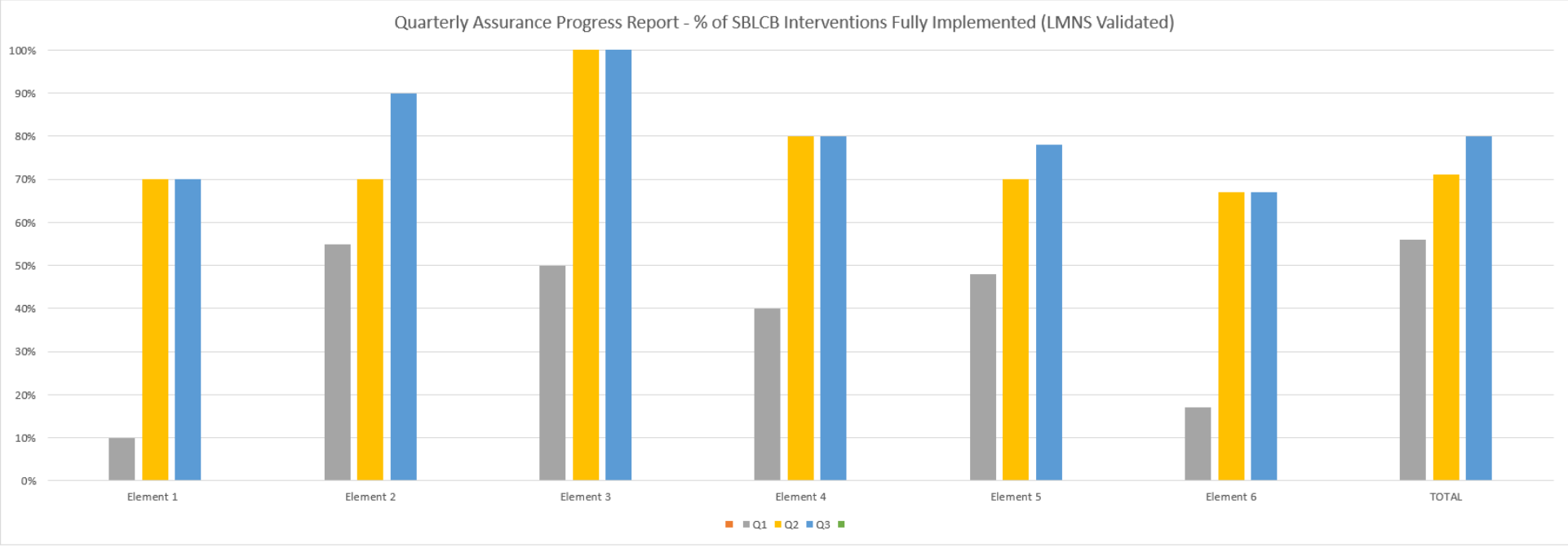
				Current Compliance
Ref	**Intervention**	**Target**	**Comments / Actions**	**NLAG**
6.1	Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements.	Full implementation	A Diabetes Specialist Midwife post has been appointed to complete the MDT. Discussions regarding clinic configuration are still ongoing.	Not implemented
6.2	MDT diabetes team members with a responsibility to interpret CGM to demonstrate completion of annual CGM training.	Annual training completed	Training certificates to be provided by outstanding MDT members at SGH.	Partial

Conclusion

The Trust submitted the evidence for quarter 3 submission on the 8th March 2024 and following self-assessment declared an overall compliance rate of **80%** across all elements of the Saving Babies Lives Care Bundle, demonstrating an improvement from 71% in quarter 2.

Of the 70 interventions, full compliance has been demonstrated in 56 (80%), partial compliance in 13 (27%) and non-compliance for 1 (3%) intervention. Evidence is yet to be validated by the LMNS as part of the quality assurance process, once complete the Trust's position will be confirmed at the next Quality Assurance Meeting in March 2024.

The division continue to undertake multidisciplinary quality improvement and clinical audit work, aiming to provide assurance for the partial or non-compliant interventions for quarter 4 submission.



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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)059

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Mike Robson and Gill Ponder, Non-Executive Directors and Performance, Estates and Finance Committees-in-Common Chairs
Contact Officer/Author	Mike Robson and Gill Ponder, Non-Executive Directors and Performance, Estates and Finance Committees-in-Common Chairs
Title of the Report	Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report
Executive Summary	This report provides an overview of the key matters presented to and considered by the Performance, Estates and Finance Committees-in-Common from the February and March 2024 meetings. It also includes matters for escalation to the Boards, matters where additional assurance is required, confirm and challenge of the Board Assurance Framework (BAF), any action(s) required of the Boards.
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common Terms of Reference for HUTH and NLaG
Prior Approval Process	The attached report has been approved by the committee Chairs
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail BIC below:

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

Report for the meeting of the Trust Boards in Common to be held on:	11 April 2024
Report from:	**Performance, Estates and Finance Committees-in-Common**
Report from meeting held on:	28 February 2024 and 27 March 2024
Quoracy requirements met:	The following dates of Performance, Estates and Finance Committees-in-Common meetings were quorate: • 28 February 2024 • 27 March 2024

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance, Estates and Finance (PEF) Committees-in-Common (CiC) at their meetings held on 28 February and 27 March 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:

27 March 2024

- Board Assurance Frameworks (BAF)
- Annual Plan (update)
- Deep Dive into Length of Stay and Beds
- Care Groups Transitional Arrangements
- Contract approved for HUTH/20/291 Routine Radiology Reporting Services to include out of hours
- CQC Action Report
- Financial Report – Month 11
- Group Integrated Performance Reports (IPR)
- Estates and Facilities update

28 February 2024

- Board Assurance Frameworks (BAF)
- Annual Plan (update)
- Update on Process for Revenue Investments benefits realization
- Deep Dive into Elective Care
- Linear Accelerator Lease Contract approved
- CQC Action Report
- Financial Report – Month 10
- Integrated Performance Reports (IPR)
- Estates and Facilities (general update)

3.0 Matters for reporting / escalation to the Trust Boards

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

PEF CiC meeting - 27 March 2024

a. **Financial position** – Concerns remained about the underlying deficit of £107million and the impact this will have on the financial planning for 2024/25.

b. **Annual Plan and Cost Improvement Plan** – the Committees were assured that the initial £55million of CIP savings had a high confidence level of delivery out of the £85million total. Concerns remained about the 2024/25 timeframe for achieving the remaining £30million of CIP savings, and options continue to be explored. This is the biggest risk in achieving the Draft Planned Deficit of £50.6m

c. **CQC action report** – the Committees requested a speaker attend the meeting to address the HUTH specific actions as well as a speaker for the NLaG actions.

d. **Performance** – the need to improve productivity in reducing patient length of stay and improved patient flow. An updated report will be action focused and presented to the June 2024 meeting.

e. **Late contract approval** – concerns were raised about the late presentation of contracts for approval when they have already expired.

f. **Care Group transition** – the Committees raised concerns at the lack of oversight of the Readiness Assessment of the Care Group transition, prior to implementation on 1 April 2024.

g. **Meeting clashes** – the Committees raised an issue about meetings being booked during the pre-planned CiC meetings meaning Executive Directors needed to leave the meeting early which created quoracy issues.

PEF CiC meeting – 28 February 2024

a. **Operational Planning Progress** – The Committees raised concerns about the activity levels and targets set, noting the need to realise the difficulties with the activity ambitions, especially in light of the delayed national guidance. The need to address the context of broader activity levels with the developing integrated financial plan was agreed, together with the associated workforce plan required to deliver such activity levels.

b. **Financial position** – Concerns were raised in relation to the underlying deficit and the risks to progress with Cash Releasing Efficiency Savings (CRES) programme and other financial planning for 2024/25.

c. **Elective Care Deep Dive -** The Committees raised concern about the clinical safety risk of approximately 37,000 unappointed patients who were not risk stratified at

present (only patients with an appointment are risk stratified). These appointed slot issues (ASI) are hopefully being mitigated by patients returning to their GPs if required. This was a particular issue at HUTH and was agreed to be investigated.

4.1 The committees received assurance on the following items of business:

PEF CiC meeting - 27 March 2024

a. Fire compliance – the installation of the fire alarm systems at Scunthorpe General Hospital is on track and once completed there will be a significant reduction in the fire risk score at SGH. An Engineer's Report has been received and will be reviewed prior to approval and circulation with an action plan.

PEF CiC meeting – 28 February 2024

a. CQC Actions Progress – The Committees were assured that appropriate work was in progress to ensure a consistent Group approach in addressing the required CQC actions.

b. Patient Administration System (PAS) implementation - The Committees noted their thanks to the digital team and for the effective teamwork of the patient administration team and other staff involved across the Group in the transition to the Lorenzo PAS. Significant assurance was noted for the initial stages of this successful PAS implementation which utilised an effective business planning approach and minimised any operational impact. Support was being provided to resolve any data migration or training issues identified by staff.

c. **Finance update** - The Committees were reasonably assured on the financial position to date (in terms of the month 10 position of the financial year). It was noted that the agency spend was also progressing in relation to expectations.

d. Performance – Reasonable assurance was noted for the Committees in terms of the performance metrics reported and the progress made against the national targets. Problems identified had appropriate mitigations in place and improved reporting of them was also noted.

5.0 Matters on which the committees have requested additional assurance:

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

PEF CiC meeting - 27 March 2024

None.

PEF CiC meeting – 28 February 2024

a. Consultant Job Plans

The Committees raised concerns over the consultant job planning and the potential impact this could have on the financial position of the Trusts. It was agreed to refer this matter to the Workforce, Education and Culture CiC.

6.0 Confirm or challenge of the Board Assurance Framework (BAF):

6.1 The Committees considered the areas of the BAF for which they have oversight and proposed the following change(s) to the risk rating or entry:

PEF CiC meeting - 27 March 2024

Not received at this meeting.

PEF CiC meeting - 28 February 2024

The committees queried why the reduction in risk rating for the in-year financial target had not been mirrored at NLaG and suggested that it should be reviewed and mirrored across the Group.

It was agreed that the BAF digital risk required review with the potential to increase the risk rating and for this to be consistent across the Group.

The PEF CiC requested the risk rating for estates and facilities be reviewed and aligned across HUTH and NLaG (risk 1.4 on the NLaG BAF with a risk rating of 20 and risk 7.3 on the HUTH BAF with a risk rating 10, reduced from 15).

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- note the key points highlighted in the escalation report from the PEF CiC meetings held on 27 March 2024 and 28 February 2024;
- note that the PEF CiC have referred a risk about consultant job planning to the Workforce, Education and Culture CiC for review.

Mike Robson, PEF CiC Chair for the meetings on 27 March 2024 and 28 February 2024

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Trust Boards-in-Common Front sheet

Agenda Item No: BIC(24)060

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Kate Truscott and Tony Curry, Non-Executive Directors and Workforce, Education & Culture Committees-in-Common Chairs
Contact Officer/Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Workforce, Education and Culture Committees-in-Common Highlight / Escalation Report
Executive Summary	The attached highlight / escalation report highlights matters considered by the Workforce, Education and Culture Committees in Common at the meetings held on 29 February and 28 March 2024, any additional assurance required, confirm and challenge of the BAF and any action required of the boards.
Background Information and/or Supporting Document(s) (if applicable)	Workforce, Education & Culture Committees-in-Common Terms of Reference for NLaG and HUTH
Prior Approval Process	The report has been approved by the committee Chairs
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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

Report for meeting of the Trust Boards to be held on:	11 April 2024
Report from:	Workforce, Education and Culture Committees-in-Common
Report from meeting held on:	29 February 2024 28 March 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meetings held on 29th February 2024 and 28 March 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

29 February 2024

- Board Assurance Framework
- Workforce Performance Metrics
- Group Transformation Programme
- Medical Workforce Vacancies in NLaG
- Turnover within First Year of Employment in HUTH
- CQC Actions Progress Report
- Learning and Development Progress
- Employee Relations Case Analysis
- HUTH Guardian of Safe Working Q3

28 March 2024

- Board Assurance Framework
- NLAG and HUTH: CQC Actions Progress Report
- Group Consultant engagement
- Registered Nurse and Midwifery Staffing HUTH/NLAG
- Workforce Integrated Performance Report
- Recruitment/Time to Hire KPI
- Group Values Update
- Group Staff Survey Update

- People Strategy Progress Report
- Plan for Care Group Support and Development
- Update on Portfolio Pathway Programme and Training Fellowships

*[*Items marked with an asterisk are on the boards' agenda as a standalone item in accordance with the board reporting framework – as applicable]*

3.0 Matters for reporting / escalation to the Trust Boards

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

29 February 2024

a. Low mandatory training compliance within NLaG. This remains below target at 78.89% against a target of 85%. Concern – gaps in Trust skills and training leads to quality issues.

b. High non-registered nursing vacancy rate at NLaG. The rate is now 11.4%, which is 3.1% above the target of 8%. The rate is not improving and there is no robust plan in place at the moment. Concern – places pressure on existing staff, on budgets and potentially impacts the quality of care.

c. Pace and impact of the Care Groups implementation and the effect on staff. The Committees-in-Common expressed concern regarding the timescale of 1 April, as interviews for key positions are still ongoing. It was agreed that more assurance and a risk assessment was required. Concern – the anxiety and stress on staff.

d. Age of the Medical Workforce and high locum costs in NLaG. 11.7% of consultants are over 66 years and 18.4% are approaching retirement age. The NLaG Committee-in-Common was not assured and recommended a refocus and establishment of a working group to develop a plan to address the ageing workforce. Concern – sudden loss of expertise that impacts delivery of care.

e. GMB staged a demonstration outside HUTH regarding the working conditions of OCS. The other unions were not aware of this issue. The Head of Facilities at HUTH is to attend the Committee-in-Common in March 2024 to give an update. Concern – to make sure the Terms and Conditions of people who work on our behalf should be aligned to the Trusts.

28 March 2024

a. HUTH Training Suite underneath the Day Surgery Unit is being developed and will be operational in Q1.

b. NLAG Maternity Services at Goole retained a 'Good' CQC rating.

c. Concern was raised across both Trusts regarding the need for additional investment to support the organisational development of staff in the new Care Groups to ensure success.

4.0 Matters on which the committees received assurance

4.1 The committees received assurance on the following items of business:

29 February 2024

a. NLAG and HUTH: CQC Actions Progress Report – Reasonable assurance was obtained due to the reduction in the number of actions with limited assurance. The HUTH report is a work in progress, to be aligned with the NLaG report.

b. Workforce Performance Metrics (HUTH) – Reasonable assurance was obtained due to mandatory training compliance and low vacancy rate with further work to be undertaken to improve appraisal rate. Positive assurance of OD and FMLM support to the Cardiology team at HUTH was received.

c. Workforce Performance Metrics (NLaG) – Limited assurance was obtained due to high absence rates and high non-registered nursing vacancy rate.

d. Learning & Development Progress (HUTH) – Reasonable assurance was obtained due to the hard work undertaken by the Learning and OD team to reschedule training and maximise capacity, due to the issues with the recent estates issues.

e. Learning & Development Progress (NLaG) – Reasonable assurance was obtained due to the review of the leadership development programme, which will prioritise Care Group leadership in the first instance.

f. Employee Relations Case Analysis (HUTH) – Reasonable assurance obtained due to the number of cases returning to the usual amount and the average time to complete a case is 48 days.

g. Employee Relations Case Analysis (NLaG) – Reasonable assurance was obtained the team will stop using Allocate to record data and will use Excel spreadsheets similar to HUTH.

h. Guardian of Safe Working Hours Q3 (HUTH) – Reasonable assurance obtained due to the number of exception reports. The hard work to increase the number of rotas on eRoster to 98% was highlighted. Issues with the paediatric surgical rota were noted, a business case will be refreshed by the paediatric management team.

i. Deep Dive into Turnover within First Year of Employment (HUTH) – Reasonable assurance received, the report highlighted Additional Clinical Services and Estates, Facilities and Development as outliers and the reasons and destinations of leavers with actions to improve retention.

28 March 2024

a. Mandatory Training for medical staff (NLAG) will be monitored at the new Care Group Performance meetings.

b. Medical Engagement and Leadership strategy is under development and an update of progress will be received in July 2024. Limited assurance was given although it was noted that there was a plan in place.

c. HUTH Nurse vacancy position was positive (2.4%) and was over established by 89.18. 40 of these positions were to cover maternity/winter pressures and open wards. Reasonable assurance was given.

d. NLAG Nurse vacancy position was improving (7.7%) and the rotational posts were proving popular. A deep dive into the un-registered position would be planned into a future meeting. The item was given limited assurance as there was more work to do.

e. 48 face to face Group Values' sessions have taken place, the outcome of the sessions to be launched at the top 100 leaders conference in April 2024.

f. Limited assurance was given in respect of the Staff Survey results although it was noted that good progress had been made on last year's results.

5.0 Matters on which the committees have requested additional assurance:

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

29 February 2024

a. An update on progress for the investigation into different lived experiences of racism at HUTH before the September 2024 report was requested.

b. A deep dive into hotspot areas within the Group with low mandatory training compliance including subject matters was requested.

c. A deep dive into the plans to improve the non-registered nursing vacancy rate in NLaG was requested.

d. A plan from the Learning & OD team to support the Care Group leadership team develop was requested.

e. A medical workforce strategy in NLaG to address concerns with the age profile of the workforce and improve the recruitment and retention of senior medical staff.

f. A briefing paper on the issues raised about OCS in HUTH by the GMB. The Head of Facilities to attend the March Committee-in-Common to give an updated position.

28 March 2024

a. CQC Action Plan representative for HUTH required at the next meeting.

b. Group medical engagement updates will be received on a monthly basis via the Chief Medical Officer.

c. NLAG – An options paper relating to the Band 2/3 national profile change to be presented at the April 2024 meeting.

d. HUTH - Review of the Suspension and Discipline report and how often it should come to the meeting.

e. Group current Values and how staff are feeling following the staff values sessions to be discussed further at the June 2024 meeting.

f. HUTH Wellbeing manager has been replaced by a Group People Promise Manager. More details regarding the scope of the role to be discussed at a future meeting.

g. Lorenzo issues and the impact on staffing. Jackie France to be invited to the April 2024 meeting to give the committees a status check.

h. Group focus on retention figures and processes to be aligned.

i. The Performance, Estates and Finance Committees-in-Common requested a review of Consultant Job Plans and their impact on productivity. The Workforce, Education and Culture Committees-in-Common discussed this and although the systems in place are not yet sophisticated enough to measure productivity a further review of job planning will take place at a future meeting.

6.0 Confirm or challenge of the Board Assurance Framework (BAF):

6.1 The committee considered the areas of the BAF for which it has oversight, and no changes were proposed from the meetings in February and March.

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- note the report;
- note the issues for escalation from the committees and where further assurance has been requested.

Tony Curry and Kate Truscott

Workforce, Education & Culture Committees-in-Common Chairs

2 April 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)062

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April, 2024
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	Myles Howell, Group Director of Communications
Title of the Report	National Staff Survey results for HUTH and NLaG
Executive Summary	Presentation summarising the 2023 national staff survey results for both HUTH and NLaG
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)	The report includes a summary of the organisations' performance against WRES and WDES standards.
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

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Group Staff Survey Update

Boards in Common

Thursday, 11 April 2024

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Introduction

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

A target of 60% completion rate was set for all managers and teams across the Group.

- NLaG increased its completion rate from 35% to 48% (3512 staff responded compared to 2415 last year)

- HUTH increased its completion rate from 37% to 50% (4620 staff responded compared to 3160 last year).

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Overall positive score

The Picker “positive score” allows organisations to compare results historically, and to other similar organisations on a question-by-question basis, for all questions that can be positively scored. Both organisations have significantly improved on their overall scores.

- HUTH was the second most improved Picker Trust in 2023, moving from 59th/65 of the Picker league table for overall positive score to 48th/62 against the Picker average
- NLaG is 15th most improved out of all the 62 Picker trusts, moving from 62nd/65 last year to 55th/62.

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Key indicators

The survey comprises over 100 questions, however reporting focuses on nine key areas, seven of which measure performance against the NHS People Promise:

1. **We are compassionate and inclusive**
2. **We are recognised and rewarded**
3. **We each have a voice that counts**
4. **We are safe and healthy**
5. **We are always learning**
6. **We work flexibly**
7. **We are a team**
8. Staff engagement
9. Morale

In 2022 both organisations results were significantly worse than the national average for all key indicators.

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NLaG

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	6.89	2359	7.03	3486	Significantly higher
We are recognised and rewarded	5.54	2359	5.76	3489	Significantly higher
We each have a voice that counts	6.36	2345	6.52	3454	Significantly higher
We are safe and healthy	5.73	2355	5.99	3452	Significantly higher
We are always learning	5.07	2283	5.39	3242	Significantly higher
We work flexibly	5.62	2352	5.82	3467	Significantly higher
We are a team	6.39	2357	6.49	3479	Not significant
Themes					
Staff Engagement	6.43	2359	6.65	3496	Significantly higher
Morale	5.49	2358	5.84	3495	Significantly higher

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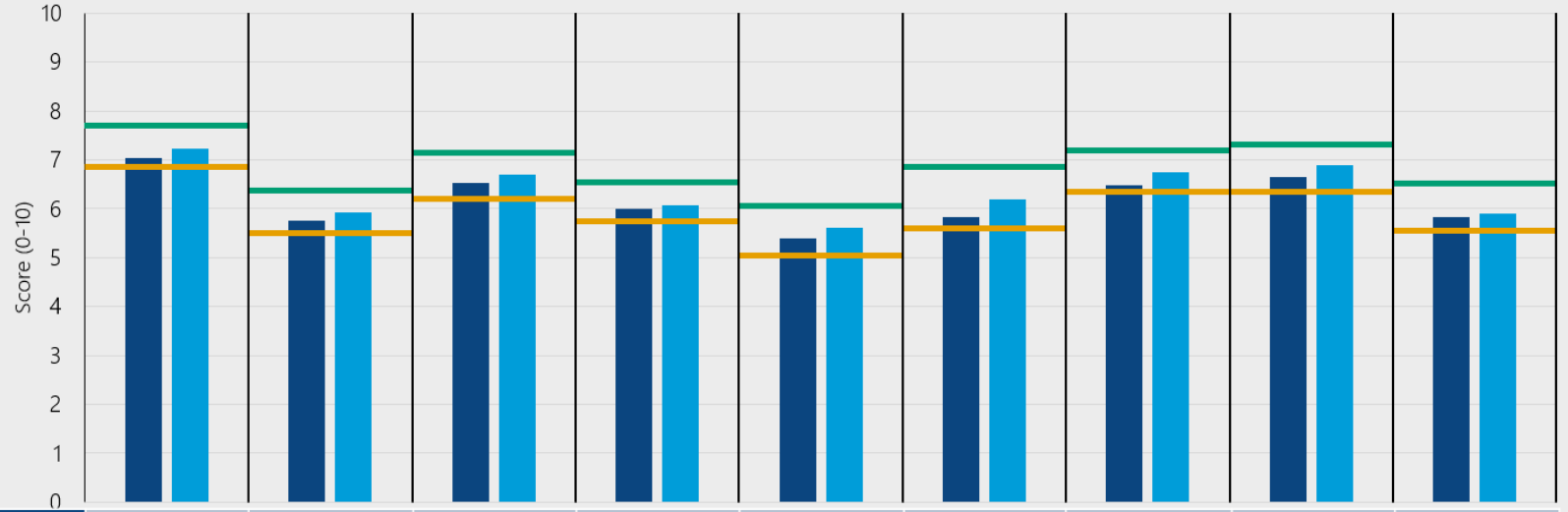
People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.03	5.76	6.52	5.99	5.39	5.82	6.49	6.65	5.84
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	3486	3489	3454	3452	3242	3467	3479	3496	3495

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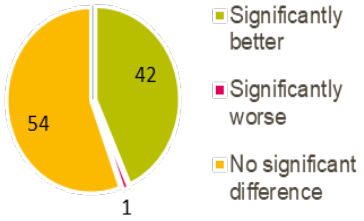
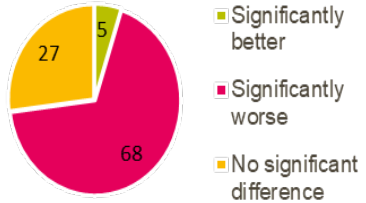
Comparison scores for NLaG in 2023

53%	q25c. Would recommend organisation as place to work
52%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
67%	q25a. Care of patients/service users is organisation's top priority

Comparison to 2022**



Comparison with average**



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HUTH

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	6.96	3155	7.15	4594	Significantly higher
We are recognised and rewarded	5.49	3157	5.87	4588	Significantly higher
We each have a voice that counts	6.38	3143	6.51	4566	Significantly higher
We are safe and healthy	5.67	3147	6.01	4558	Significantly higher
We are always learning	5.19	2956	5.69	4262	Significantly higher
We work flexibly	5.63	3150	5.99	4567	Significantly higher
We are a team	6.35	3153	6.61	4591	Significantly higher
Themes					
Staff Engagement	6.40	3159	6.66	4598	Significantly higher
Morale	5.48	3159	5.88	4597	Significantly higher

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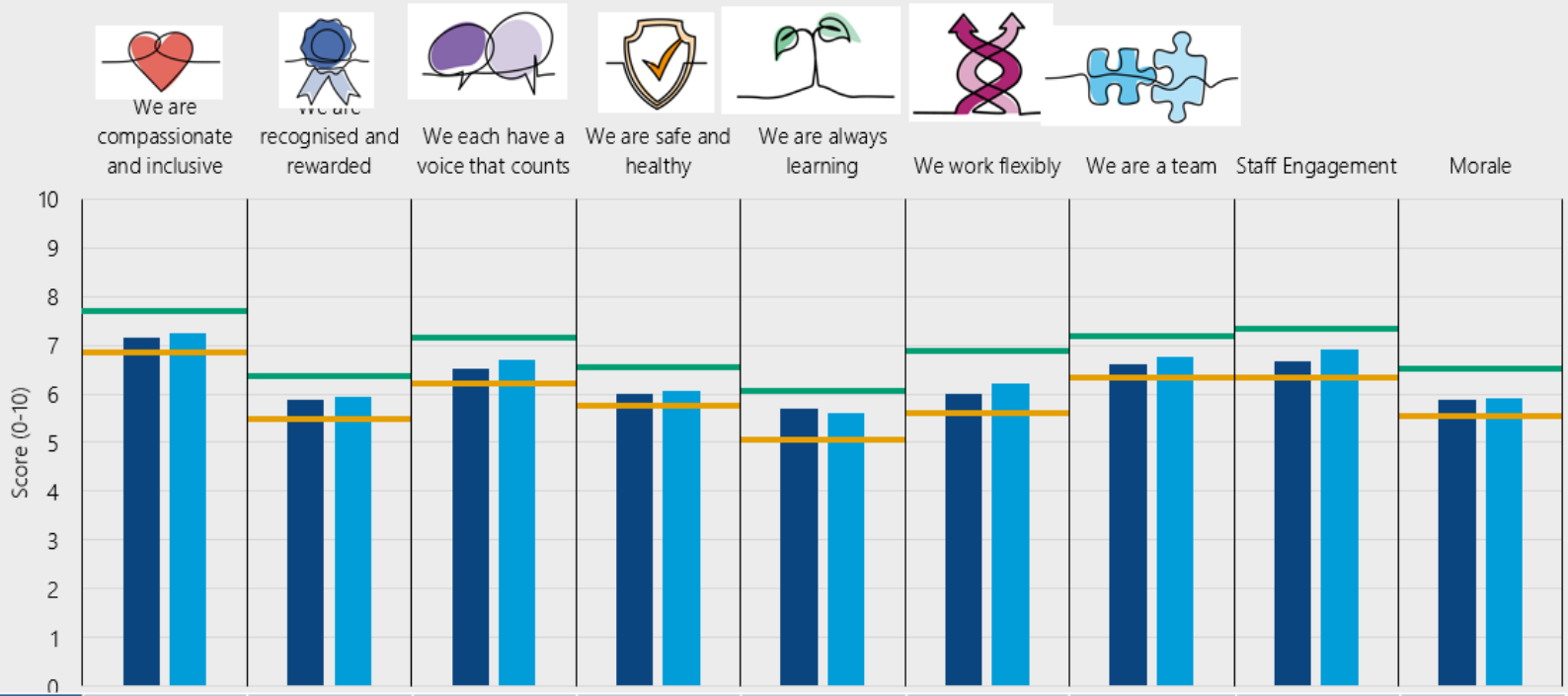
People Promise elements and themes: Overview

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.15	5.87	6.51	6.01	5.69	5.99	6.61	6.66	5.88
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4594	4588	4566	4558	4262	4567	4591	4598	4597

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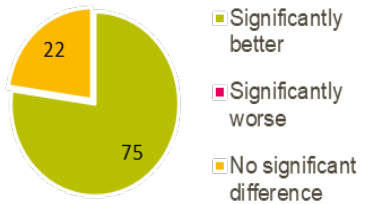
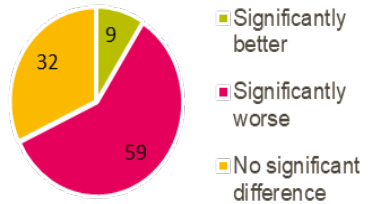
Comparison scores for HUTH in 2023

		Comparison to 2022**	Comparison with average**
55%	q25c. Would recommend organisation as place to work		
55%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation		
66%	q25a. Care of patients/service users is organisation's top priority		





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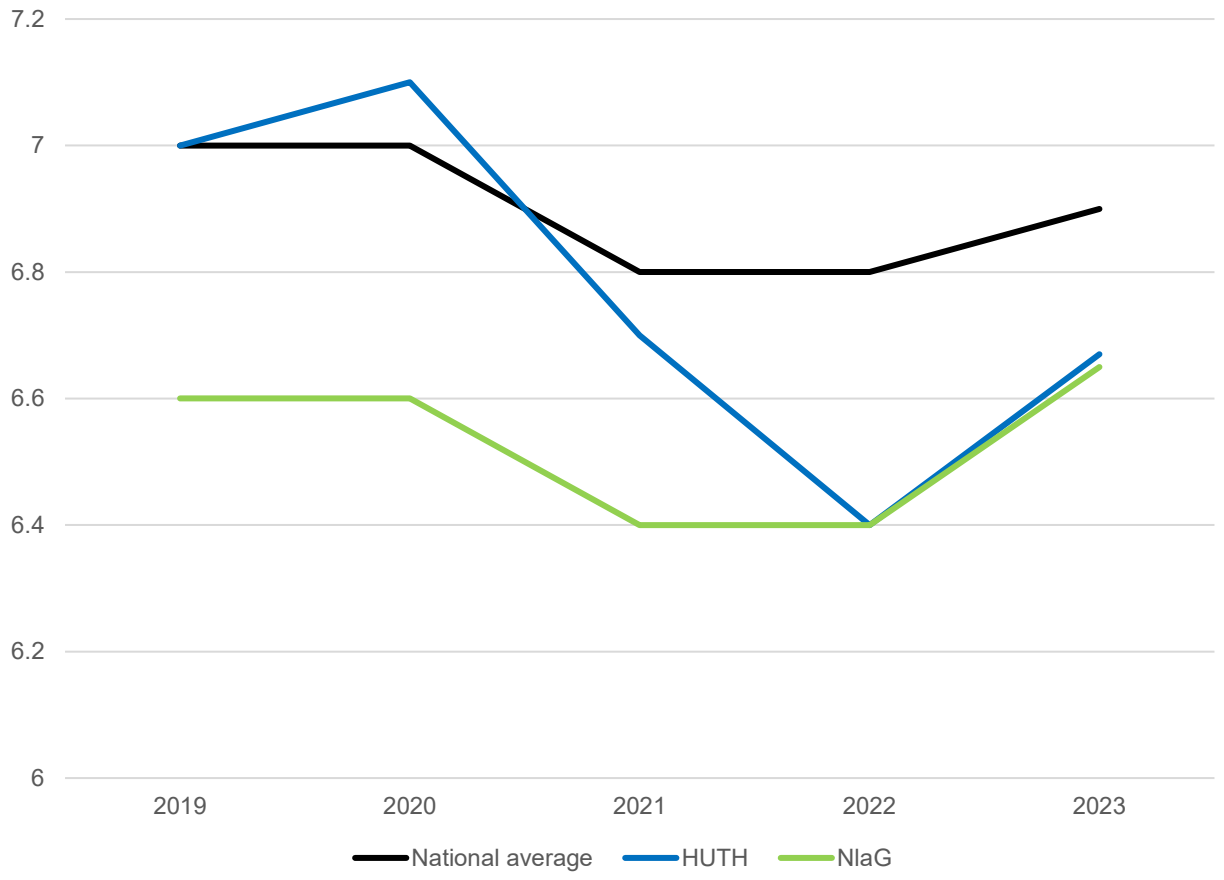
Staff engagement

Staff engagement is seen as a strong indicator of cultural health in an organisation.

Both trusts have seen a significant improvement in staff engagement in the 2023 survey.



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Top five scores

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

NLaG top 5 scores vs Picker average	Org	Picker Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	**55%**	**48%**
q23a. Received appraisal in the past 12 months	**85%**	**83%**
q11c. In last 12 months, have not felt unwell due to work related stress	61%	59%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	92%
q4c. Satisfied with level of pay	33%	31%

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Bottom five scores

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

NLaG bottom 5 scores vs Picker average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	**52%**	**63%**
q4d. Satisfied with opportunities for flexible working patterns	47%	57%
q19a. Staff involved in an error/near miss/incident treated fairly	51%	59%
q3e. Involved in deciding changes that affect work	44%	52%
q11a. Organisation takes positive action on health and well-being	49%	57%

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Workforce Race Equality Standard

HUTH - all non-white staff	2022	2023	Nat av.
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	32.95%	33.38%	28.11%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	35.61%	31.45%	26.20%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	46.55%	54.06%	49.64%
Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	16.38%	17.74%	16.17%

NLaG - all non-white staff	2022	2023	Nat av.
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33.12%	34.62%	28.11%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	37.34%	35.48%	26.20%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	47.10%	45.81%	49.64%
Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	22.37%	21.93%	16.17%

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Workforce Disability Equality Standards

HUTH - staff with a LTC or illness	2022	2023	Nat av.
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	34.48%	34.63%	30.35%
Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	20.56%	18.15%	15.87%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	29.03%	29.51%	25.86%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	47.59%	48.02%	50.44%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.	49.24%	54.45%	51.54%

NLaG – staff with a LTC or illness	2022	2023	Nat av.
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31.94%	28.15%	30.35%
Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	20.31%	15.92%	15.87%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	34.30%	28.21%	25.86%
Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	50.19%	51.77%	50.44%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.	43.98%	52.75%	51.54%

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Workforce Disability Equality Standards

HUTH - staff with a LTC or illness	2022	2023	Nat av.
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	35.85%	29.29%	28.55%
Percentage of staff satisfied with the extent to which their organisation values their work.	28.61%	29.67%	35.66%
Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.	71.43%	76.01%	73.38%
Staff engagement score	6.02	6.18	6.46

NLaG - staff with a LTC or illness	2022	2023	Nat av.
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	30.48%	29.56%	31.17%
Percentage of staff satisfied with the extent to which their organisation values their work.	28.36%	31.17%	35.66%
Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.	69.31%	73.58%	73.38%
Staff engagement score	5.91	6.26	6.46

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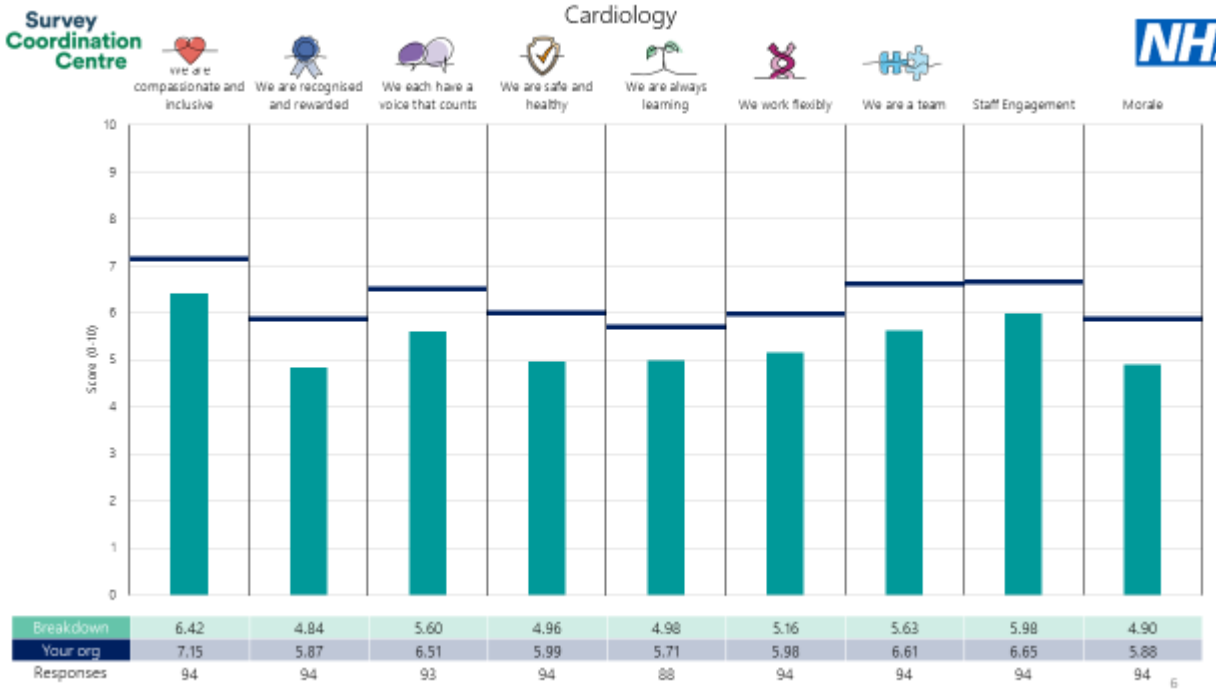
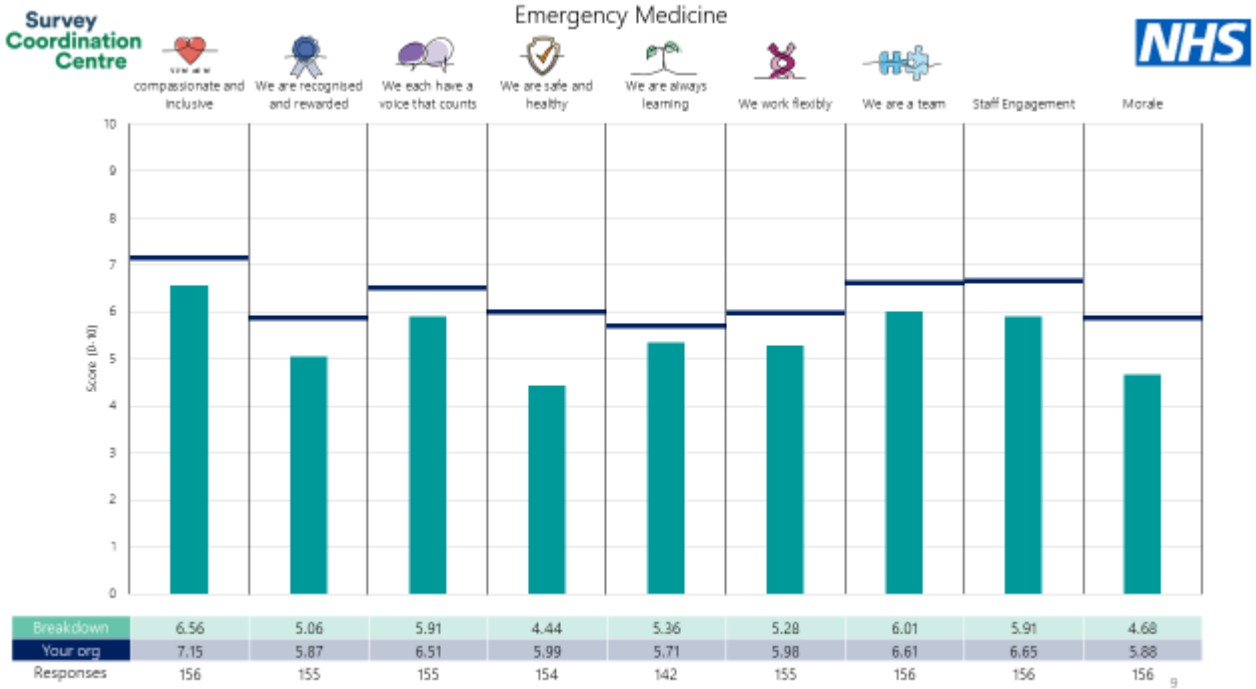
Main areas of concern - HUTH





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Main areas requiring improvement - HUTH

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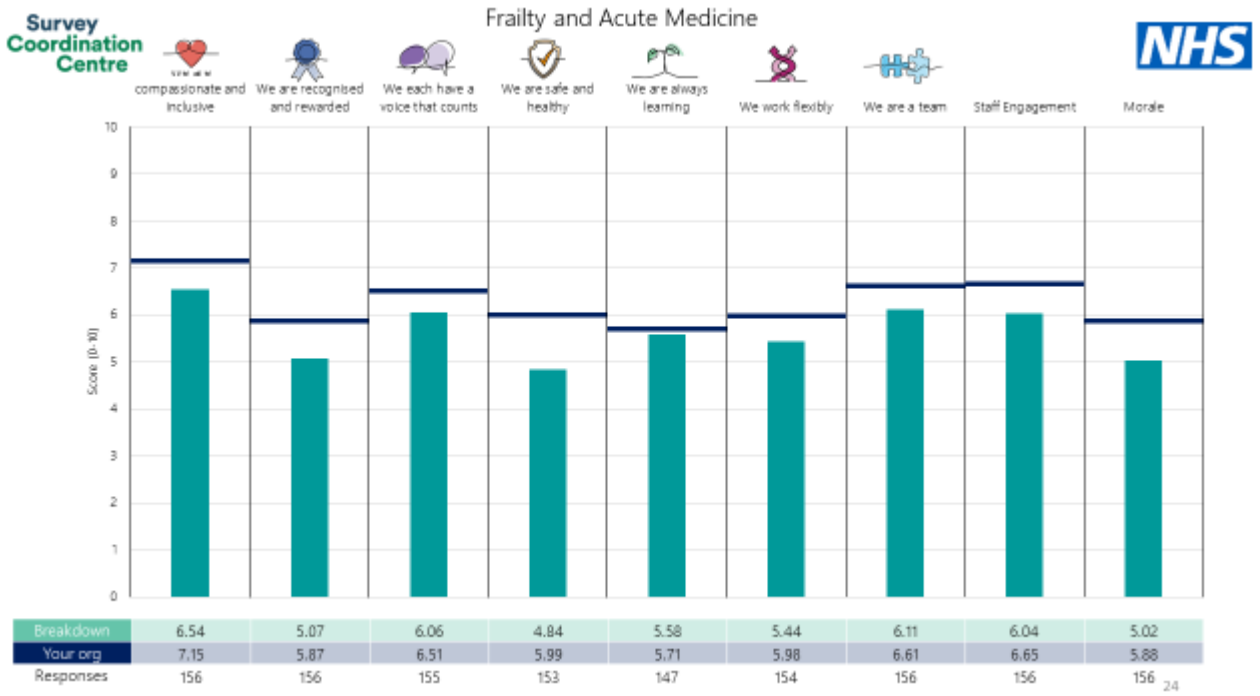

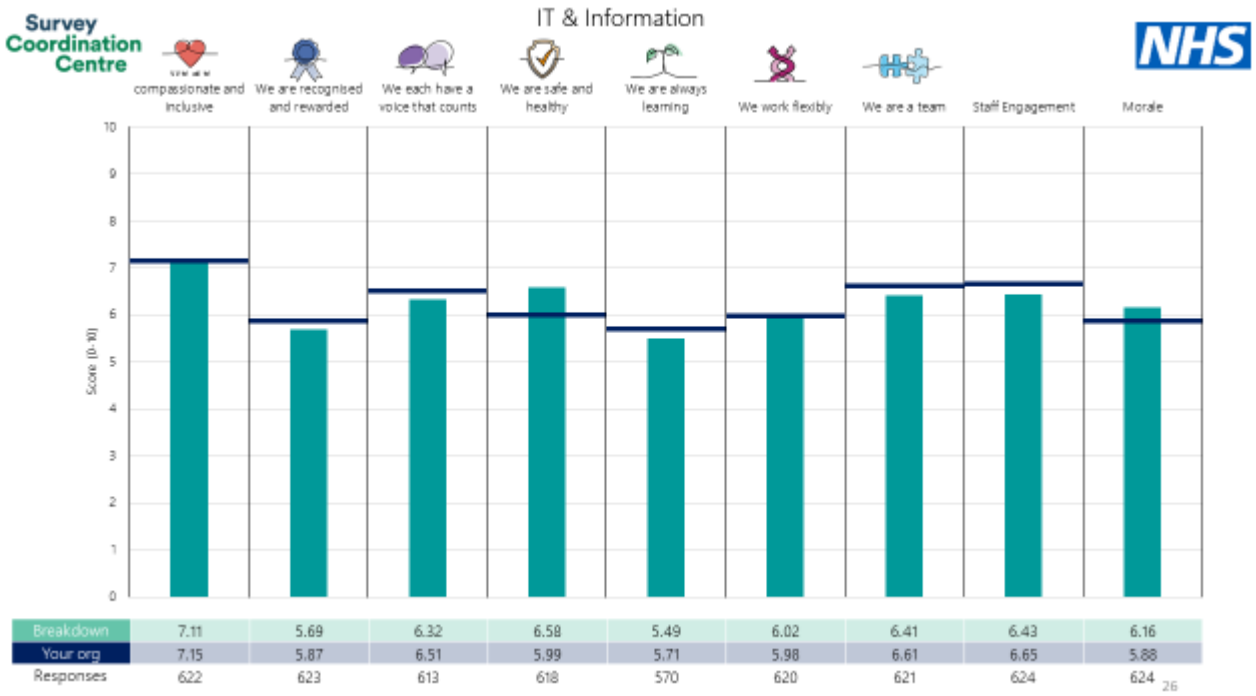

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Main areas requiring improvement - HUTH

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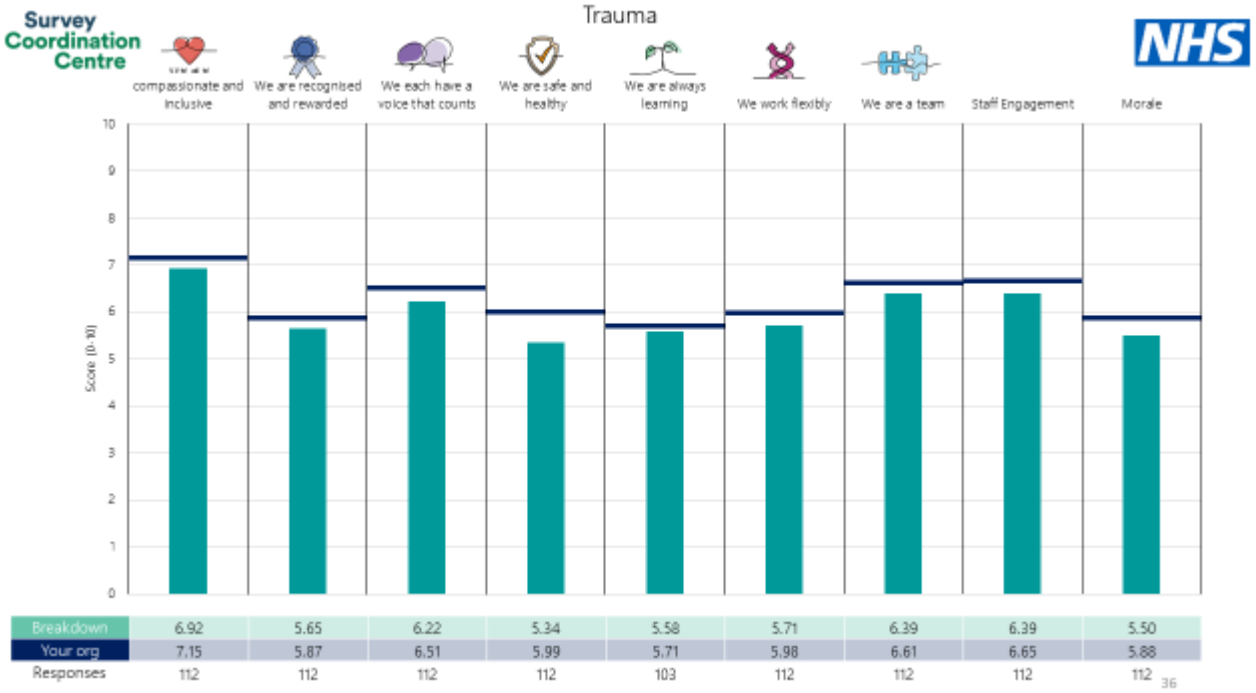

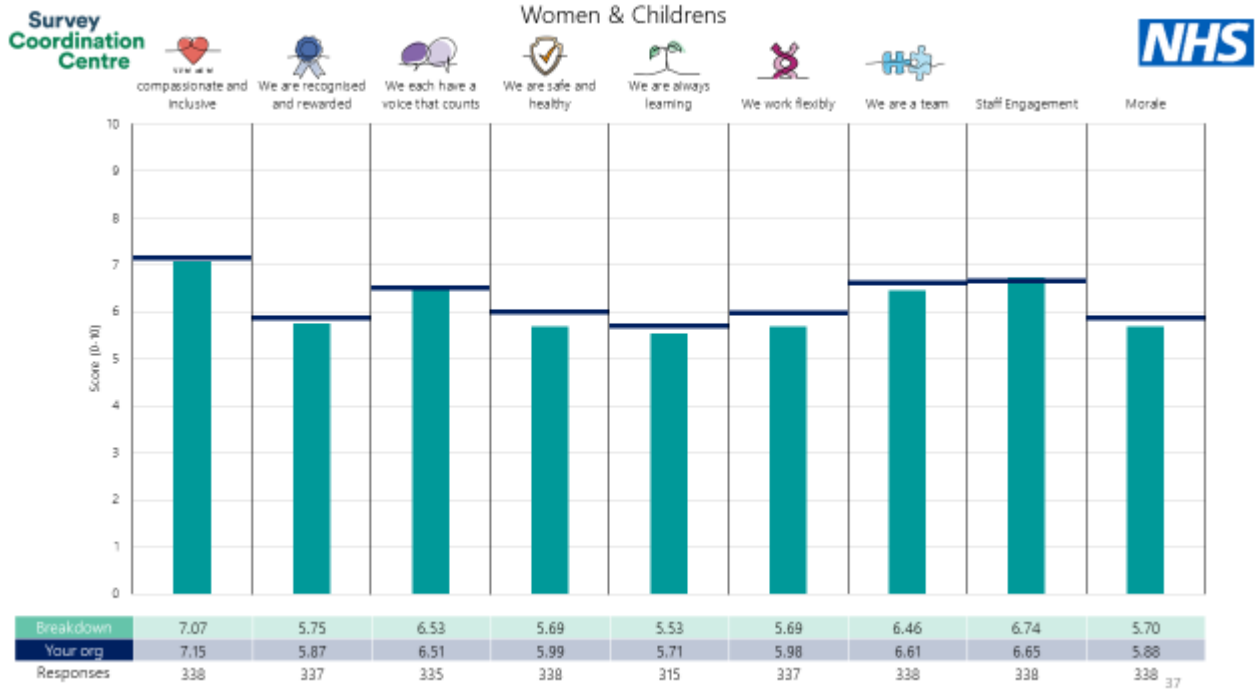

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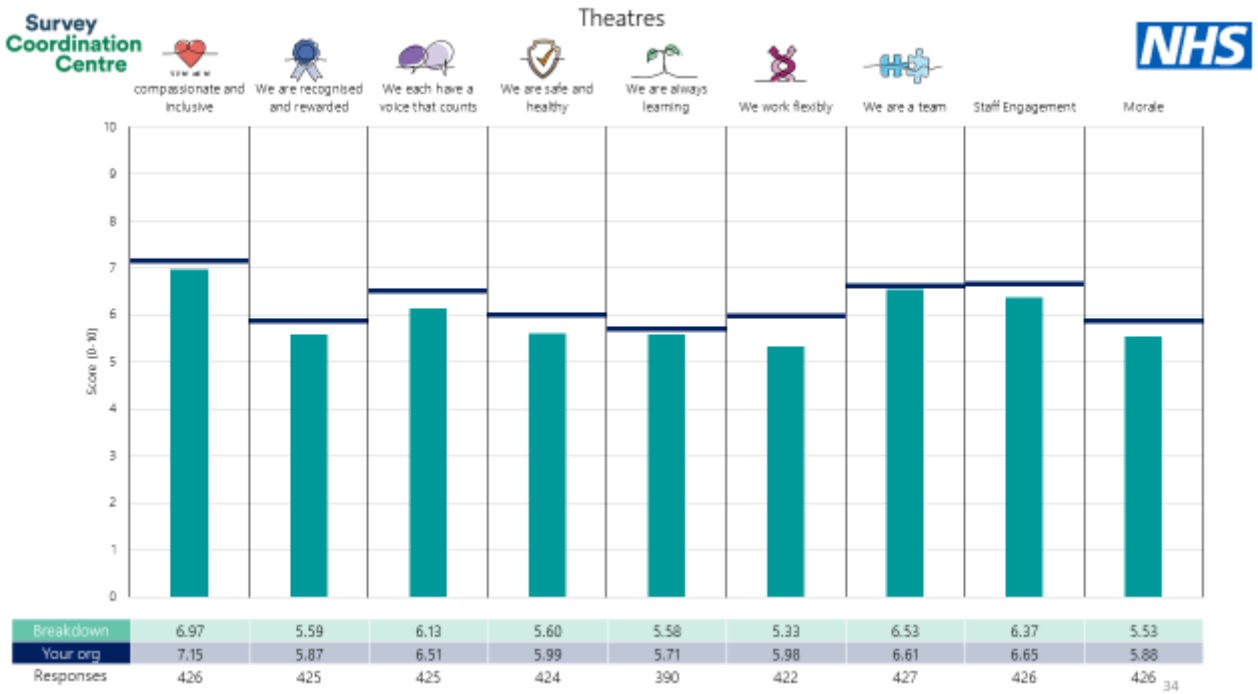
Main areas requiring improvement - HUTH



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Main areas requiring improvement - NLaG

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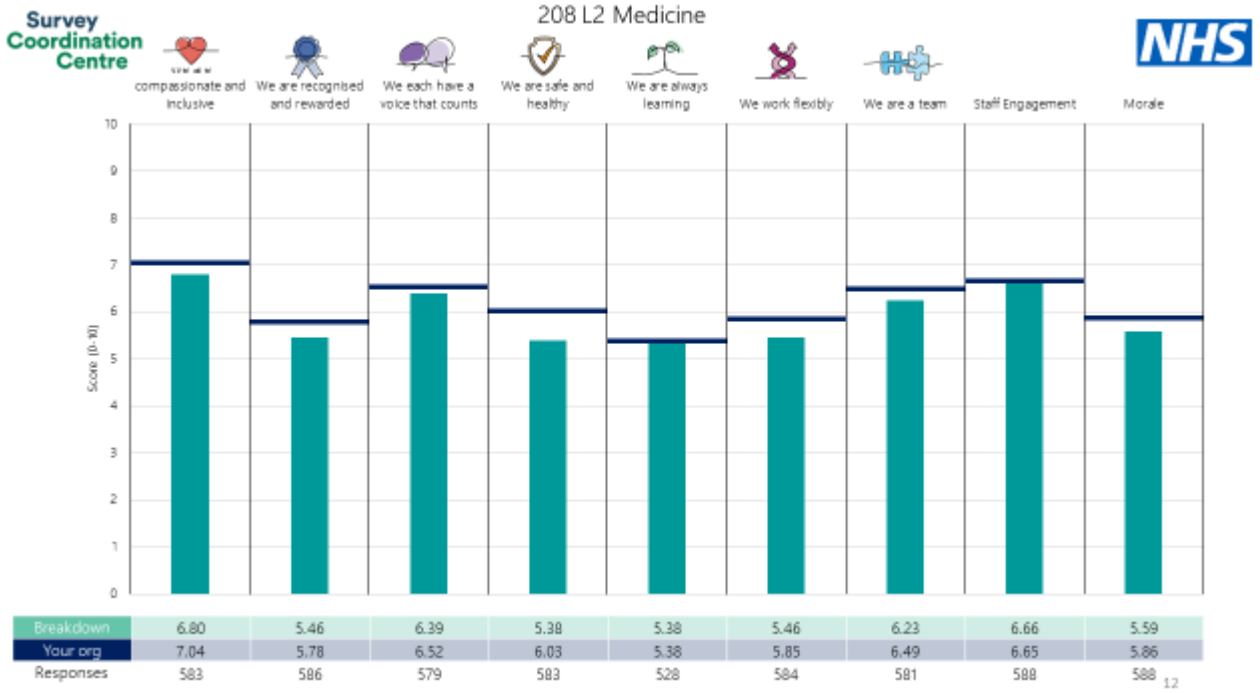

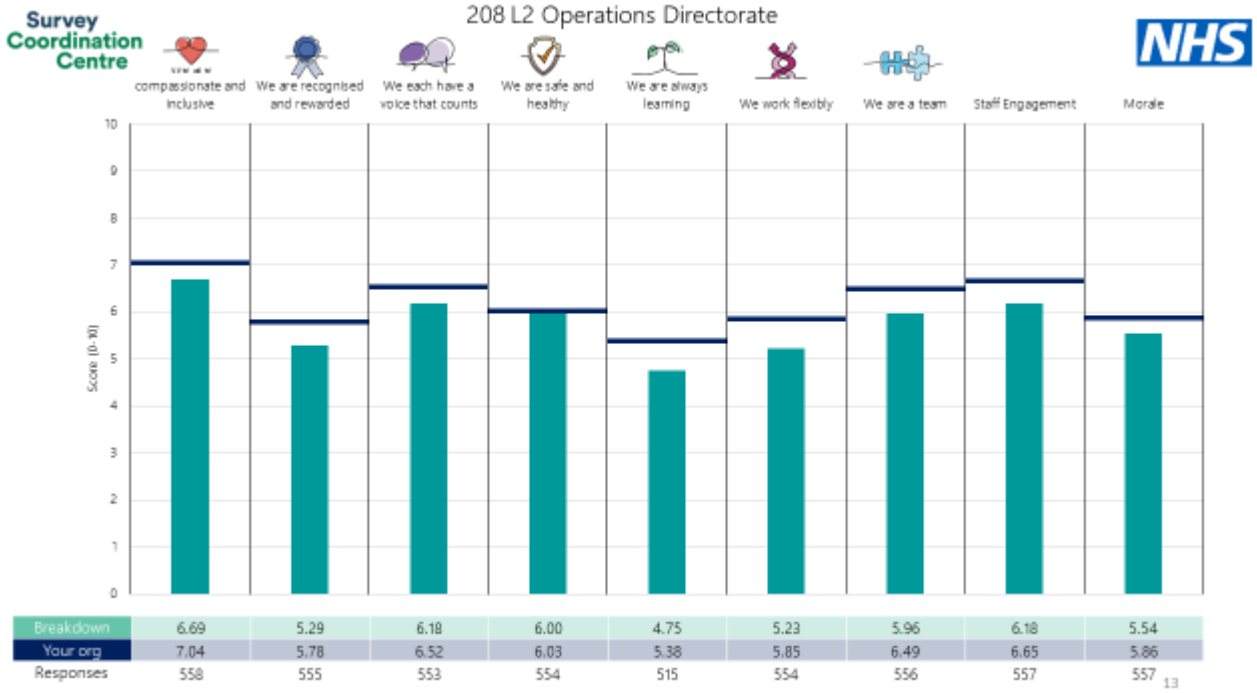

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Main areas requiring improvement - NLaG

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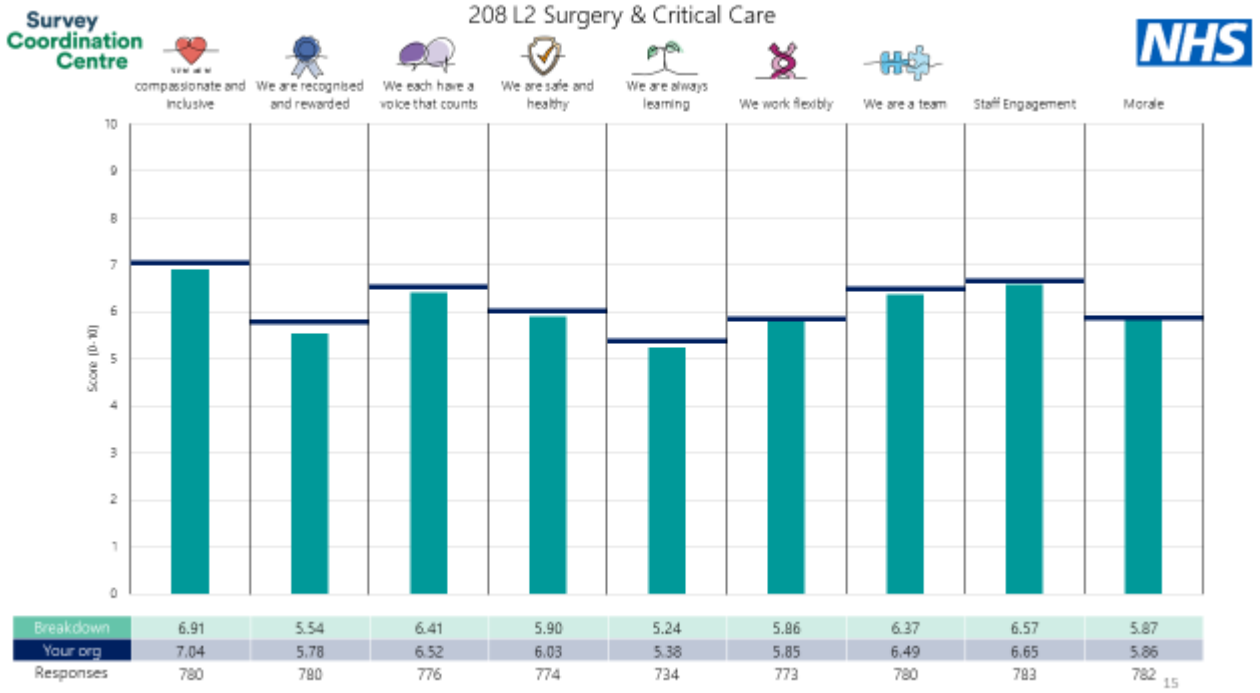

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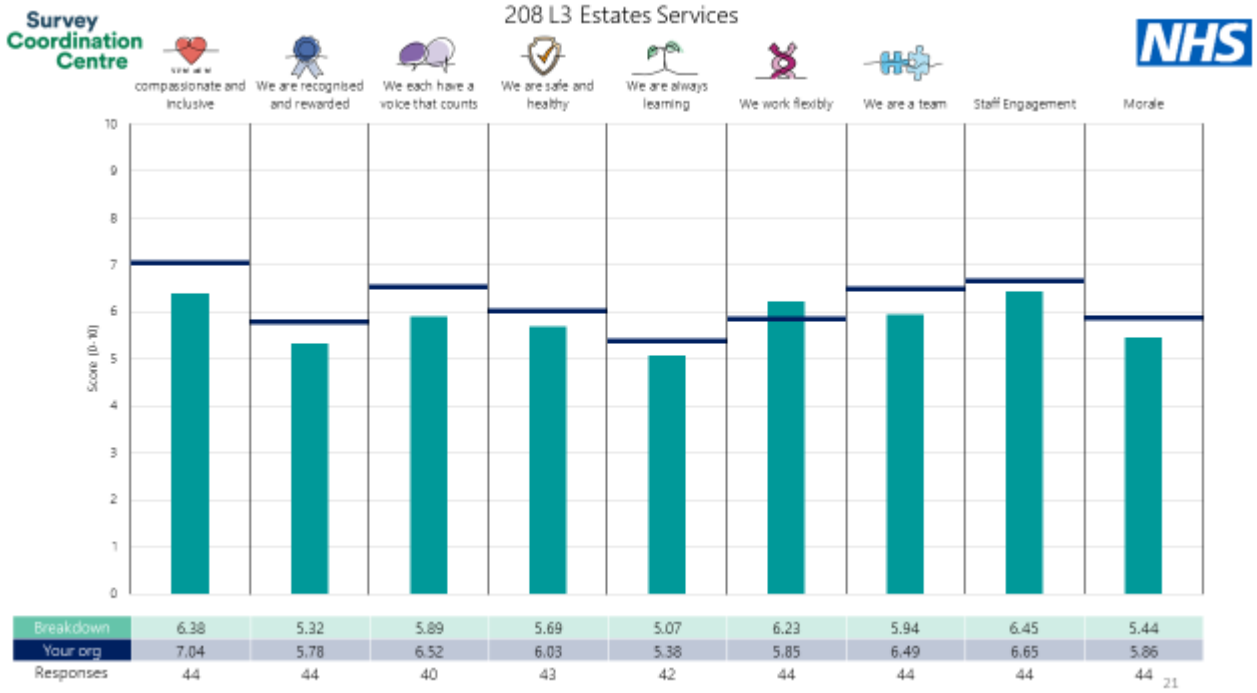

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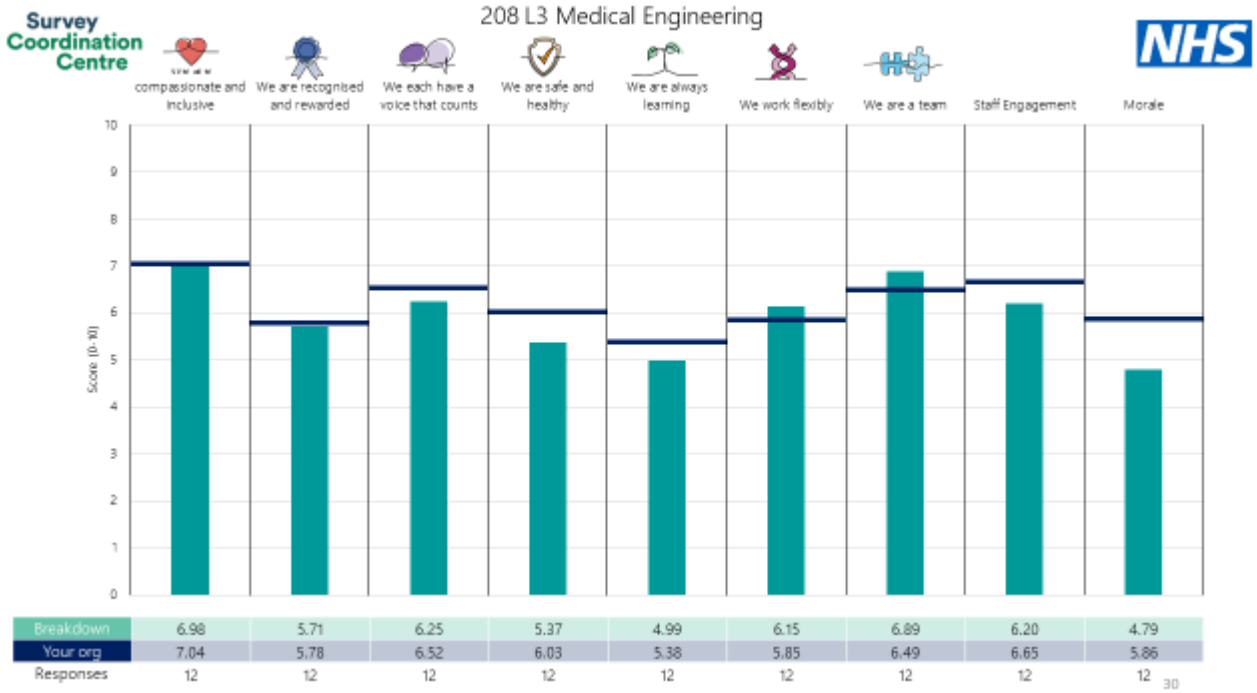
Main areas requiring improvement - NLaG



Next steps

- Develop corporate response
- Care Group management teams and directorates to develop action plans
- Monitor actions plans at Workforce Transformation and escalate issues to WECC
- Drive to increase response rate again in 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)063

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Mike Robson and Gill Ponder, Non-Executive Directors and Capital & Major Projects Committees-in-Common Chairs
Contact Officer/Author	Alison Hurley, Deputy Director of Assurance
Title of the Report	Capital and Major Projects Committees-in-Common Highlight / Escalation Report
Executive Summary	The attached highlight / escalation report provides an overview of the key matters presented to, discussed and escalated at the inaugural meeting of the Capital & Major Projects Committees-in-Common meeting held on 20 February 2024 as part of the Group Model transition
Background Information and/or Supporting Document(s) (if applicable)	Capital & Major Projects Committees-in-Common Terms of Reference for HUTH and NLaG
Prior Approval Process	The report has been approved by the committee Chairs
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance below: ☐ Information ☐ Review ☐ Other – please detail

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

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Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for the meeting of the Trust Boards in Common to be held on:	11 April 2024
Report from:	Capital and Major Projects Committees-in-Common
Report from meeting held on:	20 February 2024
Quoracy requirements met:	The Capital and Major Projects Committees-in-Common meeting held on 20 February 2024 was quorate

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the newly formed Capital and Major Projects Committees-in-Common at their meeting held on 20 February 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 (BAF)	• Monthly Capital Finance Report (NLaG/HUTH)
• Proposed Business Cases, Investments & Dis-Investments	• Draft Capital Plan 2024/25 (NLaG/HUTH)
○ New Build at Hull Royal Infirmary (HRI) (HUTH). Short form case to come to April meeting	• Major Service Change/Transformation
○ Approved replacement of Suite 22 at Castle Hill Hospital with approximately £1.5m capital at risk (CHH) – HUTH	○ Humber Acute Services Review
• Capital Contract Approvals	○ Community Diagnostic Centre Programme
○ Day Surgery Phase 2 & 3 Fit Out CHH - HUTH	• Digital Plan Delivery (bi-monthly update)
○ Day Surgery Car Park CHH - HUTH	
○ Theatre 7 & Plant Room HRI - HUTH	

○ North Lincs Community Diagnostic Centre (CDC) Fit Out & Materials Pre-Procurement - NLaG	
• North East Lincs CDC Fit Out & Materials Pre-Procurement - NLaG	
• Grimsby CDC Lease (NLaG)	

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. Board Assurance Framework (BAF) – the committees were concerned about the disparity of the risks in relation to estates, facilities and infrastructure issues and requested that these risks be aligned for NLaG and HUTH as per section 6 below.

b. Major Service Change/Transformation – various risks were noted in relation to the Community Diagnostic Centre (CDC) Programme which included the following:

- **Overall lack of capital** - especially in relation to the risks on estates, facilities and infrastructure.
- **Build risks –** which were noted as being greater in HUTH with the section 2 approval.
- **East Riding community hospital** – a risk to the space requirements due to planning constraints/restrictions.
- **Workforce risk –** the risk of being able to recruit the required staff (particularly radiographers), although recruitment is currently underway.
- **Revenue risk –** in terms of the 'go live' timescales and the ability to deliver the required activity levels.

c. Capital plan risks associated with the Digital Plan Delivery - including the outline business case (OBC) for the electronic patient record (EPR).

4.0 Matters on which the committees received assurance

4.1 The committees received assurance on the following items of business:

a. Capital spend – the committees were assured on the current capital spend plans and progress made to date.

b. Humber Acute Services Review (HASR) – the committees were assured about the level of public engagement involved in the review and the progress made to date.

5.0 Matters on which the committees have requested additional assurance:

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

a. **Estates Strategy -** The committees sought additional assurance on when the consolidated Estates Strategy would be in place for the Group as it was noted that the HUTH strategy had expired. It was confirmed that the Estates Strategy will be developed once the Clinical Strategy has been agreed (expected by the end of July 2024). This can then be used as a framework to create the capital master plans by the end of December 2024 or early January 2025, and the Finance and Estates Strategies will then be developed by March 2025. The Capital & Major Projects Committees-in-Common will be kept appraised of developments.

6.1 The committee considered the areas of the BAF for which it has oversight and proposed the following change(s) to the following risk rating or entry:

a. The committees were concerned about the risks in relation to estates, infrastructure and equipment issues which relate to risks 1.4 on the NLaG BAF (risk rating of 20) and 7.3 on the HUTH BAF (risk rating 15). The committees requested that these risk ratings be aligned, and this issue will be escalated to the Group Cabinet Risk and Assurance Committee for review.

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- note the contents of the escalation report;
- note that the Capital & Major Projects Committees-in-Common have referred a risk about workforce training compliance (which has been compounded by building works to relocate the training facilities) to the Workforce, Education and Culture Committees-in-Common for review.

Mike Robson,
Capital & Major Projects Committees-in-Common Chair for the meeting on 20 February 2024

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Front Sheet

Agenda Item No: BIC(24)065

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee – NLaG
Contact Officer/Author	Lee Bond, Group Chief Financial Officer
Title of the Report	Health Tree Foundation Trustees' Committee Highlight / Escalation Report & Board Challenge
Executive Summary	This report sets out the items of business considered by the Health Tree Foundation (HTF) Trustees' Committee at their meetings held on 10 January 2024 and 3 April 2024. It also includes matters for escalation to the NLaG Trust Board, matters where additional assurance is required and any action(s) required of the NLaG Trust Board The Trust Board is asked to: • note the contents of the report
Background Information and/or Supporting Document(s) (if applicable)	HTF Committee Terms of Reference for NLaG
Prior Approval Process	The attached report has been approved by the committee Chair
Financial implication(s) (if applicable)	N/a
Implications for equality, diversity and inclusion, including health inequalities	N/a
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Committee Highlight / Escalation Report to the Northern Lincolnshire & Goole (NLaG) Trust Board

Report for meeting of the NLaG Trust Board to be held on:	11 April 2024
Report from:	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee - NLaG
Report from meeting held on:	3 April 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Health Tree Foundation (HTF) Trustees' Committee at their meeting held on 3 April 2024 including those matters which the committees specifically wish to escalate to the NLaG Trust Board.

2.0 Matters considered by the committee

2.1 The committee considered the following items of business:

- HTF AP11 Finance Update
- HTF Trustees' Committee Terms of Reference
- HTF Wish 05/24 - Patient Safes
- HTF Finance Plan 2024/25
- HTF Fundraising Plan 2024/25
- HTF Regular Charity Manager Progress Reports
- HTF Stakeholder Map

3.0 Matters for reporting / escalation to the NLaG Trust Board

3.1 The committee agreed the following matters for reporting / escalation to the NLaG Trust Board:

a. Trustees approved the purchase of 41 safes to be installed on wards, emergency departments (Eds) and mortuaries for the safe keeping of patient property and valuables. Total cost is £10,900. Aim is to reduce loss of patient cash, valuables or property; reduce number of patient claims for same; and improve patient satisfaction that Trust has appropriate process and facility for safe custody of such items.

b. Trustees received, questioned and approved the HTF's Finance Plan 2024/25.

c. Trustees then received the concomitant HTF Fundraising Plan. This was discussed and approved.

d. Trustees were concerned that the Charity Manager's Report showed several KPIs that were not being met under the two headings of Finance and Engagement. The difficult economic climate is one reason for such performance and the HTF Fundraising Strategy 2024/25, discussed later, is focused on addressing this issue. In addition, Trustees urged the HTF Team to re-double their efforts to secure the submission of more 'Wishes'.

4.1 The committee received assurance on the following items of business:

a. HTF Manager's and Sparkle Officer's Progress Reports

b. HTF AP11 Finance Report

c. HTF Risk Register

5.0 Matters on which the committee has requested additional assurance:

5.1 The committee requested additional assurance on the following item of business:

a. HTF Stakeholder Map: Further work required to confirm draft content and develop action plan.

b. HTF KPIs: Trustees expect to see an improvement in KPI adherence over the coming months, following the roll-out of the 2024/25 Fundraising Strategy.

6.0 Confirm or challenge of the Board Assurance Framework (BAF):

Not applicable.

7.0 Trust Board Action Required

7.1 The NLaG Trust Board is asked to:

- note the contents of the report.

Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee

Northern Lincolnshire and Goole NHS Foundation Trust

Committee Highlight / Escalation Report
to the Northern Lincolnshire & Goole (NLaG) Trust Board

Report for meeting of the NLaG Trust Board to be held on:	11 April 2024
Report from:	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee - NLaG
Report from meeting held on:	10 January 2024
Quoracy requirements met:	No, not for first two thirds of the meeting due to Executive Director diary conflicts

1.0 Purpose of the report

1.2 This report sets out the items of business considered by the Health Tree Foundation (HTF) Trustees' Committee at their meeting held on 10 January 2024 including those matters which the committee specifically wish to escalate to the Northern Lincolnshire and Goole (NLaG) NHS Foundation Trust Board.

2.0 Matters considered by the committee

2.1 The committee considered the following items of business:

- HTF Work Plan
- HTF Trustees' Committee Terms of Reference
- HTF Finance Update
- HTF Social Media Policy
- HTF Regular Updates
- HTF Annual Report and Accounts * (delayed due to late appointment of auditors)

3.0 Matters for reporting / escalation to the NLaG Trust Board

3.1 The committee agreed the following matter for reporting / escalation to the NLaG Trust Board:

a. Trustees were concerned that the committee was not quorate in respect of Executive Directors attendance until about two thirds of the way through its meeting. Trustees understood that this was due to the need for attendance at higher priority activities.

4.0 Matters on which the committees received assurance

4.1 The committee received assurance on the following items of business:

a. HTF Manager's and Sparkle Officer's Progress Reports

b. HTF Finance Report

c. HTF Annual Report and Accounts

5.0 Matters on which the committee has requested additional assurance:

5.1 The committee did not request additional assurance on any items of business at this meeting.

6.0 Confirm or challenge of the Board Assurance Framework (BAF):

Not applicable.

7.0 NLaG Trust Board Action Required

7.1 The NLaG Trust Board is asked to:

- note the report;
- note the HTF Annual Report and Accounts.

Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)066

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Neil Gammon, Independent Chair
Contact Officer/Author	Neil Gammon, Independent Chair
Title of the Report	Health Tree Foundation Update - NLaG
Executive Summary	An update from The Health Tree Foundation of current position and appeals.
Background Information and/or Supporting Document(s) (if applicable)	Presentation for Trust Board – Update from Neil Gammon for The Health Tree Foundation
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:

THE HEALTH TREE FOUNDATION
Grimsby's Hospital Charity

The Health Tree Foundation

NLAG Trust Board - 11 April 2024

Chairman of Health Tree Foundation Trustees' Committee

Neil Gammon

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NHS Foundation Trust

Circle of Wishes

THE HEALTH TREE FOUNDATION
Grimsby's Hospital Charity

The Circle of Wishes - A strategic approach which has helped us unlock restricted funds and allowed for committed spending plans to help improve patient experience;

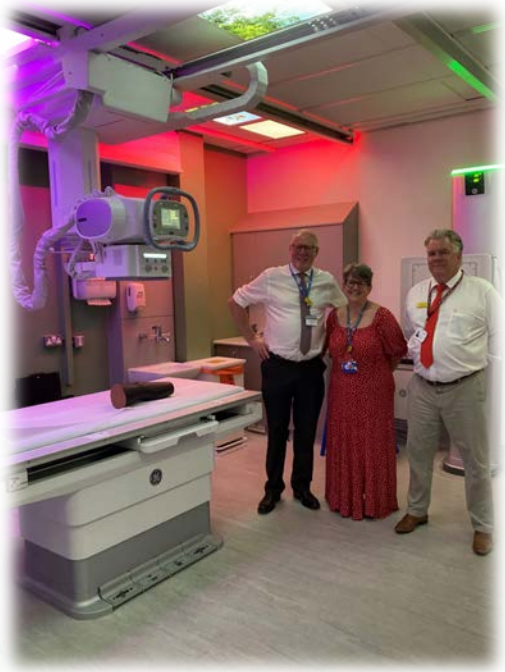
- Simple online form to apply via our website
- Submitting your wish is simple but we do ask you consider these questions before you submit:

✓ Is there a clear patient benefit?
✓ Is your wish something the Trust should be providing for patients or hospitals already
✓ Would you be happy to donate towards this wish?

Completed Appeals

The New A&E Unit at DPOW & SGH

The difference charitable donations make



X-ray room at DPOW

Urology Waiting Area at SGH

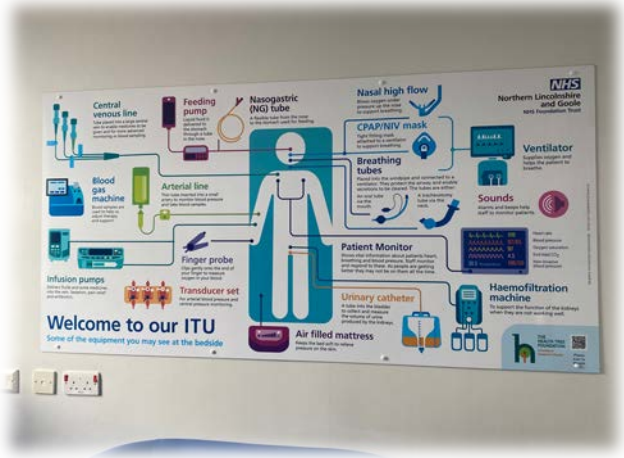
Skylight Panels for x-Ray SGH

The difference charitable donations make

Exercise equipment to help with patients' rehab

Birthday Cards!

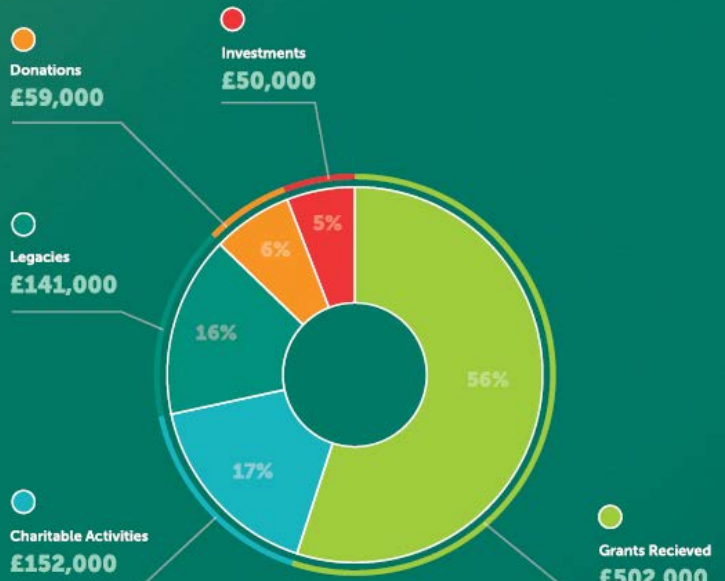
The Fishpond at DPOW



Relatives Information Board – ITU DPOW

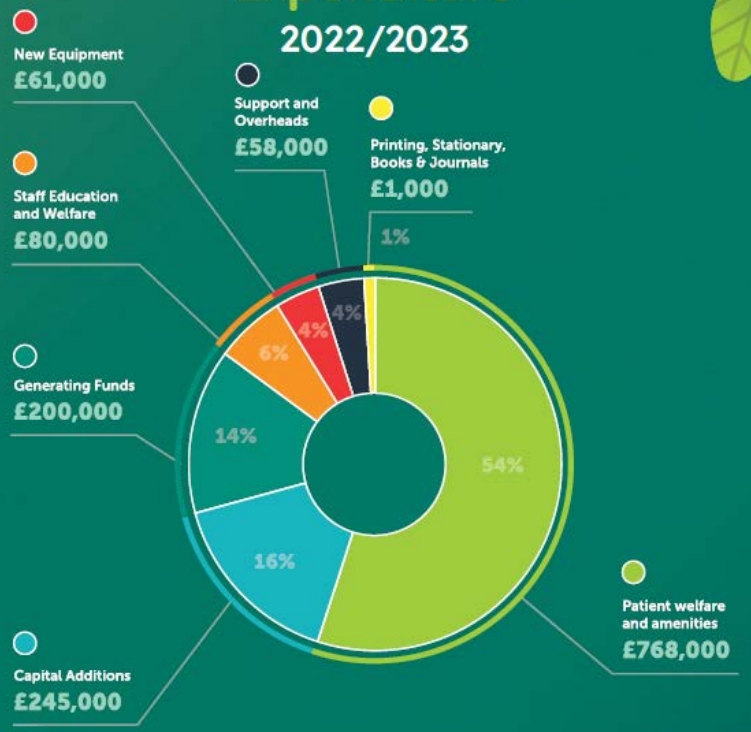
Fusion Biopsy Machine - DPOW

Income
2022/2023



Total Income:
£904,000

Expenditure
2022/2023



Total Expenditure:
£1,413,000

The Health Tree Foundation is the working name of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds.
The principal address is: Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA
Registered charity number: 1054935 | T: 03033 304514 | E: hello@healthtreefoundation.org.uk | W: www.healthtreefoundation.org.uk

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Forward Plan

- More wishes from patients
- Maintain strong trust board engagement.
- Grow major donors/ corporate supporters.
- Charity for the hospital and the wider community.
- Strategic spending goals not reactive.
- Strategic partner for the trust.

Contact the charity team on either:

Telephone: **03033 304514**

Email: **hello@healthtreefoundation.org.uk**

Thank you for your support!

Health Tree Foundation healthtreefoundation HealthTree_NLAG

www.healthtreefoundation.org.uk

The Health Tree Foundation is the working name of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds. The principal address is: Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA. Registered charity number: 1054935

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)067

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 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 Update – HUTH/NLAG
Executive Summary	The following report gives: • a progress update regarding the harmonisation and rationalisation of the Board Assurance Frameworks (BAFs) for HUTH and NLAG. • The only update in Q4 was to BAF risk 7.1 (HUTH) as the financial in-year target was met. Both BAFs now use the same format and the Group Executives are currently reviewing all controls, assurances and gaps in controls. **Recommendation** The Boards in Common are asked to note the update.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	The BAFs are considered at each of the Committees in Common and the Group Cabinet Risk and Assurance Committee
Financial implication(s)	N/A
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

BOARD ASSURANCE FRAMEWORK UPDATE
BOARDS IN COMMON MEETING
11 APRIL 2024

1 Purpose of the Report

The purpose of the report is to update the Boards in Common regarding the review and alignment of the Board Assurance Frameworks at both Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to the new agreed and common format. The report also highlights any changes in the current risks from the previous quarter.

2 Background

The HUTH and NLAG Trust Boards have previously agreed to carry over the 2023/24 strategic objectives and the associated risks to the achievement of those objectives, until the Group has agreed its new strategic objectives.

Following the establishment of the Group Cabinet Risk and Assurance Committee in December 2023, the Corporate Governance function has undertaken work to align the two Board Assurance Frameworks into the same format and ensure the contents remained relevant to each of the organisations.

This work was completed earlier this year and the contents of each Board Assurance Framework risks were added into the newly formatted documents.

3 Highlighted BAF risk changes

The BAF changes are shown in the table below:

BAF Risk	Q2 Rating	Q3 Rating	Q4 Rating	Reason for change
HUTH 7.1 -There is a risk that the Trust does not achieve its in-year financial plan	16 4 x 4	16 4 x 4	8 2 x 4	Change was due to: • The Trust achieving its in-year financial plan
NLAG 5 - The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives	12 3 x 4	12 3 x 4	16 4 x 4	Change was due to: • Care Group changes • No ongoing investment specifically with support for leaders working in different areas

4 Current Position of BAF format

The Board Assurance Frameworks are now in the new format and all of the Committees in Common have received an update for review and comment. All Board members have responded positively to the new format style.

The next phase of work, already underway, is to review the controls, assurance and gaps in controls and ensure they remain relevant and appropriate. This work will be completed by the end of April 2024. Where necessary, further narrative is required to highlight the actions in place to mitigate any gaps in controls. This will be carried out and completed in May 2024.

The Group Cabinet Risk and Assurance Committee review monthly the Board Assurance

Frameworks and the high-level Risk Registers. This process provides further assurance to the Non-Executive Directors on the robustness of actions being taken.

The Q4 risk ratings for **HUTH** are:

Ref	Risk Summary	Executive Lead	Assurance Committee	Current risk (LxC)	Change from Q3	Target Risk Score
1	The Trust does not make progress towards further improving a positive working culture this year	Group Chief People Officer	Workforce Education and Culture Committees in Common	16 (4 x 4)	↔	12
2	The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust	Group Chief People Officer	Workforce Education and Culture Committees in Common	12 (3 x 4)	↔	12
3.1	There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating	Group Chief Nurse	Quality and Safety Committees in Common	16 (4 x 4)	↔	12
3.2	There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED and patients with no criteria to reside require partnership working to determine improvement plans	Group Chief Medical Officer	Quality and Safety Committees in Common	20 (4 x 5)	↔	16
4	There is a risk to access to Trust services due to long waiting lists and demand and capacity issues.	Group Chief Delivery Officer	Performance Estates and Finance Committees in Common	20 (4 x 5)	↔	16
5	That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery, primary care and social care constraints	Group Chief of Strategy and Partnerships	Group Board, Group Cabinet Risk and Assurance Committee	20 (4 x 5)	↔	6
6	There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	Group Chief Medical Officer	Quality and Safety Committees in Common	12 (3 x 4)	↔	8
7.1	There is a risk that the Trust does not achieve its in-year financial plan	Group Chief Financial Officer	Performance Estates and Finance Committees in Common	8 (2 x 4)	↓	8
7.2	There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including 2023/24	Group Chief Financial Officer	Performance Estates and Finance Committees in Common	20 (4 x 5)	↔	20
7.3	There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	Group Chief Financial Officer	Capital and Major Projects Committees in Common	15 (3 x 5)	↔	10

The Q4 risk ratings for **NLAG** are:

Ref	Risk Summary	Executive Lead	Assurance Committee	Current risk (LxC)	Change from previous Qtr	Target Risk Score
1.1	**Patient Harm** The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience	Chief Medical Officer & Chief Nurse	Quality & Safety Committees in Common (CiC)	**15 (3 x 5)**	↔	15
1.2	**Timely Access to Care** The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care	Chief Delivery Officer	Performance, Estates & Finance CiC	**20 (4 x 5)**	↔	15
1.3	**Clinical Strategy** The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care, which is high quality, safe and sustainable	Chief of Strategy & Partnerships	Trust Boards in Common	**12 (3 x 4)**	↔	8
1.4	**Estate, Infrastructure and Equipment** The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high-quality care and/or a safe and satisfactory environment for patients, staff and visitors	Chief Financial Officer	Performance, Estates Finance & CiC	**20 (4 x 5)**	↔	20
1.5	**Digital Infrastructure** The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches	Chief Medical Officer	Audit, Risk and Governance CiC & Trust Boards in Common	**6 (2 x 3)**	↔	6
1.6	**Business Continuity** The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure)	Chief Delivery Officer	Performance, Estates & Finance CiC	**12 (3 x 4)**	↔	8
2	**Workforce** The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training,	Chief People Officer	Workforce, Education & Culture CiC	**20 (4 x 5)**	↔	15

Ref	Risk Summary	Executive Lead	Assurance Committee	Current risk (LxC)	Change from previous Qtr	Target Risk Score
	motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients					
3.1	**In Year Finance Target** The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse	Chief Financial Officer	Performance, Estates & Finance CiC	**16 (4 x 4)**	↔	10
3.2	**Major Capital** The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades	Chief Financial Officer & Chief of Strategy & Partnerships	Trust Boards in Common	**15 (3 x 5)**	↔	15
4	**Partnership & Collaboration** The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment	Chief of Strategy & Partnerships	Trust Boards in Common	**12 (3 x 4)**	↔	8
5	**Leadership** The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives	Chief Executive	Workforce, Education & Culture CiC & Trust Boards in Common	**16 (4 x 4)**	↑	8

4 Next Steps

The Group Cabinet Risk and Assurance Committee and the Committees in Common will receive the new Board Assurance Frameworks once updated.

5 Recommendation

The Boards in Common are asked to note the Q4 Board Assurance Framework update.

Rebecca Thompson
Deputy Director of Assurance
April 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)068

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Sean Lyons, Group Chair
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	**Fit & Proper Person Test (FPPT) Policy**
Executive Summary	The report provides the final FPPT Policy for the group, incorporating the requirements of the NHS England (NHSE) FPPT Framework published in August 2023 and the NHS Leadership Competency Framework for Board Members published on 28 February 2024 Key points to note following the boards' consideration and 'approval in principle' of the policy in March 2024 are the following additions: • *Scope:* the formally appointed deputies of the board (voting) directors are now listed in the policy (page 4 refers). • *FPPT checks:* additional information has been added in respect of social media checks (page 17 refers) **<u>Recommendations</u>** The Trust Boards-in-Common are asked to approve the new group FPPT policy
Background Information and/or Supporting Document(s) (if applicable)	NHS England Fit and Proper Person Test Framework for Board Members NHS Leadership Competency Framework for Board Members Guidance for Chairs on Implementation of the Fit and Proper Person Test for Board Members
Prior Approval Process	Discussed at Executive Cabinet and Programme Oversight Board Approved in principle by both boards on 5 March 2024 Final policy considered and endorsed by the Remuneration Committees-in-Common on 4 April 2024
Financial implication(s) (if applicable)	N / A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N / A

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

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Group Director of Assurance

FIT AND PROPER PERSON TEST POLICY

Reference:	Reference?
Version:	1.0
This version issued:	Date?
Result of last review:	Major changes
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Boards
Date for review:	*enter* date of review
Owner:	Group Chair
Document type:	Policy
Number of pages:	32 (including front sheet)
Author / Contact:	Group Director of Assurance

Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust actively seek to promote equality of opportunity. The Trusts seek 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 Trusts, with respect to all aspects of equality.

Contents

1.0 Purpose

1.1 In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the two trusts / wider group are required to ensure that all relevant individuals meet the requirements of the Fit and Proper Person Test (FPPT) (Regulation 5).

1.2 Regulation 5 recognises that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care. For the purposes of Regulation 5 this applies to:

- board members: executive and non-executive directors (permanent, interim (all contractual forms) and associate positions and irrespective of voting rights); and
- individuals who perform the functions of or functions equivalent or similar to the functions of a director.

1.3 Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

- is not of good character;
- does not have the necessary qualifications, competence, skills and experience for the relevant post or office;
- is not physically and mentally fit (after adjustments) to perform their duties.

1.4 Regulation 5 also decrees that these individuals cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful of not) in the course of carrying out a regulated activity or discharging any functions relating to any office or employment with a service provider. (Regulation 5 also provides that none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.)

1.5 In addition, in his 2019 review of the FPPT, Tom Kark stated that: *"The culture and management of each hospital trust flows from the management team. Thus, the quality and culture of the management team is of the greatest significance to the ethos and success of the hospital, the effectiveness and the working conditions (in the widest sense) of its staff, and ultimately the care, comfort and safety of the patients to whom the trust provides health services."* The Kark review therefore recommended that:

- All directors should meet specified standards of competence to sit on the board of any health providing organisation.
- Full, honest and accurate mandatory references should be required from any relevant organisations where an individual is moving to a post covered by Regulation 5.

1.6 These requirements play a major part in ensuring the accountability of leaders of NHS bodies and outline the requirements for robust recruitment / appointment and employment, appraisal and performance management processes for board level appointments and for ensuring that there are appropriate checks that leaders have

the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis.

1.7 NHS England has developed a FPPT framework in response to recommendations made in the Kark review. The framework takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles and introduces a set of standard competencies for all board directors and a new way of completing references with additional content whenever a director leaves an NHS board.

1.8 This policy outlines the arrangements in place within the two trusts / wider group – including the checks undertaken on appointment and on an ongoing basis – to ensure compliance with the above requirements.

2.0 Area

2.1 The policy applies to all board members: executive and non-executive directors (permanent, interim (all contractual forms) and associate positions and irrespective of voting rights) and to those individuals who perform the functions of or functions equivalent or similar to the functions of a director. Within the HUTH and NLaG group this applies to the following roles, which together make up the senior decision-making body of the two trusts and wider group:

- Group Chief Executive (Voting)
- Group Chief Financial Officer (Voting)
- Group Chief Nurse (Voting)
- Group Chief Medical Officer (Voting)
- Group Chief Delivery Officer (Voting)
- Group Chief People Officer
- Group Chief Strategy and Partnerships Officer
- Group Director of Assurance
- Non-Executive Directors (including the Group Chair) (Voting) and Associate Non-Executive Directors (Non-Voting)

- Group Director of Estates
- Group Director of Quality Governance
- Group Digital Information Officer
- Group Transformation Director
- Group Director of Performance
- Group Director of Communications
- North & South Bank Managing Directors*
- North & South Bank Site Nurse Directors and Site Medical Directors
- Chief of Staff
- Formally appointed deputies of the board (voting) directors:
    - Deputy Chief Nurse(s)
    - Deputy Chief Medical Officer
    - Deputy Chief Financial Officer

*[*The North & South Bank Managing Directors are the formally appointed deputies of the Group Chief Delivery Officer]*

3.0 Duties

3.1 The **Group Chair** has overall accountability for ensuring adherence to the FPPT framework and the requirements of this policy in accordance with the process outlined at **Appendix 1**. This includes:

- ensuring that assessments are carried out for all individuals covered by this policy on appointment and annually and at any time that something new comes to light which may call into question an individual's fitness to continue to undertake their duties;

- ensuring that the 'board member reference' is completed for any board member who leaves the organisation irrespective of whether a reference has been requested by a future employer;

- submitting an annual declaration of compliance with the FPPT to the trust boards in public and to the NHSE regional director.

3.2 The **Group Chief Executive** is responsible for supporting the Group Chair with the implementation of and adherence to this policy.

3.3 The **Group Director of Assurance** will be responsible for the development, implementation and regular review of this policy. The **Group Director of Assurance**, in conjunction with the **Group Chief People Officer** and the respective **governance and HR / recruitment teams**, will ensure compliance with this policy by ensuring that the appropriate checks have been undertaken and appropriately recorded on the FPPT files of the staff covered by this policy and on the Electronic Staff Record (ESR). The **Group Director of Assurance** will also be responsible for initiating audit or review of the arrangements outlined within this policy, as required, including liaison with the trusts' internal auditors in respect of the required three yearly reviews. The **Group Director of Assurance** will also support the chair with the preparation of the annual FPPT submission to the Trust Boards and NHSE.

3.4 **Individual Executive Directors, Non-Executive Directors and other staff covered by the requirements of this policy** are responsible for meeting the requirements of the FPPT on a continuing basis and for declaring where they may no longer meet these requirements. This will include a self-attestation that they are fit and proper person on appointment and thereafter on an annual basis.

3.5 The **Senior Independent Directors,** in conjunction with the **NLaG Lead Governor,** are responsible for conducting the Group Chairs appraisal and annual FPPT assessment and for reporting the outcome to the NLaG Council of Governors.

3.6 The **Remuneration Committees-in-Common** are responsible for considering any proposed changes to this policy and associated arrangements prior to approval by the trust boards.

3.7 The **Trust Boards** (NLaG and HUTH) are responsible for approval of this policy and associated arrangements.

4. Actions

4.1 Checks of Compliance on Recruitment / Appointment

4.1.1 The trusts have in place robust recruitment / appointment processes which cover the requirements of the FPPT, and the posts covered within the scope of this policy. These processes include a full formal FFPT assessment for new appointments including:

- the completion by the HR / recruitment team of the pre-employment checks listed in the checklist at **Appendix 2** including an initial Enhanced Disclosure and Barring Service (DBS) check. In addition, where a director meets the eligibility criteria, this will include a check against the children or adults safeguarding barred list or both. [**Note:** Under this policy, the completion of an Enhanced DBS will be an annual requirement for all staff detailed in section 2.1, who are required to sign up to the DBS annual subscription service and are personally responsible for paying the nominal annual fee to ensure their subscription remains live];

- the completion by the candidate of a self-attestation as shown in **Appendix 3;**

- receipt of references.

A full FPPT assessment should also be undertaken for an individual in a new interim cover role exceeding six weeks.

4.1.2 All appointments will be conditional on the individual satisfactorily meeting the requirements of the FPPT – all checks to be complete prior to the individual commencing in post.

4.1.3 Where an individual appointed into a role covered by the scope of this policy is sourced through an agency, the agency will be notified of the trusts' FPPT policy and process and must confirm and provide evidence that the necessary checks have been undertaken.

4.1.4 A failure or refusal by a candidate for appointment to comply with the requirements of this policy will immediately disqualify that individual from being appointed. If a candidate fails to meet the requirements of the FPPT the trust will withdraw the offer of employment.

4.1.5 Details of the pre-employment checks undertaken by the HR / recruitment team and / or sought from an agency, where applicable, will be provided to the office of the Group Director Assurance to be recorded on the individuals FPPT file. The HR / recruitment team will also ensure the details are recorded on ESR. Where checks are not applicable, a NIL return will be recorded.

4.1.6 For new 'joint' appointments within the NLaG : HUTH group, the full FPPT will be completed by the host / employing trust and a 'letter of confirmation' (**Appendix 4**) that the individual has met the requirements of the FPPT will be provided to the other trust for recording in the relevant file and on ESR. The HR / recruitment and governance teams will work together to ensure a robust and unified approach to completion and recording of the FPPT checks.

4.2 Assessment of Continued Compliance

4.2.1 The two trusts within the group recognise the need to ensure that those covered by the scope of this policy continue to meet the requirements of the FPPT and this will be undertaken through an annual assessment of ongoing fitness and will include:

- the completion of the ongoing / annual checks listed in the FPPT checklist at **Appendix 2**. [**Note:** The 'once only' elements do not need to be repeated after initial appointment, unless there is known to be any any change e.g. name change or change in right to work status.]

- The completion by the individual of the self-attestation form shown at **Appendix 3**.

4.2.2 The Group Director of Assurance, in conjunction with the Group Chief People Officer and supported by the respective governance and HR / recruitment teams, will co-ordinate the annual assessment and recording of ongoing fitness.

4.2.3 For 'joint' roles within the NLaG : HUTH group, the 'letter of confirmation' at **Appendix 4** will also be utilised / adapted in respect of the annual assessment of compliance.

4.2.4 The annual assessment will be aligned with / undertaken alongside the appraisal process which will incorporate the Leadership Competency Framework which, in turn, is intended to inform the overall 'fitness' assessment and also guide individual development plans for the coming year. The outcome of the annual FPPT checks and annual self-attestations will be provided to be Group Chair and Group Chief Executive to consider as part of individual appraisal meetings.

4.2.5 Once the annual checks and appraisals have been completed, the Group Chair (for the Group Chief Executive and the other Non-Executive Directors), the Group Chief Executive (for the group executives and other relevant staff covered by the scope of this policy) and the Senior Independent Directors, in conjunction with the NLaG Lead Governor (for the Group Chair) will review the supporting evidence and conclude for each individual whether they are fit and proper. Reporting on the outcome of the annual appraisal and FPPT will be as outlined in 4.26, 4.2.7 & 4.28 below.

4.2.6 The Group Chair will report the outcome of annual appraisal and FPPT of individual Non-Executive Directors to the Council of Governors for information. The Senior Independent Directors, in conjunction with the NLaG Lead Governor, will report the outcome of the Group Chair's appraisal and FPPT to the NLaG Council of Governors. The Chief Executive will report the outcome of the annual appraisal and FPPT of individual directors to the Remuneration Committees-in-Common.

4.2.7 The Group Chair will complete and submit to the trust boards in public and to NHSE an annual declaration (utilising the template at **Appendix 5**) that all those covered by the scope of this policy continue to meet the requirements of the FPPT. [**Note:** Whilst the FPPT framework recognises that some organisations may want to extend the FPPT assessment to other key roles, for example, those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions, the annual submission is limited to board directors / members only.]

4.2.8 A high-level summary of the outcome of the FPPT assessments will be recorded and published as part of the trusts' annual reports.

4.2.9 Where a person covered by the scope of this policy is found – through annual checks or self-attestation or as a result of concerns raised by a third party – to no longer meet the requirements of the FPPT, this will be dealt with in accordance with the appropriate trust / group policy and in accordance with the expectations set out in Regulation 5 and the FPPT framework.

5.0 Disputes

5.1 Where an individual disagrees with the outcome of the FPPT annual assessment and / or identifies an issue with data held about them in relation to the FPPT, these issues will be dealt with through the dispute resolution process set out in the FPPT framework.

6.0 Board Member Reference Requests

6.1 Where a board member leaves the organisation for whatever reason, a 'Board Member Reference' (BMR) will be completed irrespective of whether a reference has been requested by a future employer. The reference will be retained on a career-long basis. The template at **Appendix 6,** which sets out the minimum requirements for a reference, should be used for this purpose – all sections to be completed. Information in relation to additional matters can be provided if it is deemed necessary to do so.

7.0 Monitoring Compliance and Effectiveness

7.1 The arrangements set out in this policy will be reviewed annually and the outcome will be reported to the trust boards as part of the annual declaration of compliance.

7.2 A formal audit to assess the trusts' FPPT processes, controls and compliance will be undertaken by internal audit every three years and the outcome reported to the trust board. The internal audit will include sample testing of FPPT assessment and associated documentation.

7.3 Review of the trusts' FPPT processes and testing will be included in the specification for any commissioned well led / board effectiveness reviews.

8.0 Associated Documents

NHSE FPPT Framework for board members
Guidance for chairs on implementation of the FPPT for board members

9.0 References

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Available at: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

Care Quality Commission Regulation 5: Fit and proper persons: Directors, Guidance for providers and CQC inspectors. Available at: Fit and proper persons: directors - Care Quality Commission

10.0 Definitions

10.1 **Good character** – as defined in the FPPT Framework.

10.2 **Misconduct** – means conduct that breaches a legal or contractual obligation imposed on the Director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.

10.3 **Mismanagement** – means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making, and actions of the managers falls below any reasonable standard or competent management. Examples include:

- Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it was correct.
- Suppressing reports where the findings may be compromising for the organisation.
- Failure to have an effective system in place to protect staff who have raised concerns.
- Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual over the interests of people who use a public service, staff or the public.
- Failing to implement quality, safety and / or process improvement in a timely way, where there are recommendations or where the need is obvious.

11.0 Consultation

11.1 The Executive Cabinet and the HUTH and NLaG Trust Boards will be consulted on this policy, which will then be approved by both Trust Boards. The policy will be reviewed every three years or sooner should the need arise.

12.0 Dissemination

12.1 This policy will be disseminated to all those covered by the scope of this policy and will be uploaded to the trusts' intranet sites.

13.0 Implementation

13.1 The Group Director of Assurance will ensure implementation of this policy once approved.

14.0 Equality Act (2010)

14.1 The two trusts / wider group are committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

14.2 The two trusts / wider group are committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing both trusts to deliver the best possible healthcare service to the communities. In doing so, the two trusts / wider group will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

14.3 The two trusts / wider group aim 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.

14.4 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 reassignment, being pregnant or on maternity leave, being married and civil partnership, race, religion or belief, sex or sexual orientation (Equality Act 2010).

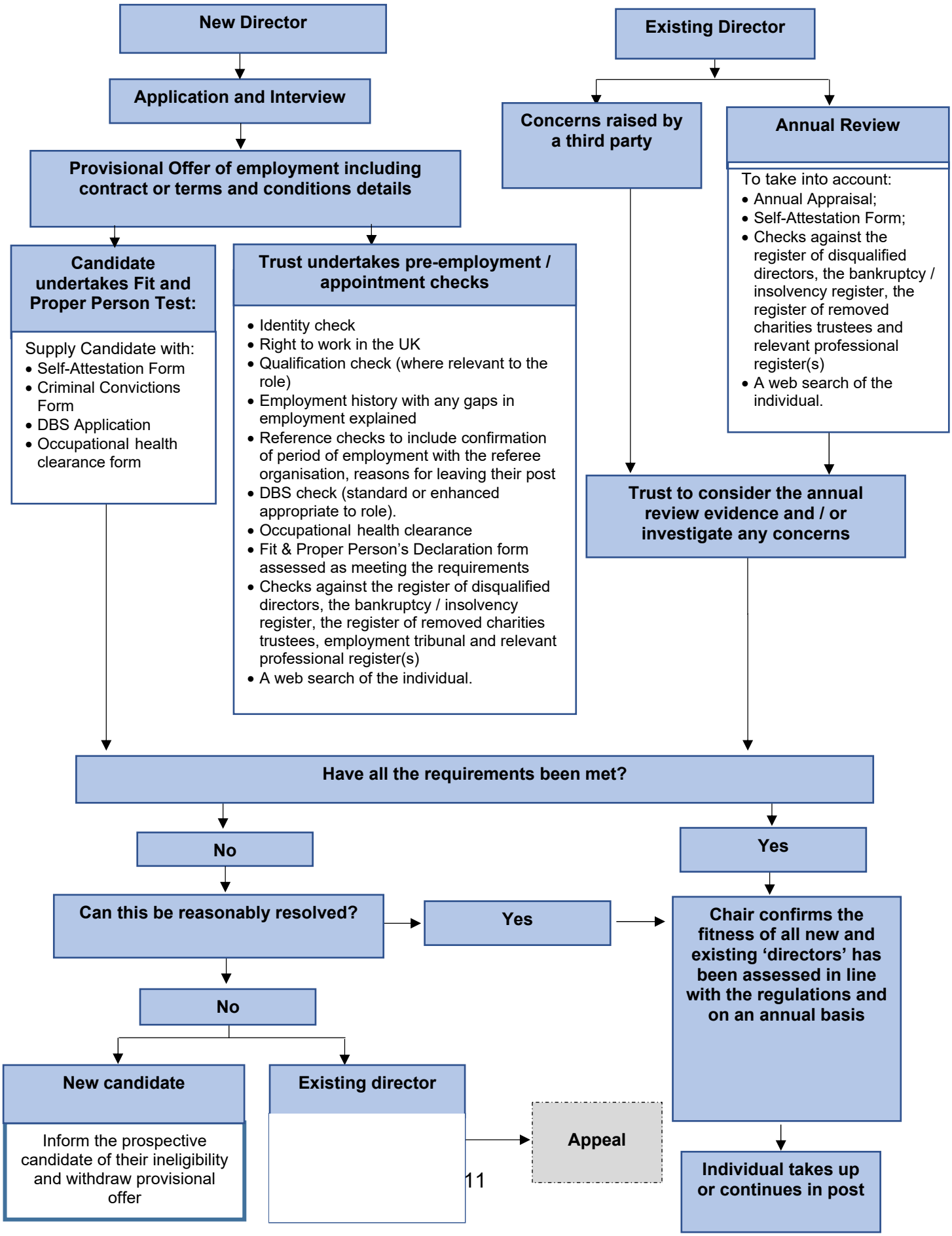
15.0 Freedom to Speak Up

15.1 Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this policy, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to either of the Freedom to Speak Up Policies and Procedures. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact either of the Trust's Freedom to Speak Up Guardian in confidence by email to huth.ftsuguardian@nhs.net and nlg.tr.ftsuguardian@nhs.net. More details about how to raise concerns with either Trusts' Freedom to Speak Up Guardians or with one of the Associate Guardians can be found on the Trusts' intranet sites.

The electronic master copy of this document is held by Document Control, Group Director Assurance.

Appendix 1

Fit and Proper Person Test Process



Appendix 2

Fit and Proper Person Test Checklist

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer / NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.	Recruitment / HR team to send details to the governance team to record in the local FPPT evidence folder
Second name/surname	✓	✓	✓	x – unless change	✓	✓			
Organisation (i.e. current employer)	✓	X	✓	N/A	✓	✓			
Staff group	✓	X	✓	x – unless change	✓	✓			
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓			
Occupation code	✓	X	✓	x – unless change	✓	✓			
Position title	✓	X	✓	x – unless change	✓	✓			
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	✓	✓	x	✓	✓	Application and recruitment process, CV, etc	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.	Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification Annually updated records of training and development completed/on going progress	* Non-Executive Director recruitment often refers to a particular skillset/experience preferred, e.g. clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (e.g. professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.	<u>Recruitment Test</u> Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file <u>Annual Test</u> Governance team to record on the local FPPT file / ESR

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role	Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file
Last appraisal and date	✓	✓	✓	✓	✓	x	Recruitment process / Board Member Reference (BMR) and annual update following appraisal	* For Non-Executive Directors, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.	Recruitment Test Recruitment / HR Team to populate ESR send details to the governance team to record in the local FPPT file Annual Test Governance team to record on the local FPPT file
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on BMR). ESR (high level) / local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters / complaints / grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.	Recruitment Test Recruitment / HR Team to send details (BMR) to the governance team to record in the local FPPT file Annual Test Governance Team to check against local case management
Grievance against the board member	✓	✓	✓	✓	✓	✓			

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓			system(s) and record, as appropriate and in conjunction with the Group Chair & Group Chief Executive, in the local FPPT file
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓			
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response	Frequency and level of DBS in accordance with local policy for board members: annually. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken / required.	<u>Recruitment Test</u> Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file <u>Annual Test</u> Recruitment / HR team to record on the local FPPT file / ESR
Date DBS received	✓	✓	✓	✓	✓	✓	ESR		
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements		<u>Recruitment Test</u> Recruitment Team to populate ESR and send details to the governance team to record in the local FPPT file

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
Date of professional register check (eg membership of professional bodies)	✓	✓	✓	✓	✓	x	E.g. NMC, GMC, accountancy bodies		Recruitment Test Recruitment / HR Team to populate ESR send details to the governance team to record in the local FPPT file Annual Test Governance team to record on the local FPPT file
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.	Recruitment Test Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file Annual Test Recruitment / HR team to record on the local FPPT file / ESR
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House		
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission		
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions		

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	Are there any matters which impact the reputation of the board member in relation to FPPT? How much does this impact the reputation of the board and the organisation as a whole in relation to FPPT?	Recruitment Test Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file Annual Test Recruitment / HR team to record on the local FPPT file / ESR
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Self-attestation form		Recruitment Test Recruitment / HR Team to populate ESR and send details to the governance team to record in the local FPPT file Annual Test Governance team to issue and record on the local FPPT file / ESR

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
Sign-off by Chair/Chief Executive	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidenced locally.	Group Chair and Group Chief Executive supported by the Group Director of Assurance
Other templates to be completed									
Board Member Reference	✓	✓	x	x	✓	✓	BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest.	Group Chair supported by the Group Director of Assurance
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only	Recruitment Test Recruitment / HR Team to co-ordinate completion and send details to the governance team to record in the local FPPT file Annual Test Governance team to record on the local FPPT file
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director	Group Chair supported by the Group Director of Assurance

Fit and Proper Person Test Area	Record in ESR	Local FPPT evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes	Test / Check Undertaken By
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for Fit and Proper Person Test	Group Chair supported by the Group Director of Assurance
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known / disclosed where there are confidentiality clauses.	<u>Recruitment Test</u> Recruitment / HR Team to send details (BMR) to the governance team to record in the local FPPT file <u>Annual Test</u> Governance Team, in conjunction with the Group Chair & Group Chief Executive, as appropriate

Note: ESR and the local FPPT files will be updated, as required, where matters arising at any point

Appendix 3

New Starter / Annual NHS FPPT Self-Attestation

NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST / HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Fit & Proper Person Test New Starter / Annual Self-Attestation*

I declare that I am a fit and proper person to carry out my role. I:

- am of good character;
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties;
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals;
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	

For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Appendix 4

Letter of Confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing.

[**LEAD EMPLOYING ORGANISATION**[1] **LETTERHEAD**]

[**DATE**]

Dear [**CHAIR NAME**[2]],

Fit and Proper Person Test

This confirmation letter is provided in connection with [**name of board member, job title of board member, organisations that the joint board member post covers**] for [**year of test, eg 2023/24**] as at [**date of conclusion of annual**[3] **FPPT for the individual**] for the purpose of the Fit and Proper Person Test.

As Chair of [**lead employer**], I confirm that I have carried out the Fit and Proper Person Test for [**name of board member**].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [**name of board member**] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [**name of board member**] is fit and proper/is fit and proper with mitigation(s) sign off as at [**date of conclusion of test**], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

I confirm that I have received the outcome for the FPPT for [**name of board member**] and that I have provided any necessary information for you to reach this conclusion.

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

[1] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.
[2] This is the name of the chair of the other organisation that the joint board appointment is made with.
[3] It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

Appendix 5

Annual NHS FPPT Submission Reporting Template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many board members in the 'Yes' column have mitigations in place relating to identified breaches?	Number of leavers	Number of board member references completed and retained

see 3.8 'Breaches to core elements of the FPPT (Regulation 5); in the FPPT Framework

Add additional lines as needed

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 6

Board Member Reference

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:
To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A: (if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in Electronic Staff Record under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):
(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS)

(This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)

Date Disclosure and Barring Service check was last completed.	Date
Please indicate the level of Disclosure and Barring Service check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □

10. Did the check return any information that required further investigation?	Yes □	No □

If yes, please provide a summary of any follow up actions that need to/are still being actioned:

11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:

12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation	Yes □	No □

and position)		

If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. **(Please visit links below for the Care Quality Commission definition of good characteristics as a reference point) (7)(12)**

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

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)069

Name of the Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday, 11 April 2024
Director Lead	Sue Liburd, Non-Executive Director, and Chair of Quality & Safety Committee
Contact Officer/Author	Sue Liburd, Non-Executive Director, and Chair of Quality & Safety Committee
Title of the Report	Quality & Safety Committees-in-Common Minutes - January and February 2024
Executive Summary	Quality & Safety Committees-in-Common minutes from meetings held on 25 January 2024 and 29 February 2024 and an Extraordinary Quality & Safety Committees-in-Common meeting held on 19 January 2024, are for inforamtion
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees-in-Common meetings held on 25 January 2024 and 29 February 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:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 25th January 2024 at 13:30 to 17:00

For the purpose of transacting the business set out below:

Present:

Core Members:

Una Macleod	Non-Executive Director HUTH (chair)
Sue Liburd	Non-Executive Director NLAG
Ashok Pathak	Non-Executive Director HUTH
Kate Truscott	Non-Executive Director NLAG
Tony Curry	Non-Executive Director HUTH

In Attendance:

Ab Abdi	Interim Managing Director Southbank (Deputising for Group Chief Delivery Officer)
Melanie Sharp	Deputy Chief Nurse NLAG (Deputising for Group Chief Nurse Officer)
Caroline Hibbert	Site Medical Director Northbank (Deputising for Group Chief Medical Officer)
Rob Chidlow	Interim Group Director of Quality Governance
Richard Dickinson	Associate Director of Quality Governance NLAG
Linda Jackson	Vice Chair NLAG & Non-Executive Director HUTH
Steve Jessop	Chief Nurse Information Officer HUTH
Corrin Manaley	Staff Governor (observing)
Rukeya Miah	Head of Midwifery HUTH (part)
Nicola Foster	Associate Chief Nurse – Midwifery, Gynaecology and Breast Services (NLAG)
Rebecca Thompson	Head of Corporate Affairs & Governance Lead
Sharon Humberstone	Nurse for Safeguarding Adults NLAG (observing)
Marie Stern	Patient Representative HUTH
Mich Green	PA to Group Chief Medical Officer (notes)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting.

Apologies were noted for Shaun Stacey and Kate Wood who had nominated deputies to attend. In the absence of an appointed Group Chief Nurse, and the Interim Chief Nurse for HUTH having submitted apologies, Steve Jessop

(HUTH) and Melanie Sharp (NLAG) had been nominated deputies to represent the Group Chief Nurse portfolio.

It was noted by Linda Jackson (Vice Chair) that these didn't represent formally appointed deputies as recruitment is ongoing, so the meeting would not technically be quorate. We can confidently say there was representation for the 3 Executives not attending today. It was noted that we are in transition to being fully quorate for the next meeting.

ACTION 001/24: Linda Jackson to take forward to all other committees that formal deputies need to be agreed prior to meetings.

ACTION 002/24: Linda Jackson to speak at the Programme Oversight Board to get some interim formally appointed deputies that can be used for the next 2 months while positions are filled.

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 18th December 2023 (HUTH) and 19th December 2023 (NLAG).**

The minutes of the meetings held on the 18th December 2023 (HUTH) and 19th December 2023 (NLAG) were accepted as true and accurate records.

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:

- 253/23 – Pharmacy - CLOSED – Item is about data presentation not contents or patient concerns.
- 283/23 – Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive – CLOSED – Once in a position how data is to be presented this can be revisited.
- 302/23 - Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive – CLOSED - Audit is still ongoing. Deadline for SI will be met. To be referenced in future papers when discussing SIs.
- 307/23 – Mental Health Act and Strategy – CLOSED – Next update in May will include an update around demographic correlation with the Mental Health Act.
- 308/23 – Mental Health Act and Strategy – Once strategy is agreed a decision to be made what data needs presenting. Kay Fillingham to contact Richard Dickinson to get item put on agenda.
- 309/23 – Stroke Pathway – CLOSED - Business case been produced. An apprentice has been secured.
- 310/23 – Medicine Deep Dive – CLOSED – There isn't a link between any incidents or workforce. 5 ED Consultants are on notice due to not

progressing. There is a robust plan in place for replacements. Regarding the challenge around automatic process and EPMA, there are no impacts on patient safety. This is being done manually at present. Ab Abdi confirmed talking with the division about general safety. There are internal professional standards and SOPs. ECIST and UEC gave feedback with some recommendations noting it was a positive journey for patients at NLAG.

- 311/23 – Community & Therapies Deep Dive – CLOSED – To go on the February agenda.
- 312/23 – IPR – CLOSED - Post meeting note was added to the minutes. MCA specialist nurse has been appointed and there is a MCA working group which is well attended.
- 313/23 – CQC Framework – CLOSED – Relates to passing of information in a timely fashion.
- 314/23 – Thirlwall Enquiry – CLOSED - Information request can be shared with other parties. This has now been done.
- Deep dives scheduled for June-23, Jul-23, Sep-23 and Nov-23 – All items to be considered within the workplan going forward.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported there were no matters referred.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

The paper was taken as read. The Executives are proposing that BAF 3.2 HUTH be reduced to 20. There are no changes proposed to NLAG quality risks. The BAF is being reviewed with a view to align the format and utilise a Group BAF from April 2024.

Kate Truscott queried if the HUTH UTC is still due to go live on 31st January. Response was the start date was still on track.

Ashok Pathak asked that the group have details once the HUTH UTC is functioning.

The group agreed for HUTH BAF 3.2 to be reduced to 20, which still represents a significant high risk in itself, but reflects the reduction in incidents of patient harm and the rapid improvement work with Yorkshire Ambulance Service (YAS) on ambulance handover. This will be reviewed monthly and increased if necessary.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Integrated Performance Report (IPR): quality & safety metrics

The report was taken as read. Richard Dickinson noted this was joint data for HUTH and NLAG using 2 different data sources and data collection. Going forward metrics will be better aligned. NLAG mortality data infections SHMI was not correct

previously. This was investigated and the result was the data set didn't show the full CHKS benchmark data where the Trust is 95 HSMR. HMSR rate of 103 is a slight rise but still within the expected range. There is concern the HUTH SHMI data has represented three months of consecutive growth and whilst "within the expected range" at 110 is at the upper limits. Focussed work is ongoing with stroke deaths and an update will be brought to the next meeting but in the meantime this would be escalated to Board.

Ashok Pathak asked for more information on the MI data and fractured neck and femurs. Response was the Ortho Geriatrician appointment is progressing. The business case has been approved and the recruitment is underway. It was noted there is a national workforce gap. It is not clear if the MI data is type 1 or type 2. Once this is clear, actions can be focussed accordingly. The group to escalate their SHMI data concerns to Board noting a focused mortality paper will be on the agenda for the next meeting.

Sue Liburd queried if anything was happening regarding measles at NLAG. Response was NLAG currently had no cases. Sheffield has a large outbreak. National guidance had been received and the IPC Infection Team have liaised with divisions. Procurement have ensured there is sufficient FFP3 masks and the CPD Team are ensuring staff are trained on appropriate use. Wards were confident with their isolation processes.

Ashok Pathak noted the TAVI report had been presented to the Cardiology team earlier this month. An action plan from the report had previously been prepared in August 2023 and there were monthly monitoring meetings with ICB and NHSE colleagues. Following the last meeting they were satisfied with progress to address the actions. Monitoring on the remaining actions would continue but would be dealt with by the HUTH Quality Improvement Group (QIG) who meet monthly.

4.2 **CQC Improvement Plan**

The paper was taken as read. Rob Chidlow updated there were three reports, as HUTH maternity had been tracked separately. In addition there were two internal audit reports, one for each Trust which both presented positive assurance in respect of action tracking.

NLAG's documents show further progress of actions considered to be fully assured to 28(22%). This meant that the Trust is fully assured that evidence is embedded and improvements would be sustained. The internal audit report gave significant assurance over governance processes at NLAG to monitor CQC actions. This was presented to Audit Committee this morning.

Sue Liburd asked for the rationale behind the revised due and achievement dates moving to 30th June. Response was this was due to organisational change, winter pressures, industrial action, IT solutions and other factors. A fresh look at the data would be carried out.

Kate Truscott queried about 2022 surgical 19 where the matron and ward show less than optimum in the way of effort in terms of achievement.

ACTION 003/24: Richard Dickinson to look into the comment - 2022 surgical 19 where the matron and ward show less than optimum in the way of effort in terms of achievement. Richard to feedback to the meeting.

Kate Truscott queried when and whom produced assurance for the medicines action. Response was when there is sufficient evidence a document will be produced. This is then taken through the Divisional Governance Team who will provide their approval. There is then central sign off process. These are then forwarded to Jonathan Lofthouse for sign off, before being submitted to the CQC.

HUTH reports take into account the November 2022 inspection. The surgery action plan has moved forward since December. At the time of the report there were 4 items that needed to be reviewed and these were close to completion. The maternity team had completed 11 out of 36 actions, and was on track to complete the remainder by April 2024. The internal Audit report for HUTH gives reasonable assurance relating to governance processes at HUTH, and sample testing supported 35 out of 35 actions being closed as fully implemented. The Internal Audit report contained two recommendations which now have actions in progress.

Ashok Pathak queried about surgical services if they were the acute delivery service or elective plans for HUTH and Castle Hill. Response was the surgery is for HUTH and Castle Hill. The 98 actions were a combination for both. 1 of the 4 overdue actions related to infection prevention control, however, the other 4 out of 5 actions in respect of infection prevention and control were showing good outcomes. The delay in the consent audit was due for completion in December. As of January there was still some data to collect.

Ashok Pathak raised a concern about maternity and the number of actions met. Response was completion of actions was due April 2024. There was a jump from 4 to 11 in December. There was a designated slot for maternity on the Quality Improvement Group (QIG) agenda. The group includes the ICB, NHSE and CQC members. These have been positive sessions and colleagues were happy with the progress. Performance in excess of the 95% target for seeing women in the right time periods on a risk-based basis since December had been sustained. ICB colleagues had been impressed on this point and there was a commitment to deliver remaining actions by April.

Kate Truscott asked staff to take away a consideration of whether if the CQC came tomorrow, would the staff be able to articulate the positive changes. Whilst she was not seeking an immediate response, there was brief discussion that if CQC triangulated what was place we would be able to demonstrate we had tackled the areas of highest risk – including triaging of women and the splitting of planned and unplanned care. Staff would still articulate staffing as a concern, as due to the high number of staff on maternity leave, staffing remains pressured.

4.3 **Nursing Assurance Report (including ward accreditation & fundamental standards, IPC, safe staffing)**

The reports were taken as read. Mel Sharp noted for NLAG this report is shorter than previously as the patient experience element was in a separate report. The mixed sex breaches assurances were covered in the IPR. The agenda stated IPC was included this month and was in the IPR. Vacancies for registered staff are at 8% which was 157 WTE. Healthcare assistants are at 11% which was 118 WTE. We had recruited to 40 WTE for our healthcare assistants. Our RN forecast for registered nurse show that we have vacancies of 37 WTE by the end of March. Focus was on our recruitment and retention. Our community nursing vacancies were the lowest for a year. There were 30 nursing incidents and 27 red flags which

was an increase on last month. There had been a lot of education for staff to report red flags. There were 8 in gynae and 7 out of 8 were due to staff who were less than 12 months qualifying and were left in charge. 4 of those shifts were mitigated by using very experienced bank nurses. The remaining red flags were spread across several areas with no themes. Red flags had been reviewed and approved by the nursing and midwifery AHP board. There had been an increase of falls by 2. 1 was moderate harm and 1 was major harm. Prompt safety huddles led by the lead patient safety nurse took place with good MDT engagement. Pressure ulcers had decreased. 15 steps is well embedded now. There was an increase in visits in November and 3 areas saw a reduction in rating to 'requires improvement'. All 3 wards were different themes. Feedback was given to the divisions at the time with follow up and an improvement plan developed. C2 and Amethyst had seen an increase in sickness and vacancies which were being monitored closely. Bank and agency redeployment were being used for patient safety. Wards were reviewed at the monthly nursing metrics panel and there were no reported red flags for those areas.

Sue Liburd queried if the increase in falls was due to patient acuity and the response was this was due to complexity, acuity and dependency. Risk assessments were done. The accident happened at nighttime. Focus work was being done to see what time of day falls happen. Visiting times had increased from 11:00 to 19:00.

Sue Liburd noted there was good news about the nursing apprenticeships and that the attrition rate is 5% when nationally it is 20%. Sue Liburd queried what we were doing for such a low nutrition rate and if there was something colleagues could learn from. Response was there was robust and clear recruitment process, and we were recruiting internally. There were clear expectations from the beginning and good support from the CPD team and university mentor.

Kate Truscott raised a concern there was fill rate of 161% on a ward. Response was this was due to a delay in updating the roster template. This ward had required a large number of staff, sometimes 2 at a time, to look after complex, sensitive patients. The percentage is expected to come down as the patient is no longer on the ward.

Steve Jessop noted for HUTH the care hours had dropped from November to December. The difference between NLAG and HUTH care hours was due to the number of extra capacity areas open and that there were 4 no criteria to reside wards. HUTH were currently 21 registered nurses over established to support elective recovery programmes primarily in endoscopy and theatre areas. There were 52 non registered nurse vacancies. There was full recruitment process taking place with an expectation these positions would be filled in the coming months. Red flags were measured slightly differently to NLAG and did not mean an incident had occurred. A flag was used for caring in the future. This was then discussed at safety meetings so the risk could be mitigated or resolved. HUTH red flags were based on the NICE recommendations. There had been progress on falls, pressure, damage and nutrition.

Tony Curry noted there had been a slight improvement in retention. Response was there were great programs for apprenticeships and international recruitment.

Marie Stern noted that HUTH now offers all sorts of activities and support for staff.

The health and wellbeing centres had a full program of activities.

Ashok Pathak queried why there is a shortage of nurses if we have over recruited. Response was some wards were over established in areas where elective recovery was needed. There were no RN vacancies on any wards. Where care hours were down, we were able to fulfill extra capacity with bank or agency.

Ashok Pathak queried which departments heavily rely on HCP's and ACP's. Response was they were on most wards. With the training programme and senior leadership, they were an essential part of the workforce. Mel Sharp also responded that this was a similar situation to NLAG for critical care and ED. The deputy chief nurse had picked this up and there were much more robust processes in place.

4.4 **Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents / MNSI)**

The papers were taken as read. Rukeya Miah updated HUTH had declared non-compliance with 5 out of 10 standards with work ongoing for the remaining 5 standards for year 6. Robust plans were being put in place with key areas of training. Training is below what it should be against staff challenges. Mitigations were in place with weekly, fortnightly and monthly check and challenge meetings. There was Trust wide training along with maternity specific training to be fulfilled. We were within our April deadline for CQC action and could give assurance these would be completed. The December Assurance LMS visit picked areas for improvement but also noted evidence of good practice. This had been shared with staff. It was noted safety action 7 is particularly important as there had been a big piece of work engaging with 2 key leads who would attend key governance structures.

Kate Truscott queried about the birthing pool where it stated that staff were not confident about using it and how this would be resolved. Response was as soon as staffing levels were stabilised (15 WTE and 10 internationally educated midwives who were just coming out of supernumerary) this would need to be reviewed.

Kate Truscott queried that maternity mental health services were no longer available. Response was this was due to prioritisation. A triage had been opened which was hoped to be a 24hr, 7-day week model. This was the key priority. Along with LMNS there would be a review looking at the need for perinatal mental health.

Nicky Foster updated that the NLAG midwifery vacancy position was 23 WTE across site despite recruiting into 11 WTE posts with newly qualified midwives and international midwives. 6 out of 7 international midwives had completed the preceptorship time and 4 more international midwives were welcomed this month. Work on recruitment and retention was ongoing. CNST year 5 had been presented the extraordinary Q&S CIC meeting last week and NLAG had submitted compliance with all 10 safety actions. Year 6 would be closely monitored and actioned to ensure good practice and support compliance. The exit from the Maternity Safety Support Programme (MSSP) was due in February. Due to concerns raised regarding unstable leadership the exit date may change. A CQC inspection took place on the midwifery services in Goole in November. There was positive high-level feedback. The formal report was

due in January. A concern was raised regarding the recruitment freeze for Band 8a and above. This would leave the service with 1 matron instead of 2 due to retirement. This gap may impact on quality and safety.

Kate Truscott queried why we were unable to report on the neonatal service at Scunthorpe. Response was this would need to be checked with neonatal colleagues.

Tony Curry queried about there only being 1 matron and whether there was any succession planning in place. Response was there were staff that can do parts of the role, but a matron was required in post to provide quality and safety.

ACTION 004/24: Rob Chidlow to bring the issue of the vacant matron's post to the attention of the Executive Team as a matter of urgency. This to also be referred to the Workforce and Education Committee to see if there are any exceptions.

Rob Chidlow noted that maternity colleagues had agreed as part of the Group collaboration that going forward, although the Trusts would still present separate reports they would adopt a consistent format.

It was noted that HUTH had previously been asked to revisit the year 4 CNST submission and reverse a previous 10 out of 10 submission. In response to that re-submission, the Trust had received correspondence resulting in the need to also review our Year 3 submission. It was likely that the evidence did not support a 10 out of 10 compliance submission for year three and a new submission would be sent to NHS Resolution with the final outcome by 8 February 2024. An action plan to remedy the shortcomings of previous year's submission had been initiated following request by Board and would be presented to the February Quality and Safety Committee.

4.5 **PSIRF / Serious Incidents (including Duty of Candor and lessons learned)**
The papers were taken as read. Richard Dickinson updated that there was a change in format due to a change in process at NLAG. There was a summary of PSIRF alternative learning responses with an overview of activities that were open maternity incidents and high profile cases. There was sufficient information to demonstrate we had processes that maintain control.

Rob Chidlow updated that at HUTH there were 47 actions arising from the previous Serious Incident Framework. These continued to be managed. 40 were considered to be overdue and work was ongoing with the surgery health group to resolve this.

Tony Curry noted the NLAG report was more comprehensive and that consistency between the two reports would be useful. Response was the report could be formatted to ensure there was similar content, but this was one of many areas where the process needs to be worked through and aligned to support the Group collaboration.

Kate Truscott queried about a major NLAG SI for audiology and if there was an update due on progress. Response was a more detailed report can be provided at a further meeting once agreed. There were 55 cases now identified

as a cluster and the process of reviewing the backlog of those cases had progressed significantly. The original NSP323 casework review was now complete and we were almost in the latter quarter of the pediatric community function set of data. The routine activity work was being triaged and managed, however there was still training that needed to take place.

4.6 **CLIP Report (including triangulation of incidents, complaints / PALS and claims and lessons learned)**

The paper was taken as read. Richard Dickinson updated that this report had previously included the complaint and patient experience information but due to timings of meetings and schedule of papers had not on this iteration. The report shows clearly where something had happened and there has been change. There was a divisional overview in the reporting rates and activities. The litigation section had been provided with a side by side illustration of all legal services activities.

Ashok Pathak queried regarding the delay in pharmacy and medication incidents. Response was there was local management reviews of any incidents along with a medicine's incident review being carried out by the Medicines and Safety Group. A review of all committees that report into our quality governance group arrangements was being done over the next few weeks. This would give parity across both organisations but the new approach had yet to be designed. There would be a reduction on paying out if we could defend ourselves. With less clinical claims we would be able to defend more cases than we have historically.

It was noted that for HUTH this paper was work in progress as this was the first time the Quality and Safety Committees in Common had received reporting for HUTH on claims and litigation. 1 of our top 3 litigations was inadequate nursing care which was a mandated category by NHS Resolution. It was noted where the paper talked about a 'high number of inquests in relation to a previous fall' it should say 'in relation to falls of patients'. The detailed improvement program was now showing a reduction in falls. The HUTH CNST premium had increased by 12% for next year compared to a regional average of 7%. This was based on a formula driven by the number of claims and payouts.

4.7 **Register of External Agency Visits**

The paper was taken as read. Rob Chidlow noted the TAVI service had progressed on actions and therefore the monthly group with ICB and NHSE agreed on 16 January 2024, to stand down that forum and update as part of the monthly QIG meeting. The Committee noted upcoming inspections presented for HUTH. The CQC reports had been considered as a separate agenda item. Assurance was given that actions are being responded to.

4.8 **Safeguarding including MCA & DOLS**

The paper was taken as read. Mel Sharp highlighted the safeguarding children and adults' level 3 training was at 72%. Medical and Dental had been identified as needing more focus. This had been shared with HRBP and the groups had been asked to pick this up. There was a high percentage of staff withdrawing and not attending training, meaning there were valuable places that other staff would be able to access. It had been recognised there needed to be a new approach to address the DNA rate to improve overall compliance. There was a

Mentimeter survey which would be distributed to all staff to ascertain the barriers of face to face and virtual training. A domestic abuse coordinator post had been recruited for 1 year via a national charity and would commence on 12th February. This would be based at NLAG as there was an increase in domestic abuse to staff, visitors and patients. This post would focus on a system level change offering an increase in support referrals and identification along with offering confidence to staff to be able to challenge and support patients with timely referrals. Group working with HUTH had started as it was a CQC requirement that staff receive training on LD and autism through the Oliver McGowan training. We were completing an options appraisal of how this training could be rolled out.

4.9 **BREAK**

4.10 **Patient Experience Report (including learning from complaints**

The paper was taken as read. Rob Chidlow updated that responsibility for the patient experience teams now sits under the Group Chief Nurse, where previously there had been different configurations at the individual trusts. The report demonstrated that HUTH currently had twice the volume of PALS complaints compared to NLAG. Whilst partly applicable to the difference in size of the trusts, it reflected the levels of care not being at the level we would aspire to, consistent with CQC findings. Tentatively, both organisations had lower PALs reported in the year to date than 2022/23, but still a marked increased from the pre-Covid period linked to treatment delays which was consistent with the national picture.

A HUTH CQC finding was that we were poor in our patient experience, and practically NLAG are 2 years ahead with this journey. In November 2022 there were 236 overdue complaints at HUTH which had reduced to 127 by December 2023. A new quality process had now been applied across the group where Jonathan Lofthouse reads every complaint and Rob Chidlow has also read every complaint since November. This additional quality measure has slightly impacted on compliance with KPIs, but reduced the number of reopened complaints.

A change for the committee is the inclusion of friends and family performance data, and benchmarking to region and national organisations. The HUTH inpatient friends and family score was in the bottom quartile.

Mel Sharp updated that there is a lot of joint working taking place now. Learning logs need to be more robust with learning from our complaints. We would be moving forward to measure our compliments more.

Kate Truscott queried about there being different time frames for responses of 40 days (HUTH) and 60 days (NLAG) and whether this was a choice. Response was there were complex complaints that would never achieve 40 days. A paper was presented and approved by NLAG Trust Board three years ago with a recommendation for 60 days. It had been noticed that more complex complaints were coming through across the divisions. As part of harmonizing Group processes, a decision would be made on whether to report to 40 day or 60 day measure consistently.

Ashok Pathak noted the compliments that the Chief Executive and Chairman

receive do not cascade down to the workforce. Response was that we do not count HUTH maternity colleagues' cards received so there were some quick wins to be had. Marie Stern noted that often the staff did not feel confident and sell themselves or their services.

Una Macleod queried what the plan was to understand why the HUTH friends and family scores were so low. Response was the report shows some learning from previous complaints. Once we triangulate the data, we would be able to present this in the same way NLAG do. There were some quick wins along with the ongoing improvement work which should be reflected in the next quarter. It was queried whether a note from the Chief Executives office would help with staff moral noting when a patient has said something positive.

4.11 **Clinical Effectiveness Report (including clinical audit, NICE compliance & deviations, GIRFT, PROMS etc)**

The paper was taken as read. Richard Dickinson flagged the national dementia audit data which showed both trusts were outliers. This was a key function and component that both HUTH and NLAG had plans for. NLAG had a lead from the safeguarding team working with colleagues and Symphony to fix it.

It was noted that there was a significant difference between the Trusts in respect of compliance with NICE guidance, with NLAG reporting a 89% compliance rate, but HUTH was 65% (up from 61% in November 2023). Solutions were in train regarding the NICE guidance points and there was a push to get compliance over the 90% target.

The Sentinel national audits SNAP data was available. There were some improvements for NLAG and a slight reduction on some scores for HUTH. It was challenging for NLAG to get data for patient selection meaning the patient samples were not a specimen. These were relevant for a cohort for a national audit or local audit. This was a prioritised workstream which posed a challenge at times. HUTH commentary was about the NELA and other projects where there were outlier alerts and the progress with the local audit plans. The content could be broad for this paper. Work was required to work through and agree what subset of data we were going to report in each cycle rather than having every topic covered every time.

Caroline Hibbert noted there were a number of national audits, databases, collections of data that we were not contributing to. This was concerning because if we were not contributing to national databases we would not know where we stood nationally. We need to look at how we make resources available to commit to the other databases.

Ashok Pathak added his concern regarding the database collection and that this should also be part of the workforce group due to difficulties in recruiting and retention.

Ashok Pathak noted resection rates had increased along with another issues relating to pain management and the lack of anesthetists. Response to this was that there was work ongoing with particular focus on Dementia patients. At NLAG there has been a Quality Improvement initiative in this area.

Tony Curry queried if the issue of pain management incidences that were raised elsewhere in the hospital generally needed to be reviewed across the Group. Response was that Caroline Hibbert was referring to the work being carried out on the Abbey pain score. There had been a separate scoring system for dementia patients. Pain scoring had been mandated across the organisation so that every time you had a set of clinical observations done you cannot proceed until you had the pain score. This had been rolled out in ED and would be rolled out across the organisation in the next few weeks. This would give us evidence that patients were regularly being asked every time we took the patient's blood pressure or took a temperature the pain score would be recorded. There was another system to look at how quickly patients get strong analgesia from the EPMA system. There was a similar issue at NLAG and a quality improvement initiative was undertaken. It was found the initial pain assessment was good, but the reassessments needed work. Focused QI work was undertaken, and tremendous improvements were seen. It was noted that both HUTH and NLAG's quality improvement teams had been merged together.

NLaG Specific Business Items

4.12 There were no specific business items discussed.

HUTH Specific Business Items

4.13 There were no specific business items discussed.

5. ITEMS FOR INFORMATION / TO NOTE

The following items for information were noted:

- 5.1 Quality Governance Group NLAG
- 5.2 Mortality Improvement Group NLAG
- 5.3 Patient Safety Champions NLAG (meeting did not take place due to quoracy)
- 5.4 Patient Safety & Clinical Effectiveness Sub-Group HUTH
- 5.5 Non-Clinical Quality Sub-Group HUTH
- 5.6 CQC Appendices for item 4.2 HUTH
- 5.7 Quality and Safety Committees in Common Workplan
- 5.8 Quality and Safety Committees in Common Terms of Reference

6. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- Workforce and Education Committee – Discussion with the Chairs about staffing.
- Workforce and Education Committee – Compliments and how they are properly disseminated throughout the Trust.
- Recruitment freeze – are there any exceptions where patient safety is deemed to be of concern?
- HUTH BAF risk 3.2 – patient harm reduction from 25 to 20. This was reviewed and endorsed subject to being reviewed monthly.
- HUTH visibility of performance of the UTC and its impact on ED.
- HUTH SHMI for acute MI and fractured neck and femur being elevated is causing concern. This is under investigation, but ongoing action planning needed to be developed.
- HUTH TAVI – there has been stringent monitoring. On 16th January, due to success of addressing the actions, the level of monitoring has now been reduced. This has been subsumed into the quality commitment framework.
- Family and friends test – HUTH's FFT scores are in the bottom quartile nationally and the lowest regionally. Learning has been identified and proactive action has been taken to improve the scores in the next quartile.
- Linda Jackson to speak at the Programme Oversight Board to get some interim formally appointed deputies that can be used for the next 2 months while positions are filled.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Quality and Safety CiC meeting:**

Thursday 29th February, at 09:00 to12:30, in Main Boardroom, DPOW

The committee chair closed the meeting at 17:05 hours.

Cumulative Record of Attendance 2024

			Jan	Feb	Mar
Core Members					
Una Macleod	U M	Non Executive Director (HUTH)			
Sue Liburd	SL	Non Executive Director (NLAG)			
Ashok Pathak	AP	Non Executive Director (HUTH)			
Kate Truscott	KT	Non Executive Director (NLAG)			
Tony Curry	TC	Non Executive Director (HUTH)			
Kate Wood	KC	Group Chief Medical Officer	CH		
Shaun Stacey	SS	Group Chief Delivery Officer	AA		
Vacant		Group Chief Nurse Officer	MS		
In Attendance					
Rob Chidlow	RC	Interim Group Director of Quality Governance			
Vacant		Group Director of Assurance	RT		
		ICB Observer			
Marie Stern	MS	Patient Representation (HUTH)			

Attended	Apologies / Deputy sent	Apologies

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 29th February 2024 at 09:00 to 12:30 in Main Boardroom, DPOW

For the purpose of transacting the business set out below:

Present:

Core Members:

Una Macleod	Non-Executive Director HUTH (chair)
Sue Liburd	Non-Executive Director NLAG
Kate Truscott	Non-Executive Director NLAG
Tony Curry	Non-Executive Director HUTH

In Attendance:

Kate Wood	Group Chief Medical Officer
Melanie Sharp	Deputy Chief Nurse NLAG
Rob Chidlow	Interim Group Director of Quality Governance
Richard Dickinson	Associate Director of Quality Governance NLAG
Rukeya Miah	Head of Midwifery HUTH
Rebecca Thompson	Head of Corporate Affairs & Governance Lead
Aswathi Shanker	Managing Director South Bank (Deputising for Shaun Stacey)
Stuart Hall	Vice Chair (HUTH)
Michela Littlewood	Associate Director of Quality HUTH
Jo Ledger	Interim Chief Nurse (HUTH)
Greta Johnson	Director of Infection Prevention & Control (HUTH)
Kevin Allen	Public Governor NLAG
Belle Baron-Medlam	Head of Compliance & Assurance (NLAG) (Item 4.2 only)
Rosemary Hoyle	Practice Development Matron (Falls) (Item 4.11 only)
Nicola Foster	Associate Chief Nurse, Midwifery (Item 4.3 only)
Mich Green	PA to Group Chief Medical Officer (notes)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting.

Apologies were noted for Shaun Stacey, Chief Delivery Officer (represented by Aswathi Shanker) and Marie Stern, Patient Representative (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 19th January 2024 (extraordinary meeting) and 25th January 2024.**
The minutes of the meetings were accepted as true and accurate records.

1.4 **Matters Arising**
The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. None were raised.

1.5 **Committees-in-Common Action Tracker**
The action tracker was updated prior to the meeting. ALL actions had been updated and on track.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**
The committee chair reported there were no matters referred.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**
Rebecca Thompson presented the paper and advised that the format had changed to align both Trusts and in preparation for a single BAF across the Group. There are no changes to the risks and no specific action required from the Committees in Common. The group were asked for comments. Executives had asked for a more slimline format and there had been engagement with internal auditors during the re-formatting process. This is on the Board Development agenda and was still a work in progress. It was noted that the Group need to be aware of key and emerging risks and it was noted there was an additional monthly Executive Risk and Assurance Committee meeting where the BAF was scrutinised.

Una Macleod queried if the Group BAF would be ready for 24/25. Response was it is thought this will be later in April when the strategic objectives had been agreed.

Tony Curry noted it would be useful to see actions against any gaps in controls.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Integrated Performance Report (IPR): quality & safety metrics**
The report was taken as read. The report showed performance figures for both organisations. Mortality is a key concern in HUTH as well as the management of VTE. Sepsis screening and EPMA waits are a concern for NLAG. There has been a new high of friends and family test responses received. Formal complaints remain complex and lengthy but the KPI of 85% had been maintained. There had been an increase in falls in the acute setting. There had been a decrease in pressure ulcers in acute and in the community. Lowlights are care hours were below 6 for wards at Grimsby and Scunthorpe. Wards had seen an increase sickness for registered and unregistered nurses. Agency and bank staff were being used and there were no red flags, concerns or staffing issues. 2 MRSA cases had been linked to canula care. Increased surveillance had meant there had been no further cases. Mental capacity assessments were low. Focus work had been done and fed back to staff showing a slow improvement. It was noted that the IPR shows

electronic reporting not paper reporting.

Jo Ledger updated for HUTH that work continued regarding pressure ulcers and there was focused work around education. Complaints response times had increased. Work was continuing with the friends and family tests aimed at learning and improving scores, although response rates were high except for maternity. Greta Johnson advised that HUTH were on trajectory for CDIF compliance. A MSSA survey had been completed for NHSE with the intention to do regional work. There had been a measles case which had resulted in a further 4 cases. 3 were linked to the hospital and 1 was an unrelated staff case. A further case had been reported and was a relative to a member of the Trust and a contact of the first index case. For UKHSA this was a concern as they worked on a large construction sites in the East Riding for a large company with 920 contractors on site. All cases were adults with no complications.

The PSIIs reported in January both had robust action plans in place.
Una Macleod queried if the friends and family denominator had now been corrected. Response was this was starting afresh and the friends and family test for NLAG was correct. HUTH's inpatient FFT score is placed at the bottom percentage of the quartile and an area for focus to improve patient experience.

4.2 **CQC Improvement Plan**
The papers were taken as read.

4.2.1 HUTH CQC Improvement Plan
The paper was taken as read. Jo Ledger updated we continue to monitor progress against the plan. There were 3 overdue actions which would be completed at the next check and challenge. Medicine had 3 elements they were working towards which were VTE, medical staffing out of hours and consent. A group piece of work was required. The Trust was compliant against the Trust-wide actions for training except for resuscitation training but the Trust was on trajectory. Maternity have set training trajectories for the next 3-6 months which would be reviewed at workforce transformation meetings and HR partners would align processes for the group. Areas for concern following the assurance reviews were mental health where activity concerns were raised. A joint piece of work has been initiated with NLAG looking at improvement. Ambulance handovers still have issues with cohorting although there is now a senior nurse at the front door to assess patients. There were good relations between YAS and the senior team. The Paediatric issue was that there was no oversight. A receptionist was there in the evening and an overnight role or cameras was being considered. The staffing issue references that more staff are needed. This was being reviewed daily to ensure staffing, but a more consistent workforce was being looked at.

Tony Curry queried when assurance became embedded and Kate Wood advised that once consistent assurance was provided with regular reviews this would become the new normal. Annual spot checks would be carried out to ensure the measures were being sustained. Ashy Shanker added that a culture change was also required to ensure consistent processes.

Rob Chidlow noted this was about data and governance. The evolution of the digital agenda meant that the Northbank did not have the balance of staff or the quality of IPR and performance measurement and the Trust was increasing resource and expertise in the Care Groups to support the governance

requirements.

The Committees discussed Safety Champions, quality improvement initiatives and how the data was triangulated to provide assurance. Una Macleod asked if the CQC would be assured if they returned today and the Committees agreed that the improvements were not sustainable at the moment.

The Committees agreed they were not assured.

Ashy Shanker responded and advised that a timetable was being put together to provide assurance.

Stuart Hall noted the commonality seen between various committees was an overload of data and there needed to be a focus on the patient. More detailed information needed to be supplied where the Trusts were not assured.

Kate Wood updated that NLAG were not moving with Aqua but were developing an in-house QI academy.

4.2.2 HUTH Maternity CQC Improvement Plan and S31 Update
Combined and discussed in 4.3.1

4.2.3 NLAG CQC Improvement Plan
The paper was taken as read. Belle Baron-Medlam updated over 50% of actions are rated as significant assurance. In February 2023 the Trust was at 12%. 23 closed actions had been submitted to the CQC with a further 5 to be submitted in the next week. 20 actions were in the final stages of sign off with a paper being provided to divisional governance for review. There is a decrease in limited assurance actions for 2019 The quarterly monitoring assurance process had been completed and had not identified any actions that needed re-opening but the Trust was maintaining the majority and continuing to monitor. Internal audit had reviewed the CQC assurance for NLAG and a rating of significant assurance was maintained with no actions. There were communications from the CQC and the adoption of the national new assessment approach was expected to apply from February 2024 in the region. The Goole midwifery led unit report had been received for factual accuracy checks and would be submitted back to the CQC.

Una Macleod queried the quarterly assurance review and asked if the process was the same across the Group. The approaches were different but would be aligned in the future taking into account the CQC framework changes.

Kate Truscott observed that many of the actions had a target date of 30 June and asked if completion of these was realistic. Belle Baron-Medlam advised that the dates had been set at the 18 month mark when the actions were first set. These dates would be reviewed individually and changed if not appropriate.

Sue Liburd expressed feeling uncomfortable with the number of limited assurance actions, in particular the record keeping results. Record keeping results showed no increase in compliance despite action plans being in place and this had now moved to 30th June. At the last Family Services CQC meeting a deep dive was carried out into the 2019 actions. A record keeping audit would be carried out on 10 records a month to ensure actions had been embedded. Although the Trust was not meeting the national standards for medical staffing, a safe service was

being provided. Work was ongoing to ensure the Trust did meet the national standards.

Sue Liburd further queried about syringe driver training and if a bespoke training request had been actioned. There was to be a review as ED staff did not have the training as part of their competency. Staff were being asked to do 1 or 2 bespoke sessions which would show in the figures next month.

The Committees were assured, but it was noted that work was ongoing to provided assurance that actions were embedded and business as usual.

4.3 **Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents / MNSI)**
The reports were taken as read.

4.3.1 HUTH Maternity & Neonatal Assurance Report
The paper was taken as read. Rukeya Miah updated on the CQC improvement plan that there were 37 actions of which 19 had been completed and embedded and 7 had been delivered and were awaiting evidence. We were on track to deliver all 37 by April 2024. ADU performance had improved and was being sustained between 93% to 95%. This took into account planned and unplanned activity. There was still work to do regarding staff training as the Trust was still not achieving its target of 85%. However, training was being delivered and the importance of freeing up staff to complete it was understood.

Workforce figures showed 4 vacancies but there had been 10 international midwives recruited. The CNST standards had been submitted and the Trust was reporting 5 out of the 10 standards as compliant. The year 6 plan was now being commenced and work was ongoing to ensure 10 out of 10 standards were achieved. Patient experience feedback showed low numbers of complaints through PALS. Service user feedback was lower than the national average. The impact of the maternity safety champion for February had been positive and improvement work was being developed.

Jo Ledger updated that there was now evidence relating to ADU performance and the Trust was confident about support arrangements. It was noted that the ADU triage was closed 10pm until 8am but an additional member of staff had been supporting the service.

Stuart Hall expressed his concern with reference to performance dropping. Response was this was due to a change in staff and has now been resolved.

Kate Wood noted the maternity team under Jo Ledger's guidance had been able to give assurance due to the improvement work being carried out.

Tony Curry asked about training compliance and how the Trusts were measured on the 85% national target, but noted that there were hot spots of low uptake which required review.

Rob Chidlow reported that the MTAC review was ongoing and that closing maternity actions relating to the section 31 was on target for the end of April 2024. HUTH's training figures (88.8%) would be reported to the Quality Improvement Group and work was ongoing to improve this further as it was a requirement for all

staff to be compliant.

The Committee agreed limited assurance but noted the improvement work being carried out.

4.3.2 NLAG Maternity & Neonatal Assurance
The paper was taken as read. Nicky Foster updated that workforce remains a challenge. Recruitment and retention work continues with 22.4 vacancies. The Pastoral support midwife post had been approved by NHSE for year 24/25. QI project, maternity triage and induction of learner were complete and due to be handed over next month. The Trust was waiting details of exit date for the maternity safety support programme.

Kate Truscott queried on page 10 the challenge on recording conversations and that this had not been implemented but it was best practice. Response was that there were IT issues which linked to patient information sharing. Headsets for trainees to listen in to conversations were being looked into. Michela Littlewood noted that HUTH had this issue and that not recording is also a risk for the Group. HUTH had written a SOP to support this. Michela Littlewood and Nicky Foster to agreed to work together regarding this issue and update at a future meeting.

Kate Truscott queried page 13 where it mentioned a temporary suspension. Response was that there had been a process issue at the time. This had now been fully restored/resolved.

The Committee agreed reasonable assurance for this item.

4.4 **Children & Young People Assurance**
The papers were taken as read.

Debbie Bray updated the current position on deteriorating patient and sepsis workstreams and advised that there was limited assurance with the current audit programme. There was assurance that there were no clinical incidents noted. Issues were around documentation quality. The improvement plan was being taken forward. Going forward Jo Ledger/Debbie Bray to work together regarding sepsis and paediatrics.

Kate Wood advised that Debbie Bray will support paediatric sepsis across the group. Medication safety within NICU was a concern. Debbie Bray was sighted and acting on this. It was being managed well and links were being made with pharmacy colleagues. The matron was scrutinising each individual case and providing feedback.

Stuart Hall noted a conversation had taken place regarding Martha's rule and was unsure what the implications would be for the group. Response was that Martha's rule was being adopted nationally from 1st April and Trust's would be invited to make an expression of interest in the pilot scheme in the coming weeks. This was going to be discussed at Cabinet. An improvement plan and revised sepsis tool was now in place.

Sue Liburd noted a paper accuracy on page 5 as the paper showed the total child deaths in North Lincolnshire was 12 and this should be 10. This would be checked and amended.

The Committee agreed reasonable assurance.

4.5 **PSIRF / Serious Incidents (including Duty of Candor and lessons learned)**
The papers were taken as read. Richard Dickinson advised that the updated paper which compared and contrasted the work across both organisations. There would be a Group paper presented to the Committee in April 2024.

Michela Littlewood updated that a meeting took place on 27th February to combine future work. 2 new PSSI cases reported in January were being investigated. As HUTH was down to 18 outstanding SI actions and these were being managed as the Group transitioned to Care Groups. Ulysees vs Datix was an ongoing risk and was being reviewed.

Uma Macleod queried duty of candor compliance. Response was this was due partly to documentation and training that was not yet embedded. There was a daily incident review meeting where review processes were assigned. Risk and governance facilitators were being reviewed in preparation for the new Care Groups. Both NLAG and HUTH incident meetings were being jointly attended by colleagues from across the Group to allow for learning.

Kate Truscott queried on page 11, that 32 out of 44 actions are overdue and asked when they would be completed. These actions were being reviewed by the current Health Groups and actioned accordingly.

ACTION 005/24: Richard Dickinson/Michela Littlewood to review duty of candor. This needs to be tracked and reported back to the Committee with more detail.

4.6 **Mortality including Learning from Deaths**
The paper was taken as read. Kate Wood update that the HUTH team had been asked to update the mortality strategy with a gap analysis using the template from NLAG. There was no depth of understanding of actions and significant work to collate the information and detail to stimulate quality improvement and change. Assurance could not be provided until a full rewrite was done.

Una Macleod raised concerns regarding FNOF and acute MI. Response was that there was a coding element and process in place and that sepsis and stroke needed to be added to the list. Appropriate oversight was needed as there was no governance structure in place at the moment. The specialty teams would be asked to take ownership in the new Care Group structure.

ACTION 006/24: Kate Wood to give a verbal position update in March 2024. This item to be added to the March agenda.

Tony Curry queried whether the Trusts were on target for the SHMI and it was reported that although HUTH were in the SPC chart limits there was more work to do.

Kate Wood updated that NLAG's early recognition and completion of respect forms continued to be an issue. Educational training was available as Yousef Adcock had developed a video for use with training. Respect form completion was an issue across the system.

The Committees were not assured but there was an understanding regarding the issues.

4.7 **CQUINs**

The paper was taken as read. Michela Littlewood updated that HUTH have 2 additional CQUINs and NLAG had one additional CQUIN from the national CQUINS for 2023/24. Michela Littlewood advised that it was unlikely that CQUINS would continue nationally but the ICB would want any outstanding issues addressing. Identification, frailty and emergency department had done better than expected and changes to medication in the community were taking place. There were challenges elsewhere, for example, supporting patients to drink and mobilise. Work was taking place regarding the pressure ulcer risks and Flu vaccination performance was at 54.4%.

Richard Dickinson updated for NLAG and advised that financially incentivised schemes 3/7 were fully achieving and there were 2/4 non financial schemes achieving. The Trust was forecasting to be fully completed by the end of the year. A radically different approach to flu vaccinations next year would be undertaken.

The Committees agreed reasonable assurance for NLAG and limited assurance for HUTH.

4.8 **IPC BAF**

The paper was taken as read. Kate Truscott noted that these papers were received late yesterday. The expectation is that papers are to be submitted by deadline date to allow time for consideration prior to meeting. Rob Chidlow acknowledged the late submission.

The Committees discussed the IPC BAF requirements and whether the two BAFs could be aligned in the future. The IPC BAF is not mandated but is intended to show data collection and evidence against IPC criteria.

ACTION 007/24: Kate Wood/Jo Ledger to agree how the two IPC BAFs could be aligned.

NLaG Specific Business Items

4.9 There were no items discussed.

HUTH Specific Business Items

4.10 **CNST Action Plan**

The paper was taken as read. Rob Chidlow updated there was an action to check the compliance on the Northbank going back to years 3, 4 and 5. Work had commenced regarding the year 6 requirements. Assurance was given that movement had taken place on this. Work would take place with the new Group Director of Midwifery who would take this reporting forward. Training was on track and the focus would be on the saving babies' lives initiative.

The Committees agreed reasonable assurance.

4.11 **DEEP DIVE – HUTH Falls prevention workstream (carried forward from 2023)**

The paper was taken as read. Rosemary Hoyle updated that coming out of Covid, falls were scrutinised due to an increase in the number of fallers. A gap analysis

was completed using the CQC report from Kettering and the NICE standards. The strategy was developed along with a task and finish group in April 2022. Falls mandatory training was implemented across the organisation and was at 87% for online training and 60% for face to face training for all registered practitioners. It had been agreed that all medical staff up to and including registrars should complete this training. More training was being developed. The team was going out onto the wards and supporting teams in clinical areas. A quality improvement plan had been developed with Orthopedics and DME which was now being rolled out across the organisation, i.e. a yellow bracelet that identified a patient with a falls risk. High risk patients were identified and tag support is provided and Sensor pad work had been carried out in some areas. Success was celebrated with improvement boards acknowledging staff achievements. There was concern in March 2023 due to the level of harm increasing. 2 WTEs were employed to support the falls educator. Support was given to wards with more education and support in clinical areas. A virtual ward had been developed which allowed the wards to refer into the team. Interventions could then be put in place for patients before falls occur. A weekly patient safety summit had been put in place from September 2023 where Band 7's presented and shared good practice along with sharing ideas and solutions. A monthly newsletter was sent out. The Trust had joined the Aqua collaborative. Psychological effects of falls and the impact on the patient and staff were being looked at to support developing an MDT approach. This would review the patient's pathway in the acute setting and community. January to February 2024showed a 50% reduction for fractured neck of femur in comparison to 2023. The last 6 months there were 11, the previous 6 months there were 25. The next target was to reduce by 50% against last year's figures. A system approach was needed.

5. ITEMS FOR INFORMATION / TO NOTE

The following items for information were noted:

- 5.1 Quality Governance Group NLAG
- 5.2 Mortality Improvement Group NLAG
- 5.3 Patient Safety Champions NLAG (meeting did not take place due to quoracy)
- 5.4 Patient Safety & Clinical Effectiveness Sub-Group HUTH
- 5.5 Quality and Safety Committees in Common Terms of Reference

6. ANY OTHER URGENT BUSINESS

Junior Doctors Strike

Kate Wood updated that both organisations had gone through due diligence to support all colleagues. Thanks were given to all involved. The HUTH Trust remains under pressure. The Junior Doctors strike had significantly impacted ED performance and this was reflected in the CQC report. The UTC had opened and was starting to take activity. This would be at full capacity by April. The IPC issue seen in January was now resolved. NLAG ED pressures have shown long ambulance waits, however, patients remained safe. The IPC teams were preparing for measles cases.

Lorenzo

The EPR change over to Lorenzo had taken place due to CAMIS being out of date as of today. This was fully risk assessed. It was noted that Lorenzo was not the final solution and a joint solution would be explored to ensure costs were kept to a minimum.

Quality Priorities

Rob Chidlow gave a verbal update regarding the quality priorities for next year. HUTH to bring into scope end of life and deteriorating patients and align these across the Group. The group setting to be formalised to allow the committees to see what these priorities were.

ACTION 008/24: Rob Chidlow - Quality priorities formal paper to be brought to the March meeting.

Sue Liburd queried if mortuary services were coping with the number of bereavements. Response was that they were.

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:

- Maternity triage overnight. The Trust has sustained achievement of the 95% performance KPI to see women in the required risk based times during the day in January and February 2024. However, the CIC was not assured over arrangements in place at night and further assurance was requested.
- CQC Maternity actions. The CIC wanted further assurance regarding how the completed actions would be sustained. It was agreed that regular updates would be received until the CIC was assured that the actions were embedded and being sustained.
- Mortality – The CIC is very concerned about the increasing SHMI (including #NOF and acute MI) and had expected to receive a report on how this would be addressed. No clear plan was presented, but an update will be presented in March 2024. Governance work streams are being developed and work was ongoing to review how mortality was triangulated and reported.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Quality and Safety CiC meeting:

Thursday 28th March, at 09:00 to12:30, in Main Boardroom, DPOW

Cumulative Record of Attendance 2024

Core Members					
Una Macleod	UM	Non Executive Director (HUTH)			
Sue Liburd	SL	Non Executive Director (NLAG)			
Ashok Pathak	AP	Non Executive Director (HUTH)			
Kate Truscott	KT	Non Executive Director (NLAG)			
Tony Curry	TC	Non Executive Director (HUTH)			
Kate Wood	KC	Group Chief Medical Officer			
Shaun Stacey	SS	Group Chief Delivery Officer			
Vacant		Group Chief Nurse Officer			
In Attendance					
Rob Chidlow	RC	Interim Group Director of Quality Governance			
Vacant		Group Director of Assurance			
		ICB Observer			
Marie Stern	MS	Patient Representation (HUTH)			

Attended	Apologies / Deputy sent	Apologies

QUALITY & SAFETY COMMITTEES-IN-COMMON EXTRAORDINARY MEETING

Minutes of the meeting held on Friday 19th January 2024 at 11:00 to 12:30

Via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director NLaG **(Chair of the meeting)**
Tony Curry	Non-Executive Director HUTH
Ashok Pathak	Non-Executive Director HUTH
Dr Kate Wood	Group Chief Medical Officer

In Attendance:

Robert Chidlow	Interim Group Director of Quality Governance
Richard Dickinson	Associate Director of Quality Governance NLAG
Nicky Foster	Associate Chief Nurse Midwifery, Gynaecology and Breast Services NLAG
Stuart Hall	Vice Chair HUTH
Jenny Hinchliffe	Deputy Chief Nurse NLAG
Jonathan Lofthouse	Group Chief Executive Officer
Pete Sedman	Group Deputy Chief Medical Officer
Rebecca Thompson	Head of Corporate Affairs
Julia Chambers	Lead Midwife HUTH
Joanne Ledger	Interim Chief Nurse HUTH
Mich Green	PA to the Group Chief Medical Officer **(notes)**

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting.

Dr Kate Wood informed the Committee that this meeting had been convened as the CNST submissions must be completed and signed off by Group Board by the beginning of February. An extraordinary Group Board meeting is scheduled for 23rd January to allow fulfillment of statutory responsibilities. The submission is required to be reviewed and scrutinised by the Quality and Safety Committee prior to presentation at Board. Maternity Teams from HUTH and NLaG were in

attendance to present their progress against CNST standards and highlight areas of compliance and noncompliance.

For information, in year 4, in this region, CNST submissions 12 out of 21 Trusts declared 10 out of 10 of which included NLaG and HUTH. The average score was 8.5 out of 10, but this will have reduced due to Trusts having to remeasure.

It was noted that NLaG have been in the Maternity Support Programme for 2 years so have had intense scrutiny on CNST submission.

The following apologies for absence were noted:

Una Macleod, Kate Truscott, Wendy Booth, Lorraine Cooper, Linda Jackson, Shaun Stacey

1.2 **Declarations of Interest**

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

1.3 **NLAG CNST Presentation** – Nicky Foster (Associate Chief Nurse Midwifery)

Nicky Foster took the group through the presentation. It was noted NHS Resolution is in year 5 of the CNST Maternity Incentive Scheme (CNST MIS) to support the delivery of safer maternity care. Trusts demonstrating achievement of all 10 safety actions will recover the element of their contribution to CNST MIS funds. Trusts not achieving will not recover their contribution but may be eligible for a small discretionary payment from the scheme.

A Board declaration form must be submitted to NHS Resolution by noon 1st February 2024. All 10 safety actions must be achieved. A declarations form must be signed off by the Trust Chief Executive Officer who must attest that the Board of Directors are satisfied with the completion of evidence. There must be no reports covering 2021 to 2023 financial years that conflict with the declaration. These reports are to be brought to the MIS teams attention prior to 1st February 2024. The form must be countersigned by an ICB accountable officer.

Safety Action 1 - Compliant. There is appropriate evidence.

Safety Action 2 – Compliant. There is appropriate evidence.

Safety Action 3 – Compliant. There is appropriate evidence.

Safety Action 4 - Compliant. There is appropriate evidence.

Safety Action 5 – Compliant. There is appropriate evidence.

Safety Action 6 – Compliant. There is appropriate evidence.

Safety Action 7 - Compliant. There is appropriate evidence.

Safety Action 8 – Compliant. There is appropriate evidence.

Safety Action 9 – Compliant. There is appropriate evidence.

Safety Action 10 – Compliant. There is appropriate evidence.

Points for additional consideration include: in safety action 1, one case was non-compliant due to the case not being closed on the system within the specified time. MBRRACE and NHSR have stated that mitigating circumstances will be taken into consideration and further details are included within the safety action summary. Another case was where a mother was booked in another Trust. Their surveillance wasn't input antenatally into the system within the timeframe meaning this was classed as non-compliant for NLaG because she delivered in our area. CNST guidance states where cases have been assigned to another Trust with shared care and deadlines have been breached, circumstances will be taken into consideration.

Shortfalls/deficiencies have been identified for safety action 4, but the Trust can declare compliance due to action plans in place.

Both internal and external assurance was given to the group.

NLaG are submitting compliance for all 10 safety actions.

Dr Kate Wood noted that safety action 1 where 93% was achieved against a expectation of 95%, there is documentary evidence to support discussions with MBRRACE articulating we specify to the Board what happened, and mitigating actions in place. Safety action 4 has action plans in place to support. This is allowable under CNST. Scrutiny on the 10 CNST standards has not had the similar level of external scrutiny currently that has happened with HUTH but will be overseen externally through a meeting which is in the diary for next Friday with the LMNS and ICB.

Sue Liburd invited questions for scrutiny.

Ashok Pathak queried if the medical and midwifery workforce are long term locums or locums on a frequent regular basis? Response was there is minimum use of locums. The right checks need to be in place for them to be suitable and safe to work within the service. In obstetrics there were 5 locums used over the course of the year. A report was produced and was able to triangulate names against induction as stipulated through the Standard Operating Procedure (SOP).

Sue Liburd queried about the birthing parent out of region and how far out of the 2 months timeframe were we? Additionally, is this a common occurrence? Response was it does happen occasionally but is out of our control as it is another Trust. CNST guidance is very clear where it has been assigned to another Trust and deadlines have been breached, there is some mitigation for the Trust. We were not far outside of the 2 months' timeframe.

Tony Curry observed it was helpful to get a summary of assurance steps.

The group agreed for NLaG to declare compliance and take it to the Trust Board for sign off.

1.4 **HUTH CNST Presentation** – Julia Chambers (Lead Midwife)

Julia Chambers took the Committee through the presentation and asked for the evidence to be scrutinised ahead of the submission to the Group Board on 23rd January 2024. HUTH are proposing compliance with 5 out of 10 CNST standards.

The CNST Maternity Incentive Scheme (CNST MIS), details of the 10 safety actions were summarised and details of the maternity premium was presented. Eligibility for a small discretionary payment was further detailed.

All 10 safety actions evidencing has a deadline of 7th December 2023 with a Board declaration by noon on 1st February 2024. This must be signed and dated by the CEO after authorisation by the Board of Directors.

Assurance was given from external validation points for the CNST including MBRRACE-UK data and NHS England & Improvement around the MSS data set, National Neonatal Research Database and HSIB. Trust submissions are checked by the CQC during visits within that time period and are cross referenced. All supporting evidence is available on the maternity Y drive and is available for the Executive Team to review.

A significant review of evidence for all 10 safety actions was completed with external input from Lesley Heelbeck (MIA), Mike Wright, Heather McNair (ICB). This gives an overall non-compliance for CNST year 5.

Safety Action 1 – Compliant. There is appropriate evidence.

Safety Action 2 – Compliant. There is appropriate evidence.

Safety Action 3 – Compliant. There is appropriate evidence.

Safety Action 4 – Non-Compliant. This is due to audit and the presentation of audit results to the required Boards. Short term OBS and Gynae locum doctors and organisations need to audit their compliance against this process. HUTH have a registered audit with these plans, and it has been undertaken, however the results have not yet been published or reviewed through governance forums. Another audit regarding the compliance against the standards for the attendance of consultant obstetricians within their roles and responsibilities has been undertaken but the results haven't been published or reviewed through governance forums.

Safety Action 5 – Compliant. There is appropriate evidence.

Safety Action 6 – Non-Compliant. A new saving babies lives version 3 came out in June 2023. There is a new National implementation tool to help track compliance. The requirement is to meet 70% overall for all 6 standards with 50% in each standard. This target has not been met. An action plan is in place which is also reviewed externally which is predominantly audit evidence. There is a task and finish group to focus on this.

Safety Action 7 – Compliant. There is appropriate evidence in our folder.

Safety Action 8 – Non-Compliant. There are no minutes recording the Trust Board sign off for the maternity training plan. There is no evidence that training has been co-produced with service users. There is no evidence for achieving training percentages. Concerns have been raised throughout the year with staffing in the unit and having to pull staff from training to support the clinical workforce. An action plan is in place to get this to 90% for year 6.

Safety Action 9 – Non-Compliant. There is no evidence the Trust Claims scorecard has been presented to Trust Board.

Safety Action 10 – Non-Compliant. This is due to no evidence to Trust Board. There is, however, external assurance.

Sue Liburd invited comment and questions for scrutiny.

Richard Dickinson queried about the scheme that exists with NHSR and the potential to get funding to support change. If there is non-compliance funding can be applied for. Response was there is an action plan which has been put into the rosters. Staffing levels are now improving after a recruitment drive including returning staff. There was an issue with the year 4 submission which has had to be re-submitted resulting in additional posting.

Ashok Pathak queried what the total amount paid in this premium is and how much are we losing? Ashok Pathak queried if we are on target to achieve full compliance? Ashok Pathak queried how do we compare in compliance with others? Ashok Pathak queried if there was any way that the lack of trainees or having to take them out of training sessions can be improved? Ashok Pathak queried if neonatologist have specific areas of coverage for diabetes or if they cover all neonatal ailments? Ashok Pathak queried how soon are we expected to reach the targets for neonatal safety and quality?

Response was a CQC inspection triggered a recap of the year 4 submission and there is an on-going review of our declarations for year 3. This was due to things not coming to Board. The year 5 submission shows actions are being picked up. The CNST training requirements for the year were reduced from 90% to 80% towards the end of the year, but due to staffing levels at HUTH it still was not possible to meet this lower threshold late in the year. Training non-compliance has been escalated to HUTH Board throughout the year. The money at risk that the Trust will have to hand back is £609,449. Year 4 was £550k plus an additional allocation of £350k. The £350k was due to others not being compliant in years 3 and 4. A plan is being prepared to ensure all details that haven't been to Board or Safety & Quality Committees in Common for year 6 are picked up early. There is more staffing in place now giving a robustness of day to day staffing ensuring people can undertake their training. From 31st December 2023 we are carrying 2 midwifery vacancies. The issue is 10 international midwives that are not included in the numbers. There is also a high level of maternity leave. Staffing levels are based on the 2021 birth-rate plus review. A refresh has been done and will come back to Board as part of the bi-annual establishment review. This also doesn't include the ADU and triage model. It was clarified that diabetes is not neonatal diabetes but diabetes in the pregnant woman which is the new standard into saving babies lives version 3. We have a specific clinic dedicated to diabetes, but it

doesn't have all of the required personnel within it. The task and finish group are working to get the team together and ensuring all evidence is given. The perinatal report has been done for a number of years now. This has been updated to ensure it gives the right learning and evidence and is presented locally and within the LMNS. This is going through the governance process and will be incorporated in the report to Trust Board.

Ashok Pathak asked that presentations be sent prior to the meeting. It was noted that this is an extraordinary meeting, called at short notice. Ordinarily papers would arrive in a more timely manner. The group were assured that following this meeting the papers for the Board meeting will go out giving additional time for scrutiny and further questions.

Stuart Hall noted the database collects all evidence and queried how comfortable are we in relation to the robustness of that evidence? Response was we are incredibly comfortable. Lengthy debates have taken place looking at the data and technical guidance which is why it has been pulled out that evidence isn't there to demonstrate the Board has had assurance even though the information is there. The process has provided an external challenge along with an internal challenge.

Stuart Hall queried where the detailed action plan is and who is it going to be published to? Response was in the past there hasn't been a proactive robustness knowing which are the appropriate meetings for papers to go to.

Stuart Hall queried where the header sheet for submission states 'there are no reports covering either year 22/23 or 23/24 that relate to provision and maternity services that may subsequently provide conflicting information to the declaration', are all points covered off? Response was we need to document for NLaG that we are not aware there is anything that contradicts it. It was felt there aren't any further reports from the wider stakeholders that would contradict 5 out of 10 declarations for HUTH. Rob Chidlow queried if there are any other reports in situ or inspections that might contradict it, and it was confirmed there weren't.

Tony Curry queried how much internal and external peer review is available and how much are we using to get that assurance about submission? Response was towards the end of the cycle there has been comparison of processes and evidence internally. Externally we have Mike Wright who is working with other maternity departments, some quite challenged and the ICB. Additionally, the LMNS also have to give assurance over the CNST review and they see York, Scarborough, NLaG and HUTH.

In summary:
The Committee agreed this item had a good level of scrutiny which will be summarised in the highlight report to go to Board.

The CiC was satisfied that the evidence provided demonstrates achievement of 10/10 maternity standards for NLaG.

The CiC was satisfied that the evidence provided demonstrates achievement of 5/10 maternity standards for HUTH.

1.5 **AOB**

None.

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NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)071

Name of the Meeting	Trust Boards-in-Common	
Date of the Meeting	11 April 2024	
Director Lead	Mike Robson and Gill Ponder, Non-Executive Directors (Chairs)	
Contact Officer/Author	Mike Robson and Gill Ponder, Non-Executive Directors (Chairs)	
Title of the Report	Minutes of the Performance, Estates and Finance Committees-in-Common meetings held in January and February 2024	
Executive Summary	The minutes attached are the formal account of the meetings of the Performance, Estates and Finance Committees-in-Common from 24 January and 28 February 2024. The minutes include any actions and resolutions made	
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common Terms of Reference for HUTH and NLaG.	
Prior Approval Process	Approval at the February and March Performance, Estates and Finance Committees-in-Common meetings	
Financial implication(s) (if applicable)	N/a	
Implications for equality, diversity and inclusion, including health inequalities	N/a	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 24th January 2024 at 0930 to 1300 via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG - Chair)
Lee Bond	Group Chief Financial Officer
Jane Hawkard	Non-Executive Director (HUTH)
Simon Parkes	Non-Executive Director (NLAG)
Mike Robson	Non-Executive Director (HUTH)
Shaun Stacey	Group Chief Delivery Officer

In Attendance:

Adam Creeggan	Interim Director of Performance
Alison Drury	Deputy Director of Finance (HUTH)
Stephen Evans	Operational Director of Finance
Caroline Hibbert	Site Medical Director (HUTH)
Alison Hurley	Assistant Trust Secretary
Jonathan Lofthouse	Group Chief Executive
Brian Shipley	Deputy Director of Finance (NLaG)
Sally-Ann Campbell	Personal Assistant (Minutes)

Observers

Stuart Hall	Vice-Chair (HUTH)
Ian Reekie	Lead Governor (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair welcomed those present to the meeting. The following apologies for absence were noted:

Ivan McConnell, Group Chief Strategy and Partnerships Officer (represented by Adam Creeggan), Kate Wood, Group Chief Medical Officer (represented by Caroline Hibbert).

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 18th December 2023 (HUTH) and 20th December 2023 (NLAG)**

The minutes of the meetings held on the 18th and 20th December 2023 were accepted as a true and accurate record subject to the following amendment:

> Jane Hawkard did not attend the meeting on the 18 December 2023 and was removed from the attendance list.

1.4 **Matters Arising**

No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

5.3 NLaG – Workplan - 24 May 2023 – following a discussion it was agreed that the process for revenue investments would be brought to the Committees in February.
7.1 NLaG – Unplanned Care - 23 August 2023 – it was confirmed that there were no trends – now closed
8.5 NLaG – Business Planning Timetable – 18 October 2023 – this item was on the agenda – now closed
6.1 NLaG – Finance – 18 October 2023 – this action would be discussed at Audit Committee – now closed
5.1.2 NLaG – CQC report – 22 November 2023 – updates had been received – now closed
7.1 HUTH – 7.11 Part 1 - Industrial action to be financially reconciled is included in the Financial Report on the agenda – now closed.
– 7.11 Part 2 – vacant posts information will be addressed at the February PEF CiC meeting as planned
6.1 HUTH – Performance Report – 27 November 2023 - covered in the Performance Report – now closed
4 HUTH – Action Tracker – Cancer trajectories – 27 November 2023 - covered on the agenda – now closed
3 HUTH – Minutes – 27 November 2023 - all reports on the agenda – now closed
6.2 HUTH – Ground Floor Model – 27 November 2023 – covered on the agenda – now closed
8.2 HUTH – Board Assurance Framework – 18 December 2023 – Risk 7.1 Finance Risk – the BAF was covered on the agenda and this item will be specifically addressed at the February 2024 meeting
6.2 HUTH – Screening Update – 18 December 2023 – confirmation had been received that there were no additional costs – now closed
11 NLaG – AOB – 20 December 2023 – paper would be brought to the meeting in February
8.4.3 NLaG – Corporate Benchmarking – 20 December 2023 - paper to be addressed at the February meeting, including actions 8.4.2 and

8.4.1 below
8.4.2 NLaG – Corporate Benchmarking – 20 December 2023 - now closed
8.4.1 NLaG – Corporate Benchmarking – 20 December 2023 - now closed
8.3 NLaG – Procurement – 20 December 2023 – now closed
8.1.2 NLaG – Finance Report – 20 December 2023 – covered in the Financial Report on the agenda – now closed
8.1.1 NLaG – Finance Report – 20 December 2023 – work in progress carried forward to the February meeting
7.3.2 NLaG – PCIP/Cancer Deep Dive – 20 December 2023 – application for funding had been made – now closed
7.3.1 NLaG – PCIP/Cancer Deep Dive – 20 December 2023 – ongoing issue to be addressed by Lee Bond/Shaun Stacey – now closed
7.2.2 NLaG – Planned Care – 20 December 2023 – equipment had been identified and costs received for the equipment that was needed. The Equipment Committee would consider relative priority. Now closed
7.2.1 NLaG – Planned Care – 20 December 2023 - included in the Integrated Performance Report (IPR) – now closed
7.1 NLaG – Unplanned Care – 20 December 2023 – carried forward to the next meeting
6.1.3 NLaG – LV/HV – 20 December 2023 – unable to apply for funding to continue the work on the boreholes as none was available – now closed
6.1.2 NLaG – LV/HV - 20 December 2023 – to be considered at Risk and Assurance Committee – now closed
6.1.1 NLaG – LV/HV – 20 December 2023 – the risk register had been updated – now closed
5.1 NLaG – CQC Report – 20 December 2023 – item on the agenda – now closed.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The Chair reported that no items had been referred for consideration at present to the PEF CiC.

A discussion took place around the process for managing referrals into the CiC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

The Assistant Trust Secretary (NLaG) advised that the BAF for HUTH had been shared in the December 2023 round of Committees where all of the strategic risks had been reviewed following the Group Cabinet Risk and Assurance Committee. There had not been any proposed changes to the Performance, Estates and Finance risk ratings.

The Performance, Estates and Finance elements of the BAF for NLaG was shared with the Committees with the following recommendations to:

- Receive and review the NLaG BAF

- Challenge or endorse the proposal to reduce the risk rating of SO 3.1 from 20 to 16
- Note that, as part of the development of the group model, work would be undertaken in due course to align the strategic objectives of the two Trusts and, in turn, produce a Group BAF.

The Assistant Trust Secretary confirmed that the new BAF format would be utilised from April 2024.

CiC Decision: The NLaG recommendations were approved.

***NLaG ACTION** – Inform the approval of the change of risk rating NLaG SO 3.1 from 20 to 16 to the Trust Boards-in-Common meeting.*

3.2 **Risk Register Report**

The Chair advised that as the Risk Register Report had not yet been to the Risk & Assurance Group meeting (due in early February), it was not yet available for review at this meeting. Going forward, the Risk Register would be on the agenda for the PEF CiC meeting following each review by the Risk & Assurance Group.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports & recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendation(s) & Assurance(s)**

There were no external reports, recommendations or assurances to note.

3.4.1 **CQC action report (NLaG)**

In the absence of the Acting Head of Compliance and Assurance, the CiC Chair took the report as read and noted the key points from the report as noted below:

Summary and Progress:

- No changes to ratings for those actions linked to this committee
- Actions rated full assurance increased to 28 from last month's figure of 23 and 23 of these actions have been fully closed
- There remains zero actions with a 'no assurance' rating
- The number of actions with a 'limited rated assurance' rating remained at 22
- Two actions have been added to the action plan from 2019 to provide further assurance
- Two actions 2022-MED11a and 2022-MED11b have been merged with 2022-MED10c.1 and 2022-MED10c.2 which related to qualifications and competency of staff.

Risks to delivery:

- Lack of capacity within corporate and clinical divisions
- Identifying recurrent funding for the financial cost of implementation for some funded actions
- A number of actions have passed the initial timescale for completion and have revised due dates (some are due to widening the scope of the

actions).

The CiC Chair raised concerns about the level of investment at NLaG being a potential constraint in delivering against the required NLaG CQC actions. The Chief Financial Officer agreed to investigate and feedback.

A discussion ensued around the split of responsibilities for CQC actions between the PEF CiC and the Quality and Safety CiC.

NLAG ACTIONS:

- *The Chief Financial Officer to investigate a potential lack of investment for currently non-funded CQC actions and feedback to the PEF CiC*
- *The Chief Financial Officer and Site Medical Director to review the appropriate CiC for each of the CQC actions and update the Group Chief Medical Director and the CiC and provide feedback*
- *The PEF CiC workplan to be updated in relation to the NLaG CQC actions as required once clarified by the Chief Financial Officer and Site Medical Director.*

Simon Parkes arrived at 10:18 hours.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Annual Plan (first draft)

The Interim Director of Performance presented the first draft of the Annual Plan to the CiC and highlighted the main principles of the report.

The Chair expressed the CiC's thanks for the work undertaken in producing the report which was well received by the Committee.

The CiC Chair queried whether a plan was in place to submit the annual plan to the required deadline given the central guidance was not yet available. The Interim Director of Performance advised that the dynamic timescale and potential short notice once the guidance became available may cause short notice requests for final amendments and ratification.

4.2 Financial Report – Month 9

The Group Chief Financial Officer presented the individual reports for Month 9 2023/24 position of the Group, HUTH and NLaG. The planned amalgamation of these documents for the next CiC meeting was noted.

Following an in-depth discussion the CiC noted the following key points for escalation to the Boards-in-Common meeting:

- The in-month position for month 9 was identified as £1.6m deficit which is £2.1m adverse to plan. It was noted that the adverse variance was solely due to the industrial action during December and January.

- The Group reported a year-to-date (YTD) deficit of £20.5m which is £1.5m better than plan. The year end forecast is £22.9m, £2.3m adverse to plan due

to costs of industrial action in December and early January. This position may deteriorate further if industrial action continues in February and March 2024. It was also essential that annual leave was not carried forward into 2024/25 as no accrual had been assumed in the year end forecast position.

- Cash support would no longer be needed by NLAG in 2023/24, but current forecasts suggested a requirement in early Q1 of 2024/25.

- There was a risk that NLAG Capital would be underspent at year end due to delays with the Community Diagnostic Centres. Items included within the 2024/25 plan were being brought forward to free up the extra capital that will now be needed for the CDC's in 2024/25 to mitigate the risk.

4.3 Integrated Performance Report

The integrated performance reports for both NLaG and HUTH were received by the CiC and key details were highlighted by the Group Chief Delivery Officer and the Interim Director of Performance. It was anticipated that an integrated report would be available for the meeting of the CiC in April and a Group narrative would be added.

The CiC held a discussion and the following areas were highlighted as areas where improvement was required:

- Urgent Care performance – Emergency Department (ED) and Ambulance handovers
- Cancer performance
- Recovery of elective activity
- Improving treatment times for long waiting patients
- Reducing the delays in people leaving the acute setting

4.3.1 Update on Cancer Improvement Trajectories

The Group Chief Delivery Officer presented the report to the CiC and outlined the key highlights for both HUTH and NLaG. The information presented was based on data submitted for November and the forecast for December 2023.

The topics covered included the following as captured in the report:

- Key highlights for HUTH
- Key highlights for NLaG
- Commonality across HUTH and NLaG
- Performance against metrics and improvement trajectories.

A request was made to link cancer initiatives to the performance improvement trajectories to enable the Committees to see when performance was expected to improve and to gain assurance that the initiatives were on track and delivering the planned benefits to patient waiting times.

***CiC ACTION** – To link cancer initiatives to planned improvements in performance to provide assurance that initiatives were on track to deliver improvements to patient waiting times.*

4.4 **Estates and Facilities – Security Update**

The Group Chief Financial Officer confirmed that this report had been to the NLaG and HUTH Board meetings and was utilised for the associated workplan.

CiC members were asked to consider future requirements for the PEF CiC. It was agreed to provide an amalgamated Estates and Facilities report in future supplemented by required annual reports for items such as Security and the workplan would be updated accordingly.

CiC Action – to provide an amalgamated Estates and Facilities report in future supplemented by required annual reports.

4.5 **Contract Approvals**

4.5.1 **Provision of Outpatient Pharmacy Dispensing Services - NLaG**

The report detailed the tender exercise process for the provision of outpatient pharmacy dispensing services for NLaG as referred to by Group Chief Financial Officer and sought approval to award the contract to the preferred supplier. The CiC considered the report which addressed the slight increase in costs, whilst noting the plan to align the end date of this contract in line with the HUTH contract and amalgamate the two services into one contract in future.

CiC Decision - The PEF CiC approved the renewal of the NLaG contract and amalgamation of future contracts.

4.5.2 **Provision of Total Healthcare Waste Management Services - HUTH**

The Group Chief Financial Officer provided an overview of the contract renewal for the Total Healthcare Waste Management Services with the plan to align all contracts across the Group in future. The extension was requested for 18 months until a full tendering exercise would be undertaken for all sites.

Following discussions about the increase in costs, the CIC noted the plan to extend the contract to coincide with the end of the NLaG contract enabling a future joint NLaG and HUTH contract.

CiC Decision - The PEF CiC approved the renewal of the HUTH contract and the amalgamation of a future contract.

4.5.3 **Master Vendor Contract**

The Holt Master Vendor contract was deferred to the February meeting of this committee.

***CiC ACTION** - Add the Holt Master Vendor contract to the February PEF CiC agenda.*

4.6 **Emerging Issues**

None were identified.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 Performance, Estates and Finance (PEF) CiC Terms of Reference

The CiC terms of reference had been signed off by the Board and were subsequently adopted by the CiC.

5.2 Work Plan for PEF CiC

The plan was received and agreed with one minor change to the plan for the deep dive subjects.

5.3 Capital Investment Board Minutes

The minutes were taken as read.

5.4 Performance Review & Improvement meetings (PRIMS) minutes

The minutes were taken as read. It was agreed that HUTH would produce PRIMs minutes and a standard approach would be adopted across both NLaG and HUTH.

***HUTH ACTION** - to request HUTH PRIMS meetings produce minutes in future and submit them to the PEF CiC.*

6. ANY OTHER URGENT BUSINESS

No items of any other business were raised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

There were no matters for referral to any of the other Board Committees.

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Boards-in-common meeting in the PEF CiC highlight report:

- BAF update - Risk rating change for NLaG SO3.1
- Performance
- Cancer concerns
- Ambulance handover Times
- Contract approvals
- Finance and capital position.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the new Performance Estates and Finance CiC meeting:

Wednesday, 28 February 2024 at 09:00 hours

Board Room, Alderson House, Hull Royal Infirmary

The CiC Chair thanked everyone for their attendance and contributions and requested feedback on the effectiveness of the inaugural meeting of the PEF CiC within the meeting, by a phone call or e-mail. It was confirmed that the CiC Review would then be completed and submitted as part of the review of the CiC pilot period (being January to March 2024).

The meeting closed at 12:50 hours.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y											
Mike Robson	Chair / NED (HUTH)	Y											
Lee Bond	Group Chief Financial Officer	Y											
Jane Hawkard	NED (HUTH)	Y											
Simon Parkes	NED (NLaG)	Y											
Shaun Stacey	Group Chief Delivery Officer	Y											
Kate Wood	Group Chief Medical Officer	D											
REQUIRED ATTENDEES													
	Group Director of Estates	D											
	Group Digital Information Officer	N											
VACANT	Group Director of Assurance or deputy	D											
Alison Drury (HUTH) Brian Shipley (NLaG)	Deputy Director of Finance	Y Y											
Stephen Evans (HUTH)	Operational Director of Finance	Y											
Ian Reekie (NLaG)	Governor Observer (NLaG)	Y											

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

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Northern Lincolnshire and Goole
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PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 28th February 2024 at 0900 to 1230 in the Boardroom, Alderson House, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Mike Robson	Non-Executive Director (HUTH - Chair)
Gill Ponder	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Simon Parkes	Non-Executive Director (NLAG)
Shaun Stacey	Group Chief Delivery Officer

In Attendance:

Adam Creeggan	Group Director of Performance
Stephen Evans	Operational Director of Finance (HUTH)
Craig Hodgson	Interim Group Deputy Director of Commercial and Facilities Services (NLaG)
Alison Hurley	Assistant Trust Secretary (NLaG)
Linda Jackson	Vice-Chair (NLaG)
Jonathan Lofthouse	Group Chief Executive
Brian Shipley	Operational Director of Finance (NLaG)
Dr Kate Wood	Group Chief Medical Officer
Sally-Ann Campbell	Personal Assistant (Minutes)

Observers

Ian Reekie	Lead Governor (NLaG)
Rob Stones	Director of Elective Recovery, NHS England

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Mike Robson, welcomed those present to the meeting. The following apologies for absence were noted:

Ivan McConnell, Group Chief Strategy and Partnerships Officer (represented by Adam Creeggan), Lee Bond, Group Chief Financial Officer (represented by Stephen Evans (Finance), Brian Shipley (Finance) and Craig Hodgson (Estates)).

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 24th January 2024**

The minutes of the meeting held on the 24th January 2024 were accepted as a true and accurate record with the following amendments:

To consistently note vacancies on the cumulative attendance list for all Group Director posts that had not been filled.

A query regarding the attendance of Brian Shipley at the meeting was raised, and it was later confirmed that he had attended.

1.4 **Matters Arising**

No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

3.4.1(NLaG) – CQC action report (NLaG) – 24 January 2024 – it was confirmed that the CQC report would be considered at each Committee but in future the report would be broken down into sections specific to each Committee. Going forward only actions relating to Performance would be brought to these Committees. It was noted that there are a number of financial constraints and a report would be presented at the March meeting of the Committees to address this

3.4.1 (NLaG) – CQC action report (NLaG) -24 January 2024 - as above

3.4.1 (NLaG) – CQC action report (NLaG) – 24 January 2024 - the PEF CiC would be updated on progress of the actions and the funding streams would be identified or mitigating circumstances would be identified.

4.3.1 (Group) – Update on Cancer Improvement Trajectories – 24 January 2024 – Adam Creeggan informed the Committees that actions taken would be mapped through to any improvements in methodology and performance with a report presented to the Humber and North Yorkshire Cancer Alliance Board the following week. A report would then be brought back to the PEF CiC. Jonathan Lofthouse informed the Committees that a range of funding had been received for 2023/2024 for this area of work, with recent approval gained to roll forward any unspent funds to the next financial year. An investment profile would be brought to these Committees.

4.4 (Group) – Estates and Facilities – Security Update – 24 January 2024 - a report was included on the agenda for this meeting under item number 4.4.

4.5.3 (NLaG) – Master Vendor Contract – 24 January 2024 - this item was removed from the agenda.

5.4 (HUTH) – HUTH Performance Review Improvement Meetings (PRIMs) – 24 January 2024 - the PRIMs Meetings had not taken place since the formation of the CiCs. A new group format for these meetings would be established and updates would be provided for these Committees.

7.1 (NLaG) – Unplanned Care – 20 December 2023 – it was confirmed that a review had been undertaken by Lee Bond which would be presented to the Group Cabinet. Once it had been considered by them the report would be presented at the next meeting of these Committees. This item will therefore be carried forward to the next meeting.

8.1.1 (NLaG) – Finance Report – 20 December 2023 – Lee Bond had reviewed the process for engaging locum doctors. The standard procedure for locums engaged for a long-term period was to initially offer them Trust terms and conditions. A number of long-term locum doctors had declined to be on the Trust payroll. This item can now be closed.

8.4.3 (NLaG) – Corporate Benchmarking – 20 December 2023 - this item was deferred to the meeting in March.

11 (NLaG) – Any Other Business – Holt Master Vendor contract – 20 December 2023 - this item was no longer being considered by these Committees and the item would be closed.

8.2 (HUTH) – Board Assurance Framework – 18 December 2023 – this was now a standing agenda item and was closed.

7.1 (NLaG) – Minutes – Vacant posts over six months - 27 November 2023 - a review of unfilled posts had been undertaken and had been presented to the Group Cabinet meeting in early February. The report would be updated and re-issued to the Care Groups during April. This would then be built into the 2024/25 planning process and considered again at the PEF CiC March meeting.

5.3 (NLaG) – Workplan – 24 May 2023 - this item was on the agenda and therefore closed.

Simon Parkes arrived at the meeting at 09:20

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Mike Robson reported that no items had been referred for consideration at present to the PEF CiC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

Alison Hurley advised the Committees that the BAF reports had been updated to the new Group format and further updates would be made ahead of the next iteration. Both sets of Internal Auditors have reviewed the new format and supported it. It was confirmed that once the Group Values were confirmed, and the Group strategic objectives established and aligned, the Group strategic risks would be captured and would drive the new Group BAF.

The reports would also be reviewed by the Boards in Common at the Board Development session in March 2024.

The HUTH BAF Risk 7.1 (in year financial target) had been reviewed with a view to reduce it if the Trust was forecasting achievement of the target. The risk had consequently been reduced to 8. The Committee questioned why the reduction had not been mirrored at NLaG and suggested that it should be reviewed and mirrored across the Group.

Following a discussion it was agreed to review the digital BAF risk score, and to also review and align the BAF risk rating for estates and facilities across HUTH and NLaG (risk 1.4 on the NLaG BAF with a risk rating of 20 and risk 7.3 on the HUTH BAF with a risk rating 10, reduced from 15) and report back to these Committees.

Updates on the Patient Administration System (PAS) implementation at NLAG were provided by Dr Kate Wood, Shaun Stacey and Adam Creeggan, and the Committees noted their thanks to the digital team and for the effective teamwork of the patient administration team and other staff involved across the Group in the transition to the Lorenzo PAS. Significant assurance was noted for the initial stages of this successful PAS implementation which utilised an effective business planning approach and minimised any operational impact.

ACTION – *to review the BAF in year financial risk score, the digital risk score, and the risk rating for estates and facilities for a consistent approach across the Group.*

3.2 **Risk Register Report**

Mike Robson informed the Committees that an extract from the Risk Register Report based on the Group model would be reported to the next meeting of PEF CiC.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports & recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendation(s) & Assurances(s)**

There were no external reports, recommendations or assurances to note.

The agenda was taken out of order at this point.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Annual Plan - Update**

Adam Creeggan presented the updated Annual Plan to the CiC and advised that national guidance was still awaited. The report summarised the Operational

Planning process for 2024/25 and key planning assumptions based on indicative guidance that had been issued to date. The plan detailed planned activity volumes by type against 2023/24 forecast outturn, noting that this is subject to further development prior to formal submission.

Various queries were raised including queries around the trajectory levels and the following points were clarified:

- Urgent Emergency Care 4 hour target will increase from 76% by March 2024 to 77% by March 2025
- Category 2 ambulance response times are to average no more than 30 minutes across 2024/25. This target has a 90% compliance rate, therefore an average would reflect a softening of expectation
- Zero 65 week waiters to be delivered as soon as possible or by September 2024 at the latest
- Cancer 62 day performance rates require improvement (not target specified), and the target is 77% for the 28 day Faster Diagnosis Standard to be achieved by March 2025
- Peak capacity is to be maintained in 2024/25 with an assumption that 2023/24 funding would be recurrent.

CiC members raised concerns about the activity levels, the targets set and noted the need to realise the difficulties with the activity ambitions, especially in light of the delayed national guidance. The need to address the context of broader activity levels with the developing integrated financial plan was agreed, together with the associated workforce plan required to deliver such activity levels.

3.4.1 **CQC action report - Group**

Dr Kate Wood presented the report and noted that the ratings for HUTH and NLaG were different and full alignment across the Group was required together with transformational change. It was also noted that the actions for NLaG were performance related with appropriate recording and reporting and HUTH actions would be progressed in a similar way.

End of Life data was highlighted as an area where robust data collection was still required, and work was underway to address this.

It was confirmed that once the Group Chief Nurse had commenced in role, the responsibility for the CQC action report would move to that portfolio of responsibilities.

Following a discussion, the Committees were assured that appropriate work was in progress to ensure a consistent Group approach in addressing the required CQC actions.

4.2 **Financial Report – Month 10**

The Operational Director of Finance (HUTH) presented the Group report for month 10 of 2023/24.

Following an in-depth discussion and appropriate challenge, the CiC noted the following key points:

- A year end deficit of £22.9m is forecasted for the Group, being £2.3m adverse of plan
- The £2.3m difference is due to the additional costs of the junior doctors industrial action in December 2023 and January 2024 and would otherwise have expected to deliver its planned deficit of £20.6m. The year end position may deteriorate further if industrial action continues in February and March 24
- Inconsistencies were noted in the Trust specific details in comparison to the Group position which was confirmed to be correct, which would be addressed in the next report.

Brian Shipley highlighted that the vacancy rate had reduced against the planning assumption although this was not evident in the year to date (YTD) position, it was visible in the monthly position. The was not reflected with medical staffing due to the recent industrial action. Gill Ponder requested that changes attributable to industrial action be noted, which was agreed. Gill Ponder confirmed that the Workforce, Education and Culture CiC were seeking assurance via a deep dive into the recruitment status of the medical workforce, and following concerns raised by the Committees over the consultant job planning and the potential impact this could have on the financial position of the Trusts, it was agreed to refer this matter to the Workforce, Education and Culture CiC.

There remain risks to delivering this financial position which require management such as:

- Unexpected Winter pressures
- High cost drug growth in final quarter
- Inflation awards in last quarter.
- Impact on PDC of reduced average cash balance.

Jane Hawkard queried current progress of the Cash Releasing Efficiency Savings (CRES) programme, and Adam Creeggan confirmed it was challenging with a current delivery of 89% against the plan. It was agreed that this required escalation to the Trust Boards-in-common.

The Operational Director of Finance informed members that funding was expected to be provided to cover the cost of the industrial action (being £2.5m). Additional funding may also be available from the Integrated Care Board (ICB) which would improve the Group's deficit forecast.

The use of locums was challenged at Goole District Hospital (GDH) and Shaun Stacey provided an update on the continued increase with overseas recruitment and general difficulties in recruiting to posts at GDH.

The financial position to date (in terms of the month 10 position of the financial year), provided reasonable assurance for the CiC, and the agency spend was also progressing in relation to expectations.

4.2.1 **Update on Process for Revenue Investments (NLaG)**

Brian Shipley presented the report and referred to a number of investment projects which had been undertaken during the financial year 2023/24 which included the following:

- Establish appropriate staffing levels and new patient pathways in the new Acute Assessment Units - £4.7m
- Expansion of the Emergency Departments - £2.8m
- International nurse recruitment - £0.1m
- Standardise and increase the opening hours of the Trust Discharge Lounges - £0.3m
- Extended workforce for pathology cancer standards - £0.3m
- Addressing quality, performance and capacity issues in Cellular Pathology - £0.3m
- Paediatric Diabetes Peer Review - £0.2m
- Increase the number of staff in the Medical Talent Acquisition Team - £0.07m
- Recruitment of a Vulnerabilities Nurse - £0.06m
- Additional administrative support for staffing of the commissioning for quality and innovation (CQUIN) - £0.05m
- Quality Improvement Facilitator post - £0.04m
- Additional Band 5 support for Occupational Health team - £0.4m
- Progression of Advanced Clinical Practitioner role to address attrition rates in the programme - £0.2m
- Implementation of the Lung Health Checks - £1.9m
- Tobacco Cessation Team support - £0.3m
- Provision of Alcohol Care Teams - £0.2m
- Support of Bed Capacity Schemes - £4.6m
- Support of Ockenden Schemes - £0.3m
- Cancer Alliance scheme support - £1.1m
- Recovery Support Funding (RSF) - £0.3m

The Committee thanked Brian Shipley for a well written and presented report and requested an update every six months.

Craig Hodgson arrived at the meeting at 11:20

4.3 **Integrated Performance Report – HUTH & NLaG**

Shaun Stacey presented the report and thanked Adam Creeggan and his team for producing it. An in-depth discussion took place and the following key points were noted:

- An Emergency Department 4 hour threshold target had been set at 76% to be achieved by the end of March 2024. The current position was noted at HUTH as 61.1% and 60.4% at NLaG
- There had been an improvement on the HUTH December position with regards to Ambulance handover delays which stand at 60+ minutes. Plans are being implemented to achieve a 45 minute handover as of March 2024
- HUTH's waiting list volume had remained fairly static whereas NLaG had continued to see growth in the waiting list
- The focus across the Group was the elimination of all waits over 65 weeks by the end of March 2024
- Slow improvement was evident for cancer referral times and more work is required to achieve a rate of 65% by the 31st March 2024

- Work was still needed to address the issue with the no criteria to reside (NCTR) patients, including engagement with community services to put procedures in place to enable NCTR patients to be discharged from hospital
- A new system had been developed to monitor empty beds and HUTH would trial this system and address the current manual data collection issue.

Gill Ponder raised a concern about how empty beds were filled as five patients being transferred at once into a ward at NLaG had created difficulties for staff and potential risks, which was identified on a 15 Steps Ward Review. Shaun Stacey advised that the risks were mitigated on how wards perform and noted the need to consistently apply the appropriate process.

Following a discussion, members confirmed reasonable assurance was gained with the performance metrics reported and progress made whilst noting that issues identified had appropriate mitigations in place with improved associated reporting.

Agenda item 4.4 was taken next.

Estates and Facilities – General Update

4.4

Craig Hodgson, the Interim Group Deputy Director of Commercial and Facilities Services (NLaG) presented the report and the following areas were addressed:

- Current progress of schemes to date at HUTH and NLaG
- Capital Development Programmes
- Estates and Compliance update
- Commercial and Facilities update.

Feedback was requested on the report. Gill Ponder requested the report be risk-focussed with clear links to the risk register. Jonathan Lofthouse informed the Committees that going forward clear guidance would be given on the content requirements of the Estates Reports to be brought before the CiC.

Simon Parkes requested a balanced score card approach, with key performance metrics established and details of key issues the CiC needs to be sighted on as opposed to great detail. Jonathan Lofthouse confirmed that fourteen statutory items of assessment had been identified for Estates and future reports should be built around these, as appropriate to this CiC.

Mike Robson thanked Craig Hodgson for the report and updates, which had been helpful.

Craig Hodgson left the meeting at 11:47

The meeting continued as per the order of the agenda.

4.3.1 **Deep Dive – Elective Care**

The report was presented by the Shaun Stacey who highlighted the following:

- Both Trusts had a trajectory of zero 78+ week waiters at 31 March 2024
- There had been seven breaches of the 78-week standard in January 2024 at NLaG and nine breaches at HUTH, which was primarily due to the PAS migration validation work.

CiC members acknowledged that some very good work had been undertaken to reduce the 78+ weeks to zero but this had been hindered by the Junior Doctors' Industrial Action.

Various concerns were raised about the clinical safety risk of approximately 37,000 unappointed patients who were not risk stratified at present (as only patients with an appointment are risk stratified). These appointed slot issues (ASI) are hopefully being mitigated by patients returning to their GPs if required. This was noted as a particular issue at HUTH. Dr Kate Wood agreed to investigate.

Action: *Dr Wood to investigate the clinical safety risk of unappointed patients not being risk stratified and the extent to which the risk was mitigated by patients returning to their GPs if their condition worsened.*

4.5 **Contract Approvals**

4.5.1 **Confidential Holt Master Vendor Contract – NLaG**

This item had been removed from the agenda.

4.5.2 **Linear Accelerator Lease Contract**

This contract had been discussed at the Boards-in-common meeting. The six linear accelerators at HUTH were 12 years old and had been identified on the risk register and the service could not be operated on fewer machines than were already in use. The contract for approval was for one machine on a lease agreement with an already identified budget. The Committees approved the contract.

4.6 **Emerging Issues**

None were identified.

5. ITEMS FOR INFORMATION

5.1 **Work Plan for PEF CiC**

Dr Kate Wood queried the responsibility for the Risk Register Report and suggested this was now the responsibility of the Group Director of Assurance, which will be confirmed.

Dr Kate Wood also queried whether the CQC action report would still be required at the PEF CiC and it was confirmed that relevant elements should still be addressed within this CiC.

5.2 **Performance Review Improvement Meetings HUTH & NLAG**

This item had been discussed under the Action Tracker item.

6. ANY OTHER URGENT BUSINESS

No items of any other business were raised.

Ian Reekie left the meeting at 12:18

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 **Matters to be Referred to other Board Committees**

As per item '4.2 - Financial Report', it was agreed to refer concerns raised around consultant job planning and the potential impact this could have on the financial position of the Trusts to the Workforce, Education and Culture CiC.

Action: *referral to the Workforce, Education and Culture CiC around concerns raised with consultant job planning and the potential financial impact this could have on the position of the Trusts.*

7.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Boards-in-Common meeting in the PEF CiC highlight report:

- Finance position
- Operational Planning Progress
- Deep Dive – Elective Care

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

Wednesday, 27th March 2024 at 09:00 hours
Board Room, Alderson House, Hull Royal Infirmary

The meeting closed at 12:25 hours.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y										
Mike Robson	Chair / Non-Executive Director (NED - HUTH)	Y	Y										
Lee Bond	Group Chief Financial Officer	Y	D										
Jane Hawkard	NED (HUTH)	Y	Y										
Simon Parkes	NED (NLaG)	Y	Y										
Shaun Stacey	Group Chief Delivery Officer	Y	Y										
Dr Kate Wood	Group Chief Medical Officer	D	Y										
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D										
VACANT	Group Digital Information Officer	N	N										
VACANT	Group Director of Assurance or deputy	D	D										
Alison Drury	Deputy Director of Finance (HUTH)	Y	N										
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y										
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y										
Ian Reekie	Governor Observer (NLaG)	Y	Y										

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)072

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	11 April 2024
Director Lead	Tony Curry & Kate Truscott, Non-Executive Directors / Chairs of Workforce, Education & Culture Committees-in-Common
Contact Officer/Author	Amy Slaughter, Personal Assistant
Title of the Report	Minutes of the Workforce, Education & Culture Committees-in-Common – January & February 2024
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any actions and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for review.
Prior Approval Process	Workforce, Education & Culture Committees-in-Common on 29th February and 28th March 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 Tuesday, 30th January 2024 at 09:00 to 12:30
via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) (Chair)
Kate Truscott	Non-Executive Director (NLaG)
Simon Nearney	Group Chief People Officer
Sue Liburd	Non-Executive Director (NLaG)
Una Macleod	Non-Executive Director (HUTH)
Peter Sedman	Group Deputy Chief Medical Officer (Chief Medical Officer Deputy)

In Attendance:

Amy Slaughter	Quality Governance Officer (HUTH) (Minute Taker)
Linda Jackson	Vice Chair (NLaG)
Ashok Pathak	Associate Non-Executive Director (HUTH)
Rebecca Thompson	Head of Corporate Affairs (HUTH)
Helen Knowles	Head of HR Services (HUTH)
Wendy Page	Interim Deputy Chief Nurse (HUTH)
Jenny Hinchcliffe	Deputy Chief Nurse (NLaG)
Paul Bunyan	Deputy Director of People (NLaG)
Mano Jamieson	Equality, Diversity and Inclusion Manager (HUTH)
Myles Howell	Director of Communications (HUTH) (*up to 4.6*)
Robert Pickersgill	Deputy Lead Governor (NLaG)
Fran Moverley	Freedom to Speak Up Guardian (HUTH) (*from 1.5 to 4.1.2)*
Elizabeth Houchin	Freedom to Speak Up Guardian (NLaG) (*from 2.1 to 4.1.2)*
Annabelle Baron-Medlam	Acting Head of Compliance and Assurance (NLaG) (*item 3.3.1)*
Elizabeth Evans	Guardian of Safe Working (NLaG) (*from 4.6 to 4.9*)
Louise Whiting	Employment Policy and Resourcing Manager (HUTH) (*from 4.7 to 4.8*)

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:

Kate Wood, Group Chief Medical Officer
Wajiha Arshad, Guardian of Safe Working, HUTH
Jo Ledger, Interim Chief Nurse, 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 21st November 2023 (NLaG) and 11th December 2023 (HUTH)**
The minutes of the meetings held on the 21st November 2023 and 11th December 2023 were accepted as a true and accurate record subject.

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:

Ashok Pathak asked about the letter that was to be sent to local MPs regarding exemption from visa fees for NHS staff. Simon Nearney has raised the issue with the Chief People Officer for NHS England.

Linda Jackson requested a deep dive regarding the medical workforce vacancies in NLaG. It was agreed that a report would be presented at the February 2024 CIC, following a visit to India to increase international recruitment for medical staff.

1.5 **Committees-in-Common Action Tracker**
The following updates to the Action Tracker were noted:

Simon Nearney advised that RAAC had been found in Suite 22, which had been closed with immediate effect and would be demolished within 4 weeks. Capital spend has been brought forward to allow improvement works on Scunthorpe Lecture Theatre to be completed in the financial year 2023/24. Ashok Pathak asked if there was an opportunity to use the Allam Building at HRI for training, Simon Nearney advised that all training would be allocated space on a priority basis and all avenues across the HUTH estate would be explored. Kate Truscott raised the idea of exploring opportunities with partners i.e. Hull University for alternative training spaces. It was agreed that training space requirements across the Group including the closure and demolition of Suite 22 would be escalated to the Board.

Mano Jamieson informed that a proposal to investigate different lived experiences of racism across different staff roles and grades has been drafted, which included conducting focus groups aimed at BAME staff and a structured anonymous survey. It was proposed that report a report would be presented at the September 2024 CIC. Una Macleod offered support from University of Hull colleagues.

It was noted that the overall mandatory training rate has improved, however there were hotspots notably Safeguarding and the Mental Capacity Act training within the Medicine Division.

Simon Nearney would send an email to Shaun Stacey to escalate the issue of mandatory training compliance, the issue of mandatory training compliance at NLaG would also be escalated to the Board.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported that the following matters had been referred by the Quality and Safety Committees-in-Common for consideration by the committees:

Concerns were expressed regarding the recruitment freeze for Band 8A posts and above and the potential impact on the Trusts. Paul Bunyan advised that some vacancies have been put on hold during the recruitment process of the Care Group structure to allow for any staff displacement. It had been widely communicated that if any vacancies would have a negative impact on patient safety or clinical delivery, these vacancies should have been raised by exception. Sue Liburd noted the specific concern regarding leadership in maternity at NLaG, Jenny Hinchcliffe updated that this post has been escalated and permission had been given to fill this post on a fixed term basis. Simon Nearney advised that the hold on vacancies would be lifted imminently.

The process for disseminating compliments and feedback from patients to staff was raised. It was highlighted that an aligned process was required for the group for disseminating patient feedback to staff. This also included highlighting compliments to the patient experience team for reporting purposes.

Action: Amalgamation of the process for communicating patient compliments and feedback to teams including the patient experience team.

It was acknowledged that the Quality and Safety CIC and Workforce, Education and Culture CIC receive the same staffing reports and a distinction was required between what should be discussed at each CIC to avoid duplication.

Action: Sue Liburd, Kate Truscott, Tony Curry and Una Macleod to meet to discuss how workforce would be discussed at the Quality and Safety CIC and Workforce, Education and Culture CIC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

3.1.1 Board Assurance Framework (BAF) - HUTH

Rebecca Thompson proposed a change to BAF Risk 2 (Workforce) to reduce from 16 to 12, changing the likelihood from 4 to 3.

Rebecca Thompson advised that the format of the BAF was under review and the HUTH and NLaG BAFs would be aligned following the introduction of the Group strategic objectives. The BAFs would now also be scrutinised by the Group Cabinet Risk and Assurance Committee.

Tony Curry asked if the reduction in risk was reflected in the retention figures, Simon Nearney advised that the retention rate was improving and the vacancy rate was at 2.2%, which justified the reduction in risk.

3.1.2 **Board Assurance Framework (BAF) – NLaG**
No proposed changes to the risk ratings for the BAF.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**
There were no external or internal audit report and recommendations to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Freedom to Speak Up Q3 Report**

4.1.1 **Freedom to Speak Up Q3 Report – HUTH**
Fran Moverley noted that Q3 had the highest number of individual concerns reported to the Freedom to Speak Up Guardian in a quarter since the role was implemented. 49 concerns were reported in Q3, the overall number of cases year to date was 112, which has increased further to 129 exceeding the total number of cases in 2022/23. Common themes included general concerns relating to improvement ideas or policy breaches followed by concerns about patient safety. An increase in Admin staff reporting concerns was noted. Fran Moverley and Elizabeth Houchin, the Freedom to Speak Up Guardian at NLAG, work together in partnership to align processes and have agreed a consistent way forward in reporting concerns. The assurance for the HUTH Freedom to Speak Up Q3 Report was agreed as reasonable.

4.1.2 **Freedom to Speak Up Q3 Report- NLaG**
Elizabeth Houchin informed that 104 concerns were raised in Q3, which was the highest number recorded in a quarter since the implementation of the Freedom to Speak Up Guardian role. Q3 was usually the quarter with the highest number of concerns due to the national 'Speak Up' campaign in October, the campaign was used by Elizabeth Houchin to recruit Speak Up champions. 6 concerns were raised anonymously through the staff app, Fran Moverley and Elizabeth Houchin were looking to replicate the staff app across the Group. Common themes of concerns reported were behaviour, process and patient safety. The assurance for the NLaG Freedom to Speak Up Q3 Report was also agreed as reasonable.

Sue Liburd asked if concerns have been raised about the organisational structure anecdotally, Elizabeth Houchin commented that the main concerns raised included the speed of changes and the consultation process.

4.2 **Registered Nurse & Midwifery Staffing**

4.2.1 **Registered Nurse & Midwifery Staffing – HUTH**
Wendy Page reported that Care Hours Per Patient Day (CHPPD) reduced from 7.78 in November 2023 to 7.54 in December 2023 due to the opening of additional capacity and operational pressures. The Trust was over-established by 121 WTE from a registered nursing perspective to allow backfill for maternity leave and to support expansion and development in ICU, day surgery endoscopy and theatres. 52 WTE vacancies were reported in non-registered nursing, bi-monthly mass recruitment sessions to fill these vacancies have continued to be successful. The National Apprenticeship week takes place in February 2024, during which the campaign for the next recruitment of HUTH nursing apprenticeships would run.

The Trust continued to support the existing apprenticeship programmes, consisting of 33 RNDA's, 34 TNA's, and 31 Health Care Apprentices. The majority of the nursing and midwifery students have received their NMC pin numbers. 10 mental health students have been welcomed to the Trust this year. The final cohort of internal nurses undertook their exams in December 2023, resits were planned for the end of January 2024. The focus in Registered Nurse and Midwifery Staffing has changed from recruitment to retention. The assurance of registered nurse and midwifery staffing at HUTH was agreed as reasonable.

Ashok Pathak asked about international staff who have failed a number of resits and if the reasons were due to a language barrier or difficulties with learning the skills required. Wendy Page advised that the resits were due to a lack of clinical skills and confidence and those staff were being supported by working in Band 3 positions for 6 months. Linda Jackson asked about the differences between NLaG and HUTH CHPPD, Wendy Page informed that work was ongoing to align the reporting between the two organisations. Kate Truscott asked about the midwifery establishment, Wendy Page responded that the service was challenged however the Trust has welcomed the first cohort of international midwives.

4.2.2 **Registered Nurse & Midwifery Staffing – NLaG**

Jenny Hinchcliffe declared that CHPPD were 8.6 in December 2023. The vacancy rate for registered nursing was 8.07% against the target of 8%, the non-registered nursing vacancy rate was 11.19% against the target of 8%. Turnover rates have continued to improve over the last 5 months, reducing to 10.29% in December 2023.

Nursing and midwifery staffing remained a high risk, sufficient controls have been implemented to mitigate impact on patient safety and experience and were reviewed on a monthly basis. Key issues included the potential cost of £57k associated with the additional theory hours required for the trainee Nursing Associates undertaking the apprenticeship programme with the University of Lincoln, which was highlighted following NMC scrutiny of the programme. A detailed paper regarding the costs would be presented to the Executive Team. Another issue raised was the challenges faced by the Advanced Clinical Practitioner (ACP) workforce in respect to the lack of recognition of the ACP role by medical staff. It was noted that non-registered nursing recruitment would be a focus alongside a review of the nursing apprenticeship programme process and collaborative work with ACP leadership at HUTH to enhance medical engagement. The potential for a joint vision and strategy would be scoped and joint governance and reporting arrangements would be developed.

Sue Liburd asked why the liability was with NLaG instead of the University of Lincoln for the backfill costs of the apprenticeship program, Jenny Hinchcliffe advised that further investigations were taking place alongside conversations with the university. Sue Liburd asked if the restorative clinical supervision could be accessed more than once annually, Jenny Hinchcliffe advised that annually was the minimum requirement and restorative supervision could be accessed as many times as required throughout the year. The assurance of registered nurse and midwifery staffing at NLaG was agreed as reasonable.

4.3 **Integrated Performance Report (IPR): workforce metrics**

4.3.1 **Integrated Performance Report (IPR) – HUTH**

Helen Knowles noted that mandatory and statutory training was at 88.8%, vacancy rates were at 2.2% which was supported by the over-establishment in the nursing figures. The Trust turnover was 9.3% against the target of 10%, however 20.5.% of leavers have less than 1 year service. It was noted that the ICB were developing a joint leaver and exit form. Sickness absence continues to reduce in line with the Trust target. The appraisal rate has reduced to 3% away from target.

Kate Truscott asked about the areas with higher turnover including additional clinical services, estates and allied health professionals Helen Knowles advised that staff in lower bands tend to come to the Trust to get their initial training and then move on to other organisations for professional development. Kate Truscott raised a concern regarding the high turnover of staff in their first year of employment with the Trust, Simon Nearney advised that further investigation was needed to understand the reasons for the high turnover rate. Wendy Page agreed that further investigation was needed and highlighted the number of Band 2 staff in additional clinical services who transfer into apprenticeships. Una Macleod asked for more information on staff who transfer to other NHS organisations or leave the NHS completely. Una Macleod enquired about benchmarking against other relative Trusts, Simon Nearney advised that overall turnover was slightly better than the national average for both HUTH and NLaG however data for turnover within the first year was not captured regionally or nationally.

A deep dive into turnover within the 1st year of employment was requested with a focus on inequalities. The assurance of the workforce performance metrics in HUTH was agreed as reasonable.

4.3.2 **Integrated Performance Report (IPR) – NLaG**

Paul Bunyan advised that feedback from staff who left within their 1st year at NLaG indicated that there were no comparable organisations to working in NHS and new members of staff were not prepared for the realities of the roles. The recruitment team were undertaking work to strengthen the recruitment process and manage expectations of new starters.

An issue was raised that over 2000 staff did not attend booked training sessions over the last 12 months, which equates to a quarter of the workforce. Work has been undertaken to engage with the divisions to understand why staff have not attended training, an action plan would be developed. It was noted that turnover and sickness absence rates have decreased.

An increase in applications for consultant vacancies in line with the establishment of the Group was recognised. The overall medical workforce would be reviewed to identify how they could be deployed at Group level. It was noted that international recruitment for medical staff would be required for the next 3-5 years. Meetings have taken place with the Indian government and several Indian medical establishments to develop training fellowships directly with the Trust. Clinicians from NLaG have assessed the capability of the overseas training program. Paul Bunyan noted that using the same supply of doctors allows the potential to be over-established in some areas for short term measures to address waiting lists.

Ashok Pathak asked what the definition of Trust grade doctors was, Paul Bunyan advised that Trust grade doctors are doctors who are not part of a national training programme. Ashok Pathak asked about the offer of a Certificate of Eligibility for Specialist Registration (CESR) programme to international staff, Paul Bunyan

replied that the intention is to develop a Group based CESR program in line with GMC requirements. Sue Liburd asked for an update in regard to Community Diagnostic Centre recruitment, Paul Bunyan updated that 3 sonographers have been successfully recruited virtually from the Middle East and a trip would be planned to Dubai for further recruitment. A deep dive regarding CDC recruitment would be presented at the February 2024 meeting. Linda Jackson queried the reason for the change to the CESR program, Paul Bunyan advised that the change was to address the variability in experience of doctors completing the CESR program.

Kate Truscott raised a concern about sickness absence rates, Paul Bunyan responded that sickness absence rates are reducing with support from Occupation Health for long term sickness absence and the average time taken to return to work has reduced. It was noted that the HR team were working with teams with high areas of absence to resolve any issues. The assurance of the workforce performance metrics in NLaG was agreed as reasonable.

4.4 **Staff Survey 2023/24 Progress Report Initial National Staff Survey Findings**

Myles Howell presented the initial findings from the 2023 staff survey. NLaG and HUTH both used Picker for conducting the staff survey. Initial results for both HUTH and NLaG provided an early indication of progress, however the data has been embargoed until March 2024. The completion rate for NLaG has increased from 35% to 48% and HUTH has increased from 37% to 50%. HUTH was the second most improved Picker Trust and NLaG the 15th most improved Picker Trust. Further benchmarking would take place against all NHS organisations when the data is released. A full report with and action plan was agreed to be presented at the March 2024 meeting.

4.5 **Impact of Industrial Action**

Simon Nearney provided an update on industrial action. The consultant pay award has been rejected, further conversations with the government were expected. The BMA were balloting junior doctors for a further six months of industrial action and asking members if they would take part in action other than striking. The HCSA were also balloting junior doctors for further industrial action. The SAS and Specialty doctors have voted to strike, however the government have put forward a pay award, which was under consideration. Peter Sedman acknowledged that the recent strike was the most challenging for the Group.

The assurance for the impact of industrial action was agreed as limited.

The agenda was taken out of order at this point.

3.3 **Review of Relevant External Report, Recommendations & Assurances**

The committee received and considered the following external reports, recommendations and assurances.

3.3.1 **NLaG CQC Plan**

Annabelle Baron-Medlam escalated the lack of progress in medical staff training rates. It was highlighted that better engagement with the CQC action plan from the medical staff was required. The assurance for the NLaG CQC Plan was agreed as limited.

Action: Kate Wood and Peter Sedman to instigate an action plan to increase medical staffing training rates.

Linda Jackson asked if the HUTH CQC action plan would be presented to the Board committees, Simon Nearney advised that this would be implemented once the Group Director of Assurance was in place.

The agenda returned to order at this point.

4.6 **Group Transformation Programme**

Simon Nearney noted that the Group Chief Nurse role was still vacant. The interviews have commenced for the management teams within the 16 Care Groups. Once those roles have been filled, further alignment of roles such as business manager and matron would be conducted.

The project to determine a Group set of values has begun with engagement sessions reaching over 600 members of staff across the Group, online sessions would become available to reach further staff. A project to determine the Group strategy and vison would begin in March 2024, led by Ivan McConnell. The first leadership conference took place on 12th January 2024 with over 100 senior leaders attending, further leadership conferences are due to take place each quarter.

Mano Jamieson raised the issue of the lack of diversity in the Group Leadership Team, this issue would be escalated to the Board.

Sue Liburd asked if support has been given to members of staff who have not been appointed, Simon Nearney responded that support was provided to all staff who require it. Tony Curry asked if the changes were in line with the timetabled expectations, Simon Nearney advised that the process was on track and the Care Groups would be live on 1st April 2024 with a small number of vacancies. The assurance for the Group Transformation Programme was agreed as reasonable as it was on track.

4.7 **Gender Pay Gap Report – Group**

Louise Whiting acknowledged that as separate legal entities, HUTH and NLaG were required to submit their own Gender Pay Gap reports to meet statutory reporting requirements. The Group report compared the two organisations whilst also noting the differences in size, services, the number of male and female staff and the distribution of gender across the pay bands. Both Trust's mean and median gender pay gaps were lower than the previous reporting period. The key issue for gender pay gap was the higher proportion of male staff compared to females in the upper quartile, which was predominantly medical staff. It was noted that there was a significant number of Band 2 staff in NLaG compared to HUTH. The mean and median gender bonus gap for NLaG were both higher than HUTH. The bonus data for HUTH included the £50 voucher awarded to staff with long service and for NLaG included the winter incentive bonus scheme.

Ashok Pathak asked if there was an impact on female staff who were part-time and if there was a disparity in the Clinical Excellence Awards (CEA) for female medical part-time staff, Louise Whiting advised that the pre 2018 CEA were pro rata for part-time staff and post 2018 CEA have been paid at the same value for all. Kate Truscott asked about the future of the Clinical Excellence Awards and

harmonisation of pay banding and job descriptions across the Group, Paul Bunyan advised that work was underway to align Group job descriptions and job evaluations and a Group job description template was under development. Paul Bunyan noted the number of female medical staff who have trained overseas and the impact on their ability to progress in their career due to cultural issues. Peter Sedman notified the committee that HUTH have conducted their first Local Clinical Excellence Awards, which has helped increase rates for job planning and mandatory training for doctors as they were requirements for the award. The assurance for the Gender Pay Gap reports was agreed as reasonable.

4.7.1 **Gender Pay Gap Report – HUTH**
The HUTH Gender Pay Gap report was noted and the Committees in Common would recommend approval to the Boards in Common.

4.7.2 **Gender Pay Gap Report – NLaG**
The NLAG Gender Pay Gap report was noted and the Committees in Common would recommend approval to the Boards in Common..

4.8 **EDS Standards – Group**
Mano Jamieson presented the Equality Delivery System Standards assessment, which was a national requirement. This report concerns Domain 2 (Workforce Health and Wellbeing) and Domain 3 (Inclusive Leadership). It was highlighted that HUTH have strong support for staff to access independent support and advice when suffering from stress, abuse, bullying harassment and physical violence including staff networks and the Freedom to Speak Up Guardian. The full EDS report including Domain 1 would be presented to the Board.

Helen Knowles observed that both Trusts were reporting as developing for 2023 and would be aiming for achieving in 2024. Sue Liburd queried if the action plan was robust, Mano Jamieson responded that commitment from the Board was required to push the EDI agenda. Ashok Pathak raised his concerns regarding engagement with the BAME community, Mano Jamieson advised that the BAME network was in place with several activities planned and the planned career enhancement program.

NLaG Specific Business Items

4.9 **Guardian of Safe Working Hours Q3 Report – NLaG**
Eizabeth Evans highlighted that there has been a reduction in the number of exceptions reported and one immediate safety concern was raised. It was noted that further work was taking place regarding inclusion and engagement with the Junior Doctors.

The assurance for the NLaG Guardian of Safe Working Hours Q3 Report was agreed as reasonable.

4.10 **Retention Update**
Paul Bunyan updated that flexibility has increased for both corporate and clinical staff. Leadership development programmes have been launched across the Trust. Career and development programmes, especially in nursing, have expanded. These actions have correlated with a reduction in turnover. A deep dive into retention was requested.

The assurance for retention was agreed as limited.

The agenda was taken out of order at this point.

3.1.2 **Board Assurance Framework (BAF) – NLaG**
Simon Nearney proposed changes to Strategic Objective 5 as previously discussed at the NLaG Workforce Committee in November 2023 where it was decided to increase the risk rating for Q4 from 12 to 16. The proposed change was due to the significant transformation taking place at Executive and senior levels within NLaG and across the Group.

The agenda returned to order at this point.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The minutes of the NLAG Culture and Leadership Transformation Board held on 20th October 2023 were noted.

5.2 **Terms of Reference**

5.2.1 The HUTH Terms of Reference for the Workforce, Education and Culture Committees-in-Common were noted.

5.2.2 The NLaG Terms of Reference for the Workforce, Education and Culture Committees-in-Common were noted.

5.3 The Workplan for the Workforce, Education and Culture Committees-in-Common was noted. Tony Curry asked that attendees take note of the workplan to ensure future reports were planned in line with the dates proposed.

6. ANY OTHER URGENT BUSINESS

The following items were raised:

Simon Nearney noted that the Government has put forward a consultation regarding removing nursing and midwifery staff from Agenda for Change and creating their own pay structure. This issue would be included on the agenda for the February 2024 meeting.

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:

- Specific areas within NLaG with low mandatory training compliance with particular reference to Safeguarding and Mental Capacity Act training within the Medicine Division.

- Training space requirements across the Group including the closure and demolition of Suite 22, HUTH.
- Deployment of Advanced Clinical Practitioners (ACPs).
- Medical engagement with NLaG CQC Action Plan, notable lack of progress with medical staff training rates.
- The number of staff in NLaG who did not attend booked training.
- Lack of diversity in leadership roles within the Group.
- HUTH BAF Risk 2 (Workforce) to reduce from 16 to 12.
- NLaG Strategic Objective 5 risk to increase from 12 to 16.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Thursday, 29th February 2024, at 13:30, in Main Boardroom, Diana Princess of Wales Hospital.

The committee chair closed the meeting at 12:42 hours.

Cumulative Record of Board Director's Attendance 2024

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

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 29th February 2024 at 13:30 to 17:00 at Boardroom, Diana Princess of Wales Hospital, Grimsby

For the purpose of transacting the business set out below:

Present:

Core Members:

Kate Truscott	Non-Executive Director (NLaG) (Chair)
Sue Liburd	Non-Executive Director (NLaG)
Una Macleod	Non-Executive Director (HUTH)
Kate Wood	Group Chief Medical Officer
Rebecca Thompson	Head of Corporate Affairs (HUTH) (Group Director of Assurance Deputy)
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing and Improvement (Group Chief People Officer Deputy)

In Attendance:

Amy Slaughter	Quality Governance Officer (HUTH) (Minute Taker)
Linda Jackson	Vice Chair (NLaG)
Helen Knowles	Group Director of People Services
Robert Pickersgill	Deputy Lead Governor (NLaG) (Observer)
Annabelle Baron-Medlam	Acting Head of Compliance and Assurance (NLaG) (item 3.3.1)
Jo Ledger	Deputy Chief Nurse (HUTH)
Melanie Sharp	Deputy Chief Nurse (NLaG)
Lucy Vere	Group Director of Learning and Organisational Development (items 4.2.1 and 4.2.2)
Lindsey Harding	Group Director of Workforce (items 4.4.1 and 4.4.2)
Wajiha Arshad	Guardian of Safe Working (NLaG) (item 4.7)

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:

Simon Nearney, Group Chief People Officer
Tony Curry, Non-Executive Director (HUTH)

Kate Truscott highlighted that a detailed executive summary was required for all

reports, which must include what actions are required from the committee. Support was offered from Rebecca Thompson regarding completing executive summaries.

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 30th January 2024**
The minutes of the meetings held on the 30th January 2024 were accepted as a true and accurate record subject to the following amendment:

Kate Wood identified that under item 3.3.1 the minutes should state that "*It was highlighted that better engagement with the training elements of the CQC action plan from the medical staff was required."*

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:

Sue Liburd asked about the outcome of the letter that was to be sent to local MPs regarding exemption from visa fees for NHS staff, it was noted that this action had been completed as Simon Nearney raised the issue directly with the Chief People Officer for NHS England.

Sue Liburd noted the lack of urgency for the investigation into different lived experiences of racism in HUTH. Helen Knowles indicated that the September 2024 target date for the completion of the investigation was to tie in with the WRES action plan. An update on progress was requested before the September 2024 report.

Action: Lucy Vere to provide an update in June 2024 on the investigation into different lived experiences of racism in HUTH.

Kate Truscott noted that the action for the process for capturing patient compliments and communicating these to staff was to be monitored by the Quality and Safety CiC. The question was raised if feedback and compliments to the Chief Executive were shared with staff, it was noted that all feedback and compliments received by the Chief Executive were forwarded to the Patient Experience team.

Kate Truscott asked when the deep dive into retention at NLaG would be presented, Paul Bunyan would confirm the date with Amy Slaughter.

1.5 **Committees-in-Common Action Tracker**
The following updates to the Action Tracker were noted:

It was agreed that actions 3.3.1, 8, 10 for NLaG would all be combined into one action regarding mandatory training. A focus on improving mandatory training rates had been cascaded to the operational groups. It was noted that medical staff raised several concerns regarding space for classroom training. Kate Truscott requested a deep dive into mandatory training hotspots within NLaG, to understand what the issues were, and the actions required to improve rates. Kate Wood noted the difference between HUTH and NLaG for mandatory training rates

for medical staff. Melanie Sharp advised that Christine Ramsden had started a piece of work to understand the restrictions for mandatory training attendance. Una Macleod questioned if all the current mandatory training was still required to be mandatory.

Action: A deep dive into hotspot areas within the Group with low mandatory training compliance including subject matters to be completed.

The protocol for the differences between what would be discussed at the Quality and Safety CIC and Workforce, Education and Culture CIC in respect to workforce was sent to the Group Executive team.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

No matters had been referred by the Trust Board(s) or other Board Committees-in-Common for consideration.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

Rebecca Thompson asked the committee to defer the review of HUTH BAF Risk 1 to the next meeting when the Staff Survey results would have been received. The committee were asked to note that the BAF was in the new format, however it was a work in progress. The BAFs would continue to be managed independently until the strategic objective review had been completed and the high-level risks agreed for the Group. The BAFs were scrutinised at the Group Cabinet Risk and Assurance Committee. Linda Jackson raised that she had asked for an update on the timeline for the strategic objectives at the Group Board Development session.

3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report and recommendations to note.

3.3 Review of Relevant External Report, Recommendations & Assurances

The committee received and considered the following external reports, recommendations, and assurances.

3.3.1 NLAG and HUTH: CQC Actions Progress Report for February 2024

Annabelle Baron-Medlam presented the NLaG CQC progress report. Over 50% of actions had now been rated as full or significant with 23 position reports submitted to the CQC. The number of actions with limited assurance had decreased further. There are 40 actions linked to this committee, 10 of which had been fully closed. Closed actions were subject to ongoing monitoring as part of a Quality Monitoring Assurance Process (QMAP). The Goole midwifery led unit was assessed in November 2023, the report was pending, however, no immediate actions had been issued.

Linda Jackson queried engagement with the CQC plan, Annabelle Baron-Medlam advised that engagement had been good but noted that it took time for improvements to become embedded. Linda Jackson asked about the engagement with CQC meetings for HUTH and NLaG, Kate Wood advised that both Trusts separately meet the CQC on a monthly basis. Both HUTH and NLaG have a

separate Quality Improvement Group (QIG) which includes ICB, NHSE and CQC representation and meets on a bi-monthly basis.

It was acknowledged that there was ongoing work to align the HUTH report with the NLaG report. Jo Ledger presented the HUTH progress report. The overdue actions in Surgery required demonstratable evidence and they were also built into the audit programme. The maternity workforce model had been developed and updated following the outcome of the last Birthrate plus review with a built in 24-hour triage. The capacity for AHPs and sonographers was under review. Linda Jackson acknowledged the time required to align the Trust's reports to ensure the same level of assurance is received. The assurance for the CQC Actions Progress Report was agreed as reasonable.

4.1 **Integrated Performance Report (IPR): workforce metrics**

4.1.1 **Integrated Performance Report (IPR) – HUTH**

Helen Knowles highlighted the low vacancy rate, and the sickness absence continued to achieve the target. The appraisal rate had reduced, and mandatory training remained above target. Linda Jackson highlighted that Cardiology were well below target for job planning and Kate Wood advised that she had completed 6 job planning appeals, which would go to the Cabinet for approval. It was remarked that ongoing work was taking place in Cardiology to improve the culture and Kate Wood informed the CIC that FMLM were carrying out some interventional work with support from the OD team. Linda Jackson noted that the new care group structure would help support this change. Kate Wood highlighted the groundwork for these improvements was completed before she became Group Chief Medical Officer. The assurance for the HUTH Integrated Performance Report was agreed as reasonable.

Sue Liburd asked for the deep dive into mandatory training hotspots to include subject matters.

Kate Truscott emphasised that Estates and Ancillary and Additional Clinical Services were outliers for sickness absence and asked if those areas were being supported, Helen Knowles noted that these two staff groups were also affected by high turnover within the first year of employment.

4.1.2 **Integrated Performance Report (IPR) – NLaG**

Paul Bunyan communicated that the registered nursing vacancy rate had reduced to 6.05% and was below target. The overall vacancy rate had reduced to 7.72% for the Trust and was below target. Sickness rate remains above target at 5.07%, however the sickness rate continued to reduce month on month. Role specific mandatory training remained below target at 78.89% and the process for delivering mandatory training in clinical areas would be redesigned with a mix of face to face, eLearning courses and specialist training tailored to specific areas. The vacancy position for non-registered nursing remained above target. The reported vacancy position differed to the operational vacancy position and the HR team were working with financial colleagues to amend this discrepancy.

Jo Ledger advised that a joint piece of work on registered nursing would be beneficial as HUTH was currently over-established with maternity leave and the opening of additional capacity built into the staffing model.

Kate Truscott asked why the change in process for non-registered nursing recruitment had been implemented as this change had not helped to improve the vacancy position, Paul Bunyan advised that the change provided managers with control of the recruitment into their teams.

Linda Jackson raised concerns regarding the lack of movement to improve the non-registered nursing vacancy position over the last 12 months. Jo Ledger acknowledged that the process for establishment reviews would need to be aligned across the Group. It was requested for pipeline trajectories to be included in the next report. The committee were not assured on the non-registered nursing vacancy position and the effectiveness of recruitment.

Action: A deep dive into the plans to improve the non-registered nursing vacancy rate in NLaG to be completed.

4.2 **Learning & Development Progress Report**

4.2.1 **Learning & Development Progress Report – HUTH**

Lucy Vere referred to action 8 on the tracker and suggested a full review of group training space to be presented to the committee in June 2024, which was approved. The team had been focused on repatriating training courses due to the loss of Suite 22 at CHH due to the discovery of Reinforce Autoclaved Aerated Concrete (RAAC). The resuscitation team had taken over the CHH lecture theatre for their courses with only one session required to be cancelled. However, this impacted Medical Education who had transferred their sessions to online or used space within the library. The team had to cancel 521 courses up until May 2024 however, they are now able to repatriate courses for later in the year.

The undercroft of the new Day Surgery unit at CHH had been identified as the new training centre. The surgical skills centre would be lost whilst the suite was demolished. The hard work carried out by the team to reschedule and maximise capacity was highlighted. The assurance for the HUTH Learning and Development Progress Report was agreed as reasonable.

4.2.2 **Learning & Development Progress Report – NLaG**

Lucy Vere presented the Learning and Development Progress Report. The Values Based Leadership (VBL) programme continued to be rolled out as part of the cultural transformation. Leadership development was under review. For 2024/25, the decision had been made not to apply for boot camp funding. A review of the full Group Leadership Development model was required. The leadership programme for the Care Groups was noted as top priority. Kate Wood noted that the medical leadership programmes were planned to continue for 2024/25, for 2025/26 there would be a bespoke Group Medical Leadership programme.

Linda Jackson asked about the expectations for staff in new leadership roles within the Care Groups and asked for an update at the next meeting regarding what support would be provided.

Action: Lucy Vere to provide a plan from the Learning & OD team to support the Care Group leadership team develop.

Sue Liburd asked for future reports to include impact reporting i.e. culture changes. Lucy Vere noted that a report on Organisation Development was not included on

the workplan and asked if the committee would prefer a separate report or to include Organisational Development in the Learning and Development progress report. It was agreed for Organisational Development be included in the Learning and Development progress report.

Kate Wood asked about the issue with the Oliver McGowan mandatory training, Lucy Vere advised that there were issues with the capacity and the support needed to provide the training. Face-to-face training had to be completed within 6 months of completing the eLearning.

Lucy Vere highlighted that in HUTH, there were educational advisers within the team whereas there was a different model in NLaG, which would need to be reviewed. The assurance for the NLaG Learning and Development Progress Report was agreed as reasonable.

4.3 **Group Transformation Programme**

Helen Knowles noted that the Group Chief Nurse would commence in post on 1st April 2024. It was acknowledged that the Care Groups structure had been published and was available for all staff to view on Pattie and the Hub. The next step in the process was to appoint the Business Managers and Matrons, this process was unlikely to require a consultation. It was noted that the amount of work to be undertaken before the launch of care groups and the impact of this change on staff could not be underestimated. Linda Jackson asked for further assurance regarding the Care Group structure at the March 2024 meeting, Simon Nearney would provide an update via the standing agenda item - Group Transformation Programme.

Paul Bunyan remarked that the staff terms and conditions were not currently being amended however, in the future an alignment exercise would be required for pay etc. A major concern was highlighted by the committee regarding the pace of change and the effect on staff to implement the Care Group structure on 1st April 2024.

Action: Kate Wood would raise concerns regarding the timeframe for the Care Group implementation at the next Group Cabinet meeting.

Action: The Non-Executive Directors agreed to raise concerns about the pace of change and the impact on staff at the Group Board Development session.

4.4 **Employee Relations Case Analysis 2023**

4.4.1 **Employee Relations Case Analysis 2023 - HUTH**

Lindsey Harding presented the HUTH Review of Employee Relations Cases in 2023. The number of employee relations cases returned to a usual amount for the Trust, which was 208 in 2023. Estates, Facilities and Development remained an outlier. Disciplinary cases remained the highest volume of cases followed by supporting and managing attendance panels. There were 28 cases which took over 100 days to complete, common themes were cases involving medics and those where ill health was a factor. Six claims to the Employment Tribunal were received in 2023. The average time to complete cases was 48 days. The data showed that BAME colleagues were less likely to be involved in a disciplinary process than white colleagues.

Linda Jackson asked about disability as an outlier and what measures were in place to support disabled staff, Lindsey Harding advised that reasonable adjustments were made to support staff with disabilities. Kate Truscott questioned if there was a central log of reasonable adjustments, Lindsey Harding informed that adjustments were logged by managers on individual records. The assurance for the HUTH Employee Relations Case Analysis was agreed as reasonable.

4.4.2 **Employee Relations Case Analysis 2023 – NLaG**

Lindsey Harding presented the NLaG Review of Employee Relations Cases in 2023. It was noted that the NLaG team would stop using Allocate to record casework and from 1st April 2024, they would move to the HUTH model of Excel spreadsheets. The total number of cases in 2023 was 269. From 1st April, HUTH and NLaG would be using the same reporting types. MHPS case would no longer be counted under disciplinaries. Four claims to the Employment Tribunal were received in 2023. The data shows that BAME colleagues were more likely to be involved in a disciplinary process than white colleagues, further analysis of this data was required. The assurance for the NLaG Employee Relations Case Analysis was agreed as reasonable.

NLaG Specific Business Items

4.5 **Deep Dive into Medical Workforce Vacancies**

Paul Bunyan presented the deep dive into medical workforce vacancies. The vacancy position had decreased from 25% to 12.09% however, it had now plateaued with recruitment largely keeping pace with establishment increases and turnover. The plateau had been caused by difficulties in consultant recruitment and retention. The most common reason for consultants leaving the Trust were due to voluntary resignation, with the majority reasons unknown and with no exit interview taken place. The most common reasons for SAS grades leaving the Trust were promotion or relocation. Further education or training was a common reason for leaving the Trust for Junior Doctors. The age profile of the medical workforce highlighted the number of consultants at retirement age (11.7%) and those approaching retirement (18.4%).

The Trust has an in-house Talent Acquisition team, who focus on roles in high pressure areas. The Trust had been successful in its application to the General Medical Council to sponsor suitable candidates for GMC sponsorship. Programmes to implement Training Fellowships had been developed and formal programmes are currently being considered. The Trust's own portfolio pathway programme was noted as being in the conceptual stages. The Trust continued to access international recruitment and had visited Aster Medcity in Kochi to assess their training programme and was assured of the quality of the training and candidates. A refresh of the Group branding and advertising for recruitment was underway and job plans were being redesigned to incorporate working across the Group, which could help to attract more candidates.

Sue Liburd queried if new staff accessing the cross-group opportunities would be on the NLaG payroll, Paul Bunyan advised that finance colleagues were addressing the issues for all staff members who work across multiple sites.

Kate Wood noted that the report implied that some actions were in place which were not correct including the Training Fellowship pilot in Anaesthetics. Paul

Bunyan confirmed that this section in the report was no longer factually correct, and those roles had been recruited as Trust Grades. Kate Truscott asked when the Training Fellowships would be in place, Paul Bunyan advised that engagement with the clinicians and Medical Education was required and currently there was no confirmed date for this.

Una Macleod asked if the consultant vacancy rate was across all specialties and if this was supported by locums, Paul Bunyan advised that the locum roles did not fill the establishment. Kate Wood advised that a medical workforce strategy was a priority and would be developed.

Action: A medical workforce strategy in NLaG to be developed.

Linda Jackson raised her concerns regarding the high locum costs and the age profile of the consultants and stated that a fundamental change was required with a strategy in place for the next 12 months to improve the position. Jo Ledger noted that it would be beneficial for a similar report into the medical workforce vacancies at HUTH.

Action: Paul Bunyan to raise the concern at the next Group Cabinet meeting of the age profile of NLaG consultant staff via Simon Nearney.

Action: Paul Bunyan to provide an update at next meeting on the Portfolio Pathway Programme and Training Fellowships.

4.6 **Young Volunteer Scheme (Wyke College)**

Kate Truscott highlighted the excellent programme at HUTH for Young Health Champions and Rachel Hardcastle-Pearce had communicated with colleagues at NLaG as to whether there was interest in developing the programme on the South Bank. Jo Ledger and Melanie Sharp would discuss how to progress this further outside of the meeting.

HUTH Specific Business Items

4.7 **Guardian of Safe Working Hours Q3 Report**

Wajiha Arshad presented the HUTH Guardian of Safe Working Hours Q3 report. The transition of rotas on to eRoster had improved with 98% of rotas now transferred over. 203 exception reports were submitted in Q3, the majority were due to hours worked. Areas with the highest number of exception reports were Elderly Medicine, Acute Medicine, and Neurology.

5 fines were issued in Q3, those in Plastics Surgery and Paediatric Surgery were due to the high number of hours worked during non-resident shifts. The Plastic Surgery rota had been redesigned but the Paediatric Surgery rota had not been reviewed since Covid. Kate Wood noted that the Paediatric Surgical rota was an issue that had knock-on effects onto the daytime work. The Paediatric management team had drafted a business case in 2022, which would need to be refreshed to tackle this issue.

Una Macleod asked about the expenditure of funds used for the Doctors Mess ball, Helen Knowles advised that she would check that the funds came from Charitable Funds rather than the fine income. The assurance for the Guardian of Safe Working Hours report was agreed as reasonable.

4.8 **Deep Dive into Turnover within First Year of Employment**
Helen Knowles presented the deep dive into turnover within the first year of employment for Additional Clinical Services and Estates and Ancillary. The report included a comparison between leavers in 2013/14 and 2023/24. In Additional Clinical Services, the reason for leaving for 11.04 WTE staff in their first year of employment was to undertake further education or training. In Additional Clinical Services, the destination for 40.06 WTE staff who left the Trust was another NHS organisation.

Actions to improve retention include the development of a Group wide recruitment and retention marketing strategy, a new ICB exit questionnaire, management floor walks to link in with staff, improved communication, and the appointment of a 12-month People Promise Manager.

Una Macleod asked about the option for line management to feedback to HR the reasons for staff leaving, it was noted that managers could include the reasons as part of the leaver form. Una Macleod noted her concern regarding the number of staff leaving the Trust with no destination. The assurance for the deep dive into turnover within the first year of employment was agreed as reasonable.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The Workplan for the Workforce, Education and Culture Committees-in-Common was noted.

6. ANY OTHER URGENT BUSINESS

The following items were raised:

Linda Jackson noted the GMB demonstration outside HUTH regarding the working conditions of OCS staff and asked for a briefing to be provided at the next committee.

Action: A briefing paper on the issues raised about OCS in HUTH by the GMB to be presented at the next meeting.

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:

- Low mandatory training compliance within NLaG
- High non-registered nursing vacancy rate at NLaG.
- Pace and impact of the Care Groups implementation and the effect on staff.
- Age of the Medical Workforce and high locum costs in NLaG.

- The demonstration by GMB outside HUTH regarding the working conditions of OCS.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Thursday, 28th March 2024, at 13:30, in the Main Boardroom, Diana Princess of Wales Hospital.
The committee chair closed the meeting at 16:36 hours.

Cumulative Record of Core Membership Attendance 2024

Name	Possible	Actual
Sue Liburd	2	2
Kate Truscott	2	2
Simon Nearney	2	1
Linda Jackson	2	2
Tony Curry	2	1
Una Macleod	2	2
Kate Wood	2	1
Ashok Pathak	2	1
David Sharif	0	0
Group Chief Nurse	0	0

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)073

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee - NLaG
Contact Officer/Author	Lee Bond, Group Chief Financial Officer
Title of the Report	Health Tree Foundation Trustees' Committee Minutes – January 2024 (NLaG)
Executive Summary	Minutes of the Health Tree Foundation Trustees' Committee (HTF) held in January 2024 and approved at the April meeting.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Health Tree Foundation Trustees' Committee – April 2024
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

Minutes

Health Tree Foundation Trustees' Committee
Held on the 10 January 2024
9.30am – 12.00pm
Via TEAMS

Present:	Neil Gammon (Chair)	Non-Executive Director
	Stuart Hall	Group Vice Chair (HUTH)
	Sue Liburd	Non-Executive Director
	Gill Ponder	Non-Executive Director

In Attendance:

Tony Burndred	Governor – Observer
Alison Hurley	Assistant Trust Secretary
Simon Leonard	Communications Assistant
Jamie Lewis	CEO Hey Smile Foundation
Paul Marchant	Senior Accountant
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Lucy Skipworth	HTF Charity Manager
Clare Woodard	Head of Business Development
Lynn Arefi	Executive Assistant (for the minutes)

1. Apologies

Apologies for absence were received from Lee Bond, Jonathan Lofthouse

Neil Gammon opened the meeting by welcoming Stuart Hall, Group Vice Chair Hull University Teaching Hospitals (HUTH) NHS Trust who would represent Jonathan Lofthouse at the meeting. Introductions then followed and Clare Woodard noted the changes that had taken place within Smile Foundation. She added that, in her new Smile role, she would continue supporting the Health Tree Foundation.

2. Declarations of Interest

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

3. Notes of the Previous Meeting

Notes from the previous meeting held on the 9 November 2023 were circulated and it was noted that the notes should read "Clare Woodard" and not "Woodward". Reference was made to item 4.1 on the previous minutes, and it was noted that the discussion was around "contactless donations" rather than physical cash boxes. With these items noted the minutes were agreed as a true record.

4. Matters Arising

Contactless Donations – possibility to make donations in Accident & Emergency and Community Diagnostic Centres. The Committee requested consideration be given to installing contactless card payment machines and Lucy Skipworth agreed to review different options. The need to consider security aspects was discussed and it was agreed to bring back options to the next Committee meeting.

Research available donation kit – no progress as yet. Clare Woodard agreed to work with Lucy Skipworth and report back to the April meeting.

Pennies from Heaven – working with Electronic Staff Records/Payroll team to progress this and this action will be added to the action log.

Robust Fans for staff – the Committee queried where these would be stored securely through winter if they are not being wall mounted. A more cost-effective way of managing this was required.

ACTION:
Updates on the following to be provided at the next Committee meeting as follows:

- Clare Woodard to report back on options for adding contactless card payment machines to Accident & Emergency and Community Diagnostic Centres
- Lucy Skipworth and Clare Woodard to provide an update on the donation kit options
- Pennies from Heaven update.

5. Review of Action Log

The action log was reviewed and updated as followed:

Item 6 July 23 - KPIs - ongoing
Item 7 Sep 23 – wall mounted fans/heavy duty fans - ongoing
Item 11 Nov 23 – Signage/Wayfinding - an update will be provided by Lucy Skipworth at the April Committee meeting.

6. Items for Discussion / Approval

6.1 Health Tree Foundation Trustees' Committee (HTF) Work Plan 2024

Lucy Skipworth spoke to the circulated Workplan and welcomed comments from Committee members. No comments were received and the Health Tree Workplan for 2024 was received, noted and agreed.

6.2 Health Tree Foundation Trustees' Committee Terms of Reference Review

Lucy Skipworth spoke to the revised Terms of Reference (ToR) for the Committee which had been circulated. It was noted that these had been reviewed in line with the new Group Structure, as per the track changes shown.

Gill Ponder suggested the role of HTF in ensuring that funds are spent in accordance with donor's wishes needed to be explicit and added to the ToR. In relation to Appendix A, item 2 - it was queried whether this should read "between £251 & £5,000". It was then queried whether it was correct for Item 3 to refer to the Chief Nurse. Neil Gammon thanked members for comments and added that the amendments would be made, and the revised Terms of Reference would be circulated prior to them being agreed at the HTF Committee meeting in April.

ACTION: Neil Gammon/Lucy Skipworth to circulate the revised ToR prior to agreement at the April meeting.

6.3 Social Media Policy

Lucy Skipworth provided an overview of report which was taken as read. The Committee were advised that following the circulation of the Charity Commissions News Information e-mail on 13 November 2023 sent by Neil Gammon, Gill Ponder had raised a query regarding the HTF's Social Media Policy. Gill Ponder had suggested the HTF should review the current its status against expectations that charities using social media would have a policy for such use. Simon Leonard suggested that the HTF needed a statement that indicated it adhered to the Northern Lincolnshire and Goole (NLaG) NHS Foundation Trust policy. Clare Woodard agreed that a statement could be included within the Trust's policies and the Smile's policies. Neil Gammon noted that the HTF would need to be clear it had correctly followed policies and procedures and to also ensure HTF were included within or alongside the policies of the Trust. Gill Ponder added that after reading the NLaG policy the following specific items that the HTF do, may need to be included within the Trust's policies:

- Fund raise/legacy/advertise
- Note how HTF money was spent and reference the need to ensure donors' wishes are respected.

Neil Gammon and Lucy Skipworth agreed they would look at the points made to ensure HTF are working in accordance with the appropriate policies and would report back to the Committee at the April meeting.

ACTION: Neil Gammon/Lucy Skipworth to review Social Media Policy, ensuring it stated adherence to the NLaG policy and report back to the April Committee meeting.

7. Updates from Health Tree Foundation

7.1 Health Tree Foundation Manager Update Report

Lucy Skipworth took as the report as read and highlighted key areas. Christmas had been highly successful with all in-patients receiving calendars, although feedback on this had been noted as varied. Maternity patients were gifted "My first Bauble" and a Santa Run was held in Keelby which had very good attendance. The Children's wards at both sites had numerous visits from local football clubs and fundraisers who provided gifts for the patients.

In relation to the Fairchild Legacy, following planning meetings and involvement with trust staff, work had started on the Fairchild Legacy dementia friendly wards at Scunthorpe General Hospital (SGH). Whilst the initial target for completion, the end of December 2022, could not be met due to operational pressures, Ward 16 was completed in September 2023. This would be formally opened by Jonathan Lofthouse, Group Chief Executive Officer (CEO) on Friday, 26 January 2024. Ward 17 has been confirmed as the second ward for work to commence in late February, early March due to operational/winter pressures.

Post Meeting Note: – The planned opening date had been delayed for operational reasons.

Lucy Skipwoth went on to note that during October 2022, it was agreed that HTF would help support staff room improvements to enhance staff morale and retention within the Trust. These would be funded via COVID grant funds from the 'Big Thank You' (4GT031). HTF would review the rooms and, if required would offer the addition of flooring, redecoration of the walls and vinyls or murals for decoration.

The Charity Manager and the Health Tree Team had drafted a Fundraising Strategy for April 2024 to March 2025. This Strategy would be available for Trustees to view at the next committee meeting in April 2024.

ACTION: Fundraising Strategy for 2024/25 to be added to the April agenda.

Lucy Skipworth highlighted that there had been four completed Grant Funding applications across all sites. It was noted that four had been successful with three applications since the last Trustees' meeting in November 2023 as follows:

- Humber Gateway for Community Diagnostic Centre DPOW for £2,500
- Blakemore Foundation to support The Santa Run for £150
- Caistor Lions to support The Santa Run for £200

Neil Gammon asked how are "gifts in kind" reflected financially and Lucy Skipworth confirmed that financial values were added to these items and were fully logged with an appropriate audit trail.

Neil Gammon thanked Lucy Skipworth for the update noting that there had been a lot of achievement in December.

Gill Ponder went on to note that there was a lot of positive feedback regarding the Christmas gift to patients of blankets and she was not aware that a decision had been made to gift calendars, querying whether this had been a good idea and why was this decision had been made. Lucy Skipworth advised that they had found that blankets were not as appropriate for male patients as female ones. Following a team meeting the decision to gift the calendars was taken. Lucy Skipworth added that she had taken on board Gill Ponder's comments and further suggestions for next year would be welcomed. Neil Gammon acknowledged the comments made and added that it was "difficult to please everyone".

Sue Liburd commended everyone associated in producing the report and the work and impact from this, which was very moving. Sue Liburd then referred to

the KPIs within the report and queried the target settings, whether the targets were being met and having an impact; was the appropriate social media mechanisms to reach people being utilised. Sue Liburd added that if we wanted to drive an increase in numbers of followers then maybe we should be looking at "challenging our own staff" to engage in an event via social media which could potentially enhance numbers of followers. Lucy Skipworth took on board all of the comments and advised that a Tik Tok channel would be created and HTF would also benchmark with other charities for guidance. Neil Gammon asked for an update on this be brought back to a further meeting.

ACTION: Lucy Skipworth to provide an update on the Social Media Policy and social media followers.

Jamie Lewis thanked Sue Liburd for the comments and noted the difficult challenge to establish an effective level of engagement. It was acknowledged that a lot of background work was required whilst remaining as productive as possible. Clare Woodard added that the targets were set purely to monitor the increase in followers and confirmed the potential to reach out to more people.

Gill Ponder reiterated Sue Liburd's suggestion on staff engagement. Social media was used for awareness and gave an opportunity to remind people the HTF is there when they were proposing to fundraise. Gill Ponder added that there was a lot happening and HTF was doing well, especially over the Christmas period and in the current economic climate. Gill Ponder asked if we had reached out to the Chamber of Commerce (CoC) or considered the "give as you earn" which was a direct salary deduction. Clare Woodard confirmed that the HTF is a member of the Local Business Hive but had not approached CoC, and Smile was also a member of "Bizweek" within the East Riding.

Neil Gammon requested a specific action to explore the Payroll Giving, Bizweek and Chamber of Commerce and how these would be taken forward.

ACTION: Smile/Lucy Skipworth to explore the Payroll Giving, Bizweek and Chamber of Commerce

Stuart Hall took the opportunity to advise that HUTH's Charitable Fund Committee was currently being wound up with the balance of funds transferred to WISH. It was suggested that it would be useful, whilst maintaining independencies, that there should be an ongoing rapport of the two respective bodies.

Neil Gammon advised that he had, previously, tried to make contact with WISH but had heard nothing but was happy for suggestions going forward.

ACTION: Neil Gammon/Stuart Hall to discuss HTF and WISH interaction outside of the meeting

Neil Gammon advised that he had recently learnt that the annual "Our Stars" night for NLaG would be held jointly going forward, encompassing both NLaG and HUTH now the new Group structure was in place. The initial understanding was that HTF would not be involved. Neil Gammon asked for the Committee's comments and thoughts. Simon Leonard added that it was very early stages for the 2024 Group Awards and advised that awards categories would be aligned

with a proposal put together for the CEO's consideration. Sue Liburd added that it would be a huge disappointment if the HTF did not have some sort of presence. Gill Ponder agreed and suggested the possibility of running a raffle stand on the night; further information was requested.

Neil Gammon thanked all for their views and agreed that he would approach organisers of this to understand their plans and to put in a pitch to ensure HTF participates in the event.

ACTION: *Neil Gammon to further discuss HTF's involvement in the Group Awards Celebration event*

7.2 Risk Register

Lucy Skipworth took the circulated Risk Register as read. The report updated Trustees on risks associated with the Health Tree Foundation and the impact they may have on the charity and the Trust and determined whether other risks needed to be added. Risk items HTF1 – 23, HTF3 – 23 and HTF4-23 had been updated in line with changes to the Group Structure and additional information within Gaps in Controls. The Committee received and noted the Risk Register.

11.00am Ivan McConnell, Group Chief Strategy & Partnerships Officer joined the meeting

7.3 Health Tree Foundations Communications Update

Neil Gammon introduced this item by noting that there was a formal arrangement between HTF and NLaG's where the communications for HTF were run and led by the Communications Team, which worked very well. Simon Leonard took the paper as read which provided highlights of what the Communications team had done recently to raise awareness of the charity. It was noted that this report is constantly updated, and Clare Woodard added that this was a very good addition to the meeting. Ivan McConnell added that it was useful to see this report and asked if there was a "Stakeholder map" of who HTF would wish to potentially engage with to strengthen and align objectives. Neil Gammon thought that this was a good suggestion and one that could be added and developed as a standing agenda item. Clare Woodard confirmed that there was a Stakeholder map and she agreed she would liaise with Simon Leonard and Lucy Skipworth.

ACTION: *Clare Woodard / Lucy Skipworth / Simon Leonard to explore the Stakeholder map and include as a standing agenda item for future meetings*

8. Sparkle Programme

8.1 Sparkle Update

The Sparkle report was taken as read. The Committee received and noted the contents of the report.

9. Finance Update

9.1 Finance Report

Paul Marchant was provided an overview of the month 9 Finance Report and noted that for the 9 months to end of December 2023 there was £571k of income, which was £152k behind plan but had shown recovery in December. In November, HTF were notified of three new legacies to the value of £81k for the benefit of A&E, the Big Red Heart, End of Life and Medicine and Surgery. Spend for the period was £625k for the 9 months which was £400k behind plan. The final Stage 2 NHSCT Grant of £76k was also received in November. Fund balances after accounting for commitments on 31 December were £844k, which was after accounting for expenditure commitments and ring-fenced funds of £592k.

Paul Marchant referred to KPI figures and a query raised at the last meeting about an inconsistency and what the KPIs were driven by. It was confirmed that these had now been recalculated and had been added into the financial summary which shows the KPIs on a month-by-month basis. Ivan McConnell queried how the KPIs information benchmarked against similar organisations. Paul Marchant confirmed that this had been undertaken previously, using NHS Charities Together data, but the Committee may want to refresh this. It was agreed to undertake a benchmarking exercise and to provide this on a regular basis.

ACTION: Paul Marchant to undertake a benchmark of financial KPIs

Gill Ponder referred the Committee to page four of the report and the list of expenditure; and queried that within the table the Seaview Cancer Shop donation suggested that the HTFe had given them a donation. Paul Marchant confirmed that this was a commitment, and the narrative would be amended appropriately.

Stuart Hall queried how small legacies “ringfenced” for a specific purpose are dealt with. Paul Marchant confirmed that Trustees would have to agree to spend these on something similar, and it was noted that this happened on very rare occasions.

Ivan McConnell requested whether a Year End Forecast position/profile to understand where the reserves would sit could be provided for information to the Committee. Paul Marchant confirmed that this would be done for the next report. It was also agreed that a plan for 2024/25 including spending projections be brought to a future meeting.

The Committee received and noted the month 9 finance report.

9.2 Annual Report & Accounts

Paul Marchant presented the Annual Report & Accounts to the Committee. The Trustees were asked to note the following documents, which were approved by the HTF Chair and Group Chief Executive on behalf of the Trustees on 30 November 2023:

- Annual Report & Accounts Year ended 31 March 2023
- HTF Letter of Representation dated 30 November 2023
- ASM Auditors Audit Completion Report Year Ended 31 March 2023.

Clare Woodard went on to advise the Committee that the report had been praised by Partner Charities as being one of the best they had seen, and congratulations were noted for the teams involved. This was noted as a positive showcase of the work that had been achieved. Neil Gammon seconded Clare Woodard's thanks and also added it was very good to use every opportunity to show what HTF could do.

10. Any Other Business

Patient Safes

Paul Marchant informed the Committee that he had been working with the Deputy Nurse and Patient Experience Lead in relation to the safe keeping of patient property and valuables and the potential of installing safes on the wards. Last year the HTF funded 1,000 Patient Property boxes at a cost of £4k; these were kept with the patient for their use to store glasses, dentures etc. It had now been suggested to look at installing safes on wards for storing more valuable patient property. Discussions had been held around 37 safes to be installed at a cost of approximately £14k. Paul Marchant had taken this opportunity to gain the Committee's view.

Neil Gammon queried the need for additional safes if we already have patient property boxes. Paul Marchant confirmed that the safes would be for more valuable items of jewellery and cash.

Gill Ponder commented that £14k for the number of safes did not suggest they would be installed (fixed); and queried what would stop these from being stolen. It was noted that this requirement may have arisen from the Audit Committee discussion around the number of losses incurred by the Trust and what is the reimbursements for lost patient property, with the majority of losses not for jewellery but dentures or glasses and Gill Ponder added that she was not sure that safes would address this problem. Ivan McConnell agreed with Gill Ponder's comment and asked would there be an alternative. It was agreed that here were a number of issues and processes around this which were more complex and would need to be thoroughly thought through before agreement to fund is made.

Neil Gammon thanked everyone for their comments and requested that this request be brought back to HTF as a formal request in writing in April.

ACTION: Formal request for patient safes to be presented at the April meeting

11. Matters for Escalation to the Trust Board (Public/Private)

Neil Gammon reminded Committee members that there would be a highlight report going to the Trust Board in February 2024. Neil Gammon suggested that the Trust Board was advised that meeting had not been quorate in respect of Executive Directors until about two thirds of the way through the meeting and that Trustees understood that this was due to the need for attendance at higher priority activities, which was extremely frustrating. Stuart Hall reiterated his disappointment in Executive Director attendance, and as he was representing the Group Chief Executive at today's meeting this would be reported back to Jonathan Lofthouse, Group Chief Executive.

12. Date of Next Meeting

3 April, 2024, 9.00am to 12.00pm – MS Teams

Cumulative Record of Attendance from January 2024 – HTF (NLaG)

Name	Title	2024			
		January	April	July	October
CORE MEMBERS					
Neil Gammon	Chair / Non-Executive Director (NED)	Y			
Lee Bond	Group Chief Financial Officer	N			
Stuart Hall	NED (HUTH)	Y			
Sue Liburd	NED	Y			
Jonathan Lofthouse	Group Chief Executive Officer	D			
Ivan McConnell	Group Director of Strategy & Partnership	Y			
Simon Parkes	NED	N			
Gill Ponder	NED	Y			
Dr Kate Wood	Group Chief Medical Officer	N			
REQUIRED ATTENDEES					
Tony Burndred	Governor Observer	Y			
Alison Hurley	Deputy Director of Assurance	Y			
Simon Leonard	Comms Assistant	Y			
Jamie Lewis	CEO HEY Smile Foundation	Y			
Paul Marchant	Senior Accountant	Y			
Simon Nearney	Group Chief People Officer	N			
TBC	Deputy Chief Nurse				
Lucy Skipworth	HTF Charity Manager	Y			
Clare Woodard	Head of Business Development	Y			
VACANT	Group Director of Estates & Facilities				

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)074

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships Officer
Contact Officer/Author	Adam Creeggan, Group Director of Performance
Title of the Report	Integrated Performance Report (IPR) – 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 Performance, Estates & Finance Committee-in-Common – March 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 ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

IPR Executive Summary	Date: March 2024

Access and Flow – Shaun Stacey

Highlights:

- Cancer – 28 Day Faster Diagnosis
- Inpatient Elective Average Length of Stay
- Inpatient Non-Elective Average Length of Stay

Lowlights:

- % Under 18 Weeks Incomplete RTT Pathways
-
-

Key Issues to address this period

% Under 18 Weeks Incomplete RTT Pathways

Outpatient Overdue Follow Up Appointments (Non RTT)

Ambulance Handover Delays 60+ Minutes

What improvement action was implemented?

Waiting list initiatives to recover lost activity due to industrial action.

Patient Knows best patient portal is being developed to support condition specific PIFU pathways.

45 minutes Ambulance Handover zero tolerance protocol/pathways in place

Expected Outcome and what opportunities can we leverage?

Increased Capacity will increase the volume of clock stops and potentially increase performance.

Increasing patients on PIFU should decrease Outpatient Overdue Follow Up Appointments

Zero tolerance to 45-minute Ambulance Handovers should decree the volume of delays over 60 minutes.

Executive Summary	
Urgent and Emergency Care	Since July 2023 there has been a significant increase in Emergency department attendances. This continues to create delays in the department. Delays in ambulance handovers (1028 patients waited over 60 minutes), patients waiting more than 12-hours without a decision to admit (853 patients), and patient discharged within 4 hours (59.5.%) have all fallen short of trajectory in month and are a deteriorating position against last month.
Cancer	Multifactorial issues contribute to the inability of most tumour sites to deliver 85% of the 62-day GP referral to treatment standard with indicative performance in February achieving 52.7% . The trust is behind the 90-patient trajectory and is currently showing 132 over 62+ day waits. Diagnostic tests requested within 7 days achieved 51.83% and those requested within 14 days is improving and is at 85.1%. This has positively impacted on achieving diagnosis within 28 days but has not supported the subsequent transfer to the tertiary centre by day 38. Improvement actions are being implemented to improve the front end of the pathway, these include an increase in ultrasound capacity for fine needle aspirations and plans to remove prostate biopsies out of theatre from January will increase capacity for prostate (TRUS, TP) biopsies to reduce turnaround times to below 9 days for biopsy (as per Best Practice Timed pathway), and TURBT procedures for kidney patients. Additional OPA, hysteroscopy/colposcopy, pathology outsourcing, prostate biopsy capacity and oncology sessions planned Jan-March 24. Operational challenges in February due to the PAS Migration has implemented on outpatient capacity causing a dip in performance for 2ww.
Recovery of Elective Activity	Recovery of elective activity in February 2024 shows positive Trust performance at 108% against the 19/20 baselines. The respective plan achievement by point of delivery in month is not yet available due to the data inaccuracies following the PAS migration. Workforce vacancies and short-term sickness, issues with estate and equipment and the tail gunning of waiting lists has impacted on delivery of the RTT incomplete standard and growth in the overall waiting list size. Improvement in performance by undertaking pathway risk stratification in month has occurred through utilisation of workforce capacity when clinic activity reduced due to PAS migration. The required conversion of follow-up capacity to new capacity to achieve the 25% reduction in follow-up activity against 19/20 outturn has contributed to the increasing number of overdue follow-up patients waiting to.
Diagnostics DMO1	Diagnostic DM01 performance is showing further improvement at 16.5% though is far from the 1% performance standard required. This is evident in the Diagnostic waiting list which has reduced to 13,076 ahead of the agreed target of 15652. However, the modalities/procedures with the greatest challenges are Audiology Assessments Cystoscopy Echocardiography and Non-Obstetric Ultrasound
Long Waiting Patients	The position at the end of February shows 4 x 78-week patients 3 of which are patients validated onto the waiting list through the robust validation process in place ahead of the new PAS Migration. There are 103 patients waiting more than 65 weeks that still require treatment this is an improved position compared to the 170 unvalidated patients shown in the graph, which have incorrectly pulled through during the data migration process.
Discharge	The number of patients waiting 7 and 21 days for discharge has increased in February though patients waiting +14 days has seen a reduction. Bed occupancy is at 93.7% which is above the expected 92% standard. Exit block due to Social Care Constraints such as staffing, interim bed availability, lack of availability of packages of care and infection control constraints are contributory factors to these delays in discharge.

Quality & Safety – Kate Wood

Highlights:

- Clostridium Difficile figures remain at 17 out of a national target of 20. All Recent reported cases reviewed and deemed unavoidable with no lapses in patient care.
- 85% Complaints responded to within the 60 days KPI, and we have received 1665 FFT responses.
- Significant increase in the number of MCA assessments that meet the legal requirement, 35% in December 2023 compared to 6% in November 2023.
- The SHMI value continues to remain in the 'as expected' banding with a value of 100.28 for the latest period November 2022 – October 2023
- The percentage of SJRs sighting problems in care/negative learning associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation has reduced from 25% in October 2023 to 15% in December 2023.
- VTE risk assessment shows special cause of improving nature achieving 95.6% in February 2024.

Lowlights:

- Although falls are showing an improving trend there has been an increase of 20 – x12 no harm, x7 minor harm and x2 moderate/major harm.
- MRSA Bacteraemia case identified at SGH
- X2 wards have a Care Hour Per Patient bed Day (CHPPD) below 6.0
- Data beyond December 2023 is not currently available to monitor anticipatory medication prescribed due to vacancies within the WebV team.
- There has been a pause in available data to monitor weight recorded in ePMA due to the migration to Lorenzo.
- The recording of best interest for adults who lack capacity and meet the legal requirements remains challenged.

Key Issues to address this period

Falls
The x2 falls with moderate/major harm were reviewed by a multi-disciplinary team.

MRSA
MRSA bacteraemia identified on ward 24 and will be fully reviewed on the 14th of March 2024

CHPPD
X2 wards have a Care Hour per Patient Bed Day (CHPPD) below 6.0

Anticipatory medication data
Data beyond December 2023 is not currently available to monitor anticipatory medication prescribed due to vacancies within the WebV team.

Weight recorded in ePMA data
There has been a pause in available data to monitor weight recorded in ePMA due to the migration to Lorenzo.

Best interest recording
The recording of best interest for adults who lack capacity and meet the legal requirements remains challenged.

What improvement action was implemented?

Falls
Swarm huddles were completed within 48 hours with good multi-disciplinary attendance. Both incidences were on the same ward and have been reviewed in the monthly nursing metrics meeting with no concerning trends. There was no new learning identified at both huddles and the care was appropriate for both patients

MRSA
To await the outcome of the MRSA bacteraemia review meeting and to cascade and escalate any learning.

CHPPD
The 2 wards with a low CHPPD ratio are Amethyst (5.9) and Ward 26 (5.6). Amethyst vacancy rate has decreased by 2.0 WTE and the registered staff sickness reduced in January to 7.2% - unregistered staff has increased to 9.3%. Ward 26 vacancies have decreased to 0.7% the registered staff sickness has increased to 14.2% and unregistered staffing increased to 7.00%. Both these areas sickness is being managed robustly.

Anticipatory medication data
Gaps in availability of data has been escalated to the WebV team who are working on a solution for next month.

Weight recorded in ePMA data
In the interim data is being collected manually by the QI team as part of the QI project that has commenced on pilot wards A1, IAAU, B7 and Short Stay at DPoW and wards 5, 24, 28 and Stroke Unit at SGH. An observational audit of Ambulance staff weighing patients on arrival at both EDs has been completed. Data analysis is underway and an action plan will be developed.

Best interest recording
The percentage of MCA assessments that meet the legal requirements has significantly improved from 6% in November 2023 to 35% in December 2023. We are starting to see improvements in the completion of some elements of the assessments. For example, 66% of assessments completed on Ward B6 in December 2023 had evidence that the patients had been supported to make a decision compared to 0% in May 2023. It is anticipated that through further education, Best Interest recording will

also start to improve. The MCA/DoLS Lead is continuing to provide targeted support to ward B6 staff and bespoke feedback forms for staff who have completed MCA assessment and best interest forms are shared for learning. Bitesize training sessions have been delivered to Ward B6. The MCA working group continue to meet to share learning and change ideas.

Expected Outcome and what opportunities can we leverage?

Falls
To continue to review all patients with moderate and major harm at swarm huddles and to understand and implement any new learning.

MRSA
To review the learning from the MRSA bacteraemia meeting

CHPPD
To continue to support both wards with sickness support and to ensure the wards are covered appropriately with bank and agency staff or movement of other staff to ensure patient safety is maintained.

Anticipatory medication data
Improve oversight of the percentage of anticipatory medication prescribed.

Weight recorded in ePMA data
Improve safety of weight related prescribing.

Best interest recording
Improved patient/carers experience due to compliance with the MCA.

Workforce – Simon Nearney

Highlights:

- Registered Nursing Vacancy remains below target at 6.6% against a target of 8%
- The Trust wide Vacancy rate has seen a further decrease which is still below target, this is now at 7.66% and the lowest it has been since recording of the IPR.
- The combined PADR rates remain above target at 85.7% Agenda for Change staff at 85% and Medical and Dental Staff at 96.5%

Lowlights:

- Role Specific Mandatory Training remains below target at 79.3% against a target of 85%
- Sickness rates remain above target by 1.4% and is currently at 5.6%
- The Medical vacancy rate for consultants remains high at 19.49% against a target of 15%

Key Issues to address this period

Role Specific Mandatory Training
Role Specific Mandatory training compliance has, also, seen a slight improvement in compliance (0.4%) since the previous report but remains 5.7% below the Trust target.

Sickness Rate
Sickness levels have increased in January 2023 which has peaked above this time last year.

Medical Vacancy Rate for Consultants
This month sees an increase in the vacancy factor.

What improvement action was implemented?

Role Specific Mandatory Training
Moving and Handling (all modules) and Resuscitation (all modules) compliance rates continue to be monitored closely, with the former improving by a further 1%, since the previous report, to 83%, and the latter maintaining 68% compliance. During February 2024, 259 staff enrolled onto a Moving and Handling module, with 127 completing. At 49% completion, this is a 12 % improvement from the previous report. No

improvement, however, has been noted in the volume of DNAs across the month. Further, 508 staff enrolled onto a Resuscitation module during February 2024, with 345 completing. At 68% completion, this is a 5% improvement from the previous month and the % of DNAs reduced during the same time period. As in the previous report, Mental Capacity Act and DOLS compliance remains below 80% but has seen a 1.26% improvement, being 78.86% at the time of reporting. The number of staff out of compliance for this competency has reduced by 57 to 866 @ 5.3.24, following an improved completion rate to the classroom-based provision delivered in February 2024. Any eLearning with low compliance continues to be addressed via directed communication, with accessible links, to relevant staff who are out of compliance. During February 2024, Sepsis Training and NG Tube Displacement were focus areas and slight improvements have been seen in each, though they remain significantly below the 85% target so directed communication will continue throughout March 2024. Medical and Dental remains the lowest compliance in terms of staff groups though there has been an 8.37% improvement since the previous report, now at 61.71%. This staff group also reported a 65% completion rate for all classroom-based provision during February 2024, an improvement of 8% compared to January 2024.

Sickness Rate
On further review of the data, short term absence has increased owing to an increase in absences related to cold/cough/flu. There are 3 divisions where absence levels have seen a sudden increase and therefore targeted work will be undertaken to review in detail and ensure appropriate support and advice.

Medical Vacancy Rate for Consultants
2 Consultants are scheduled to start in March, with a further 5 appointed in the pipeline.

Expected Outcome and what opportunities can we leverage?

Role Specific Mandatory Training
A full action plan to address barriers identified by Medical and Dental staff group will be developed at the meeting on 12.3.24 as indicated in the Core Mandatory training report across the page.

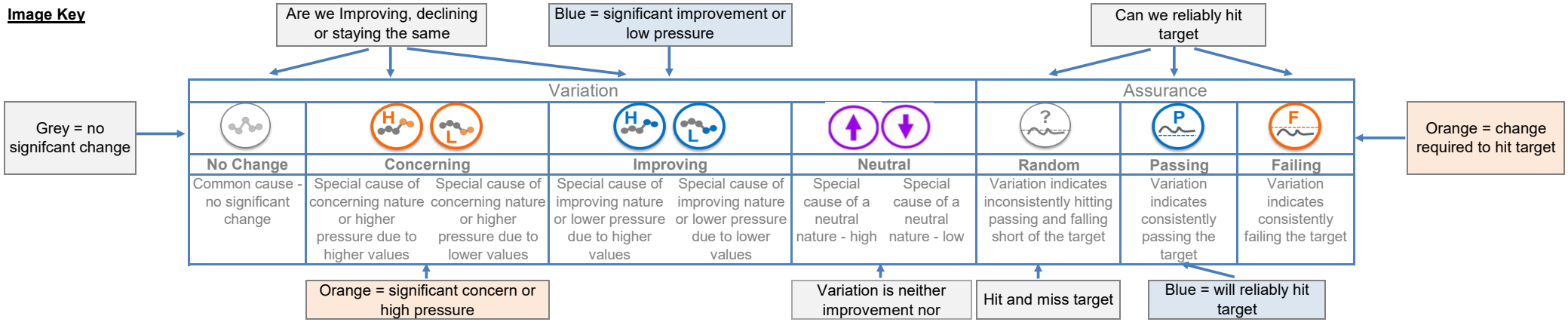
Sickness Rate

The HR team continue to provide monthly training on attendance management, which has recently been modified to increase interactivity and engagement, and ad hoc sessions where it is identified this is required.

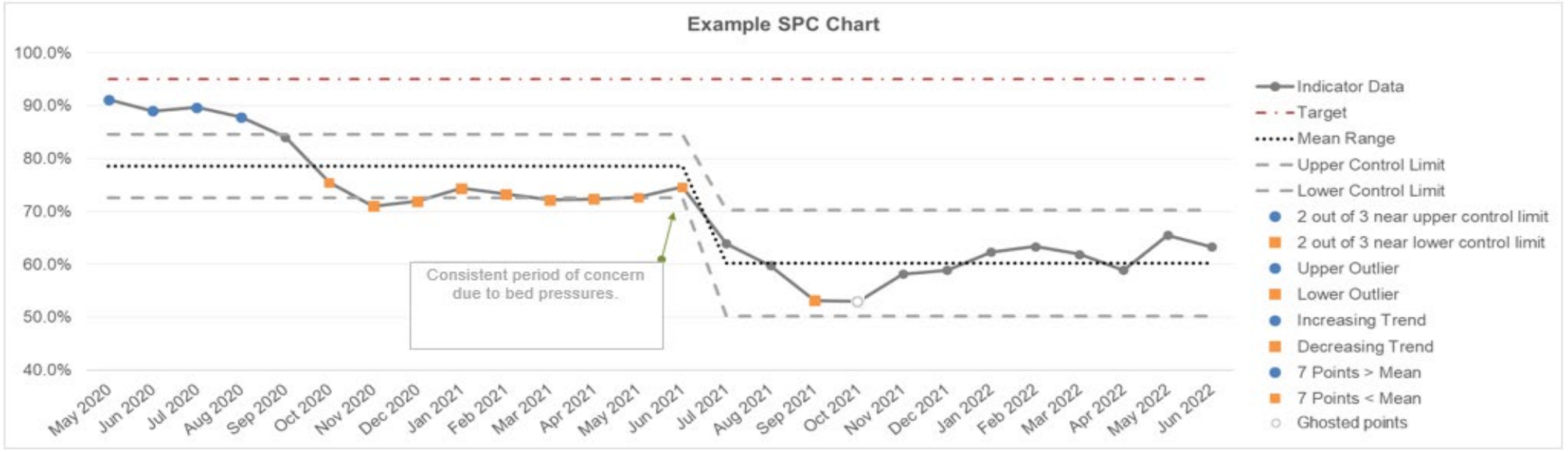
Medical Vacancy Rate for Consultants

A review of the Group's approach to sourcing Consultants to improve the process is underway, with the aim of increasing capacity focused on Consultant level recruitment. An amended AAC policy has been drafted and reviewed by JLNC and is currently undergoing further wider clinical engagement to create a Group AAC approach. In addition the use of resources within the recruitment team has been reviewed with changes in working practices underway, this includes a specific focus on sourcing via the Talent Acquisition team and allocation of a dedicated Recruitment Officer to focus on Consultant recruitment. The Group is exploring programmes to train and develop employees into Consultant roles, these include Training Fellowships and a Portfolio Pathway programme. Relationships have been developed overseas and an MOU signed at ICB level to facilitate sourcing of quality candidates into these roles for development. A Group-wide review of the branding and identity of the Group is also being developed to assist with domestic Consultant recruitment, to be included in various advertising platforms. A project plan is in place for development of these initiatives with a planned implementation date of 1st May 2024.

Image Key



Note: 'Action Required' is stated on the Scorecard when either the Variation is showing special cause concern or the Assurance is indicating failing the target (where applicable). This is only applicable where there is sufficient data to present as a Statistical Process Control Chart (SPC).



Orange Squares = significant concern or high pressure	Blue Circles = significant improvement or low pressure	Arrow = Process Limits Re-calculation point

Notes on Process Limits Re-Calculation

Process limits will be affected when there has been a change in an operational process or procedure that has resulted in a change to the data, for example a process improvement or impact.

This might be shown as:-

- The data points are consistently on one side of the mean.
- A statistically significant change in the data triggers consistent special cause variation on the same side of the mean.

Re-calculation, when appropriate, allows us to see whether we are likely to consistently achieve any target and will still allow us to see of improvement or deterioration is occurring.

The following principles apply when deciding whether to re-calculate:-

- There should be an identifiable real process change that resulted in the above.
- The change must have been sustained for an appropriate number of data points.

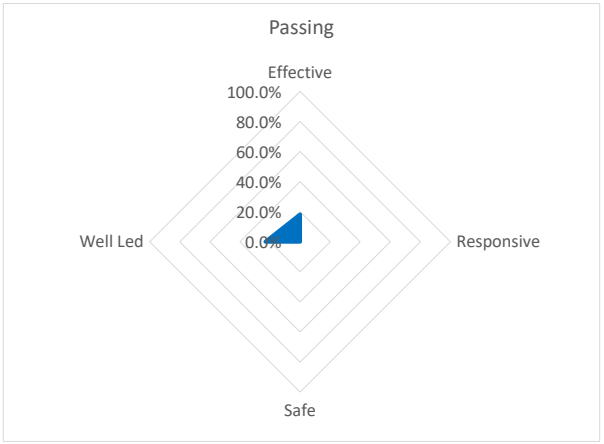
Radar

Note: Only indicators with a target are relevant for this page as it is based on the target assurance element of the indicator.
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

Total: 5



% Discharge Letters Completed Within 24 Hours of Discharge
Core Mandatory Training Compliance Rate
Medical Staff PADR Rate
Inpatient Non Elective Average Length Of Stay
Medical Vacancy Rate - Other*

Hit and Miss

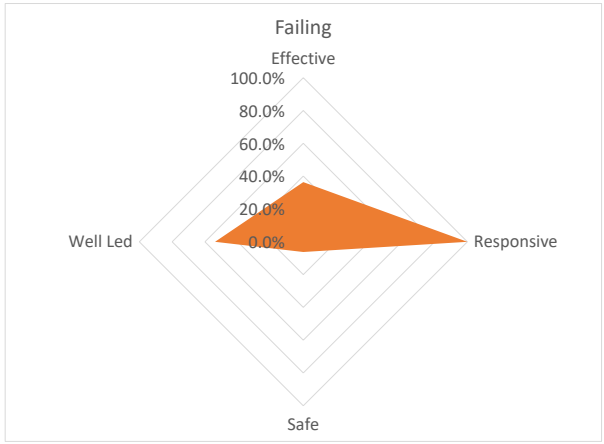
Total: 24

% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Combined AfC and Medical Staff PADR Rate
Duty of Candour Rate
Mixed Sex Accommodation Breaches
Number of Serious Incidents raised in month
PADR Rate
Patient Safety Alerts to be actioned by specified deadlines
Venous Thromboembolism (VTE) Risk Assessment Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Complaints Responded to on time
Falls on Inpatient Wards (Rate per 1,000 bed days)
Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1,000 bed days)
Formal Complaints (Rate Per 1,000 wte staff)
Spontaneous 3rd or 4th Degree Tear
Instrumental 3rd or 4th Degree Tear
Number of Deliveries With Post Partum Haemorrhage > 1500 ml
Still Birth Rate per 1000
Number of incidents with harm caused due to failure to recognise or respond to deterioration

Harm impact for weight related medication prescribing incidents
Robson Scores - Group 1
Robson Scores - Group 2
Medical Vacancy Rate*

Consistently Failing

Total: 28



% Inpatient Discharges Before 12:00 (Golden Discharges)
% Outpatient Non Face To Face Attendances
Ambulance Handover Delays - Number 60+ Minutes
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Emergency Department Waiting Times (% 4 Hour Performance)
Number Of Emergency Department Attendances
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
Outpatient Did Not Attend (DNA) Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Role Specific Mandatory Training Compliance Rate
Total Inpatient Waiting List Size
Turnover Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Sickness Rate
Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*
Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge
Cancer Request To Test In 7 Days*
Number of Incomplete RTT pathways 65 weeks

Community Acquired Pressure Ulcers (Number)
Friends & Family Test: Inpatient Score Percentage Positive
Friends & Family Test: A&E Score Percentage Positive
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H	% Discharge Letters Completed Within 24 Hours of Discharge	% Patients Discharged On The Same Day As Admission (excluding daycase)	Outpatient Did Not Attend (DNA) Rate
			Inpatient Non Elective Average Length Of Stay	Inpatient Elective Average Length Of Stay	Friends & Family Test: Inpatient Score Percentage
		L	Medical Vacancy Rate - Other*	Patient Safety Alerts to be actioned by specified	Turnover Rate
				Number of Serious Incidents raised in month	Unregistered Nurse Vacancy Rate*
				Duty of Candour Rate	Registered Nurse Vacancy Rate*
				Venous Thromboembolism (VTE) Risk Assessment Rate	Trustwide Vacancy Rate*
				Mixed Sex Accommodation Breaches	
				Falls on Inpatient Wards (Rate per 1,000 bed days)	
				Combined AfC and Medical Staff PADR Rate	
				Medical Vacancy Rate*	
	Common Cause		Medical Staff PADR Rate	% of Extended Stay Patients 21+ days	% Inpatient Discharges Before 12:00 (Golden Discharges)
			Core Mandatory Training Compliance Rate	Complaints Responded to on time	% Outpatient Non Face To Face Attendances
				Hospital Acquired Pressure Ulcers on Inpatient Wards	Ambulance Handover Delays - Number 60+ Minutes
				Spontaneous 3rd or 4th Degree Tear	Cancer Waiting Times - 104+ Days Backlog*
				Instrumental 3rd or 4th Degree Tear	Emergency Department Waiting Times (% 4 Hour
				Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Number Of Emergency Department Attendances
				Still Birth Rate per 1000	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*
				Number of incidents with harm caused due to failure to recognise or respond to deterioration	Cancer Request To Test In 7 Days*
				Harm impact for weight related medication prescribing	Number of Patients Waiting Over 12 Hrs From Decision
				Robson Scores - Group 1	Community Acquired Pressure Ulcers (Number)
				Robson Scores - Group 2	Friends & Family Test: A&E Score Percentage Positive
				Formal Complaints (Rate Per 1,000 wte staff)	Role Specific Mandatory Training Compliance Rate
				PADR Rate	Sickness Rate
					Medical Vacancy Rate - Consultants*
	Special Cause Concern	H		Bed Occupancy Rate (G&A)	Number of Overdue Follow Up Appointments (Non RTT)
					Cancer Waiting Times - 62 Day GP Referral*
		L			Number of Incomplete RTT pathways 52 weeks*
					Percentage Under 18 Weeks Incomplete RTT Pathways*
					Total Inpatient Waiting List Size
					Diagnostic Procedures Waiting Times - 6 Week Breach
					Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge
					Number of Incomplete RTT pathways 65 weeks

Scorecard - Access and Flow

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

Planned	% Under 18 Weeks Incomplete RTT Pathways*	Feb 2024	57.5%	92.0%	**Alert**		
	Number of Incomplete RTT pathways 52 weeks*	Feb 2024	977	353	**Alert**		
	Total Inpatient Waiting List Size	Jan 2024	12,624	11,563	**Alert**		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Feb 2024	16.5%	1.0%	**Highlight**		
	Number of Incomplete RTT pathways 65 weeks	Feb 2024	170	0	**Alert**		
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Feb 2024	42,548	9,000	**Alert**		
	Outpatient Did Not Attend (DNA) Rate	Feb 2024	6.0%	5.0%	**Alert**		
	% Outpatient Non Face To Face Attendances	Feb 2024	19.3%	25.0%	**Alert**		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Feb 2024	52.7%	85.0%	**Alert**		
	Cancer Waiting Times - 104+ Days Backlog*	Feb 2024	26	0	**Alert**		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Feb 2024	11.1%	75.0%	**Alert**		
	Cancer - Request To Test In 7 Days*	Feb 2024	50.6%	100.0%	**Alert**		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2024	59.5%	76.0%	**Alert**		
	Number Of Emergency Department Attendances	Feb 2024	14,485	10,114	**Alert**		
	Ambulance Handover Delays - Number 60+ Minutes	Feb 2024	1,028	0	**Alert**		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Feb 2024	853	0	**Alert**		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Feb 2024	588	0	**Alert**		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Feb 2024	46.2%	40.0%			
	% of Extended Stay Patients 21+ days	Feb 2024	13.2%	12.0%			
	Inpatient Elective Average Length Of Stay	Feb 2024	2.0	2.5			
	Inpatient Non Elective Average Length Of Stay	Feb 2024	3.3	3.9	**Highlight**		
	% Discharge Letters Completed Within 24 Hours of Discharge	Feb 2024	97.6%	90.0%			
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Feb 2024	17.5%	30.0%	**Alert**		
	Bed Occupancy Rate (G&A)	Feb 2024	93.7%	92.0%	**Alert**		

Scorecard - Quality and Safety

NHS Northern Lincolnshire and Goole NHS Foundation Trust

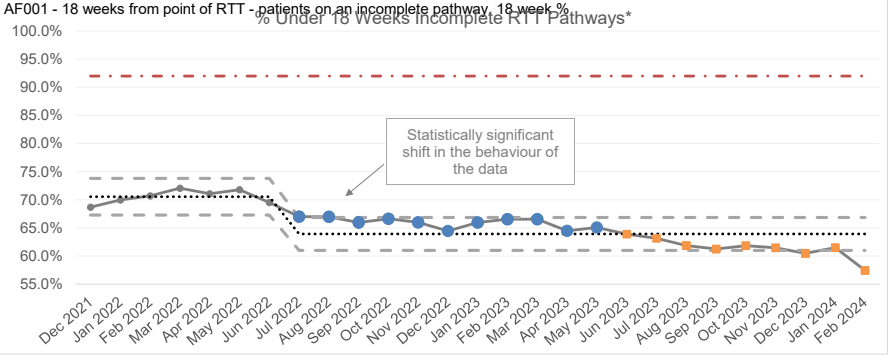
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Jan 2024	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jan 2024	0.20	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jan 2024	0.10	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jan 2024	0.05	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jan 2024	0.24	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Nov 2023	101.9	As expected	**Highlight**		As expected
	Summary Hospital level Mortality Indicator (SHMI)	Sep 2023	102.0	As expected			As expected
	SHMI diagnosis groups outcome risk percentage (infections)	Sep 2023	109.5%	No target			n/a
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Dec 2023	15.0%	18%		n/a	n/a
Safe Care	Patient Safety Alerts actioned by specified deadlines	Feb 2024	100.0%	100%			
	Number of Serious Incidents raised in month	Jan 2024	0	8.7			
	Occurrence of 'Never Events' *(Number)*	Jan 2024	0	0		n/a	n/a
	Duty of Candour Rate	Jan 2024	100.0%	100%			
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2024	4.7	5.87			
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2024	3.5	3.67			
	Venous Thromboembolism (VTE) Risk Assessment Rate	Feb 2024	95.6%	95.0%	**Highlight**		
	Care Hours Per Patient Day (CHPPD)	Jan 2024	8.5	No target			n/a
	Mixed Sex Accommodation Breaches	Jan 2024	5	0			
	Community Acquired Pressure Ulcers (Number)	Jan 2024	48	0	**Alert**		
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Jan 2024	5.3	5.53			
	Complaints Responded to on time	Jan 2024	86.7%	85.0%			
	Friends & Family Test: Inpatient Score Percentage Positive	Jan 2024	96.5%	100%	**Highlight**		
	Friends & Family Test: A&E Score Percentage Positive	Jan 2024	70.3%	100%	**Alert**		
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Jan 2024	4.0	0%			
Mental Capacity	Number of contacts with the MCA/DoLS team	Feb 2024	2.0	0%		n/a	n/a
	Percentage of MCA assessments that meet the legal requirements	Dec 2023	35.0%	50%		n/a	n/a
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Dec 2023	0.0%	100%		n/a	n/a
Prescribing	Harm impact for weight related medication prescribing incidents	Feb 2024	1	1.53			
Maternity	Robson Scores - Group 1	Feb 2024	9.5%	7.1%			
	Robson Scores - Group 2	Feb 2024	40.8%	51.1%			
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Feb 2024	6	2.80			
	Still Birth Rate per 1000	Feb 2024	0.0	3.54			
	Spontaneous 3rd or 4th Degree Tear	Feb 2024	1.2%	3.1%			
	Instrumental 3rd or 4th Degree Tear	Feb 2024	0.0%	3.1%			

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

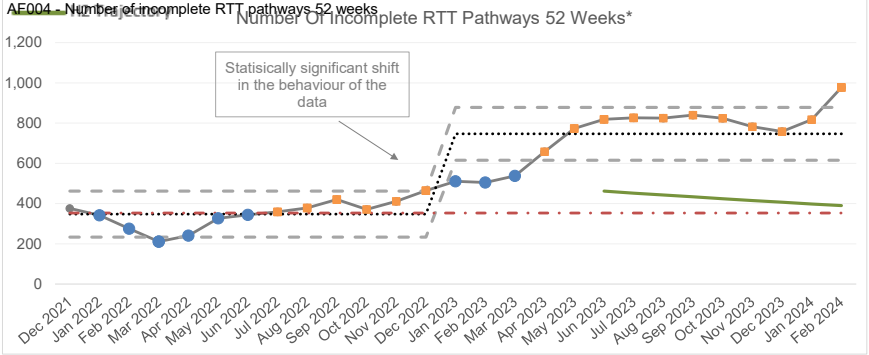
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate*	Feb 2024	10.2%	8.0%	Alert	L	F
	Registered Nurse Vacancy Rate*	Feb 2024	6.6%	8.0%	Highlight	L	F
	Medical Vacancy Rate*	Feb 2024	12.0%	15.0%	Highlight	L	?
	Trustwide Vacancy Rate*	Feb 2024	7.7%	8.0%	Highlight	L	F
	Medical Vacancy Rate - Consultants*	Feb 2024	19.5%	15.0%	Alert		F
	Medical Vacancy Rate - Other*	Feb 2024	7.5%	15.0%	Highlight	L	P
Staffing Levels	Turnover Rate	Feb 2024	10.7%	10.0%	Alert	L	F
	Sickness Rate	Jan 2024	5.6%	4.1%	Alert		F
Staff Development	PADR Rate	Feb 2024	85.0%	85.0%			?
	Medical Staff PADR Rate	Feb 2024	96.5%	85.0%			P
	Combined AfC and Medical Staff PADR Rate	Feb 2024	85.7%	85.0%		H	?
	Core Mandatory Training Compliance Rate	Feb 2024	90.1%	85.0%			P
	Role Specific Mandatory Training Compliance Rate	Feb 2024	79.3%	85.0%	Alert		F

AF001 - 18 weeks from point of RTT - patients on an incomplete pathway, 18 week %



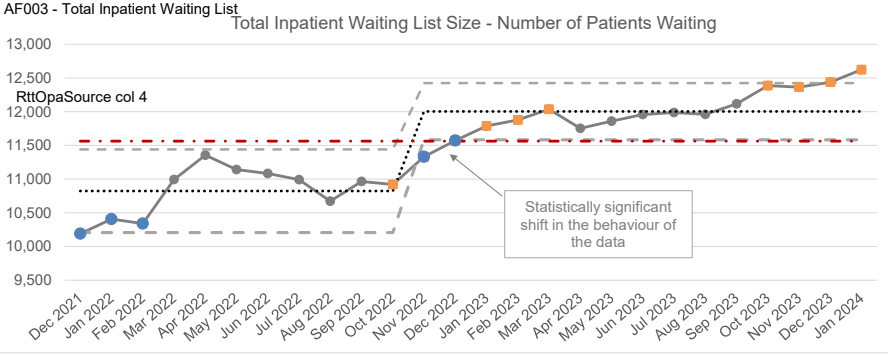
Feb 2024	Target	Variance	Assurance
57.5%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



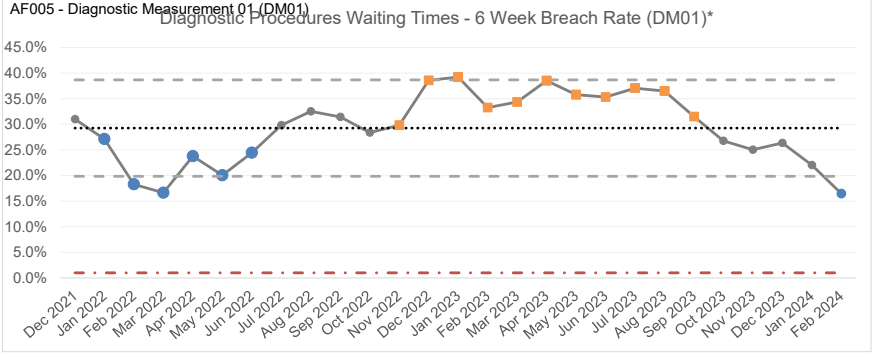
Feb 2024	Target	Variance	Assurance
977	353	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

AF003 - Total Inpatient Waiting List



Jan 2024	Target	Variance	Assurance
12,624	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

AF005 - Diagnostic Measurement 01 (DM01)



Feb 2024	Target	Variance	Assurance
16.5%	1.0%	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target

Comments

Please take note that the Trust implemented a new PAS system on 26th February 24. This may have affected data flow and resulted in some variance in the data results displayed above.
The April 24 publication will use data that has been extracted and updated from the new PAS system Lorenzo.
RTT performance deteriorating as waiting list grows as have the number of patients waiting in excess of 52 weeks. Diagnostic perfomance continues to demonstrate improvement.

Challenges:

- Reporting capacity for CT / MRI
- Workforce vacancies resulting in reduced capacity for Outpatients, subsequent increase in 52 week waits
- Balancing the risk of patient flow versus elective activity
- Acceptance of Mutual Aid
- Diagnostic Demand is greater than capacity for Echo
- Independent sector capacity following initial delays have impacted on incomplete pathways with late and limited provision for Gastroenterology throughout Q3 going into Q4
- Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted
- Significant pressures in anaesthetic assessment capacity due to pathways, sickness, vacancy and leave position - support provided through GIRFT
- Delivery of additional £13m - activity needs to increase to support delivery.
- Challenges around joint pathways with Primary Care - current shared care agreements (Rheumatology)

Key Risks:

- Ageing diagnostic equipment across mulitple modalities - loss of service provision if failures occur and clinical harm potential with assocaited delays
- Audiology DM01 decrease in performance
- Diagnostic recruitment and retention / workforce skill mix
- Impact on operational delivery due to ongoing industrial action
- Impact of ability to fill consultant vacancies in hard to fill specialties

Actions:

- Establish additional sessions to support delivery of Divisional activity plans (April 24)
- Displace lower 52ww specialties and increase Orthopaedics to tackle backlog - weekend and evening uplifts (April 24)
- Waiting list initiatives to recover lost activity due to Industrial action (March 24)
- DPOW CDC mobile pad go live (May 24)

Mitigations:

- Diagnostic equipment maintainance contracts in place, equipment risks on risk register and escalated via PRIM
- Weekly performance review in place
- Monitoring of reporting times and utilising out-sourced capacity where available
- Robust processes in place to regularly review waiting lists and focus on long waiting and high-risk patients.
- Locum staff in place where able, to maintain services
- Activity plans reviewed weekly
- Clinical risk stratification to ensure allocation of all appointments is led by clinical priority of patients
- Contract negotiations underway to secure on-going use of the Independent Sector with sign off expected with commencement of new contract
- Waiting List Initiatives have been utlised in a number of specialties to address the current long over due and patients >52 weeks, this has been done as desktop review, rather than follow up, to good effect
- Mobilisation of Community Diagnostic Centre CT/MRI vans on alternative pad locations

	Feb 2024 **170** Target **0** Variance  Special cause of concerning nature or higher pressure due to higher values Assurance  Consistently falling short of the target	This space is intentionally blank	
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Comments
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The April 24 publication will use data that has been extracted and updated from the new PAS system Lorenzo.
This data has not been validated.

Challenges:
- Reporting capacity for CT / MRI
- Workforce vacancies resulting in reduced capacity for Outpatients, subsequent increase in 52 week waits
- Balancing the risk of patient flow versus elective activity
- Acceptance of Mutual Aid
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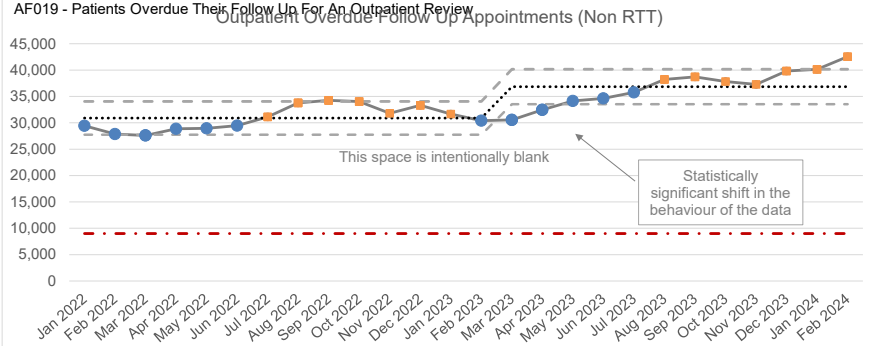
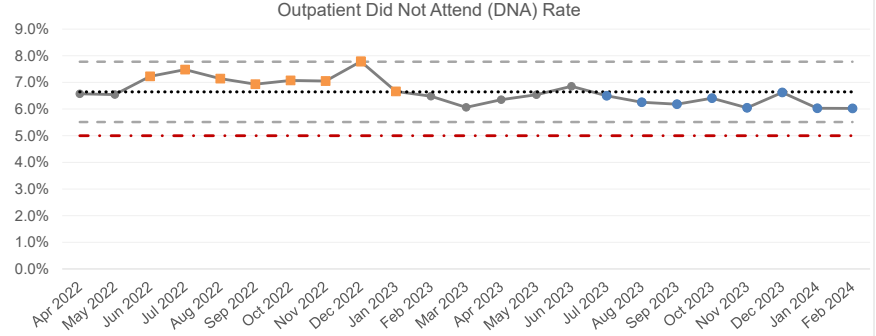
AF019 - Patients Overdue Their Follow Up For An Outpatient Review

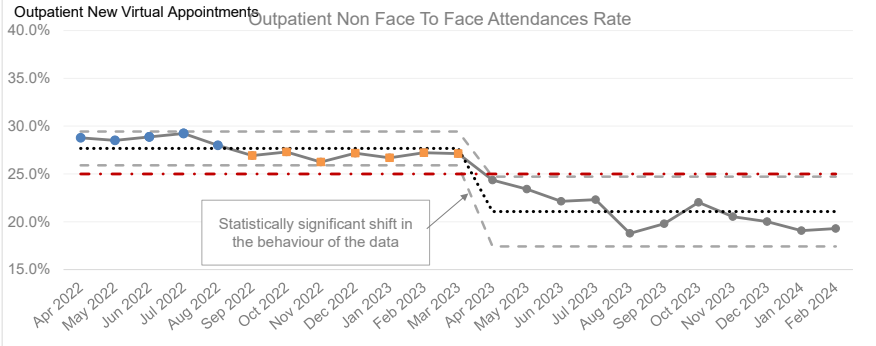


Feb 2024: 42,548
Target: 9,000
Variance: Special cause of concerning nature or higher pressure due to higher values
Assurance: Consistently falling short of the target



Feb 2024: 6.0%
Target: 5.0%
Variance: Special cause of improving nature or lower pressure due to lower values
Assurance: Consistently falling short of the target

Outpatient New Virtual Appointments



Feb 2024: 19.3%
Target: 25.0%
Variance: Common cause - no significant change
Assurance: Consistently falling short of the target

Comments

Please take note that the Trust implemented a new PAS system on 26th February 24. This may have affected data flow and resulted in some variance in the data results displayed above.
The April 24 publication will use data that has been extracted and updated from the new PAS system Lorenzo.

Challenges:

• The 25% reduction in follow-up activity continues to have a significant impact on the overdue follow-up waiting list, as we try to balance the conversion of follow-up activity to new. Despite the work invested to date, patients continue to be added to the follow-up list.
• The high number of internal consultant to consultant referrals is impacting the overdue follow-up list, an increased number of patients are being referred from ED and SDEC.
• Opportunities to progress patient validation to reduce overdue follow-ups is progressing slowly (via a direct communication to the patient) as clinical sign-up to this initiative is proving very challenging. The implementation of the new PAS is taking priority and both ENT and Gastroenterology have validated their lists and a number of patients have been discharged
• The Lorenzo Project continues to consume signficant amounts of operational leadership resource and will continue into early summer 2024
• A full evaluation of the Connected Health Network model has been completed and is awaiting review by the exec cabinet

Key Risks:

• There is a significant risk to the increasing size of the overdue follow up backlog list which has increased circa 33% since Dec 2021
• No long-term funding has been agreed for the CHN model, pump prime funding expired in March 2023 and has been funded from reserves during 23/24. No funding has been idientified for 24/25.
• Impact on operational delivery due to ongoing industrial action and implementation of the Lornenzo (Patient Administration System)

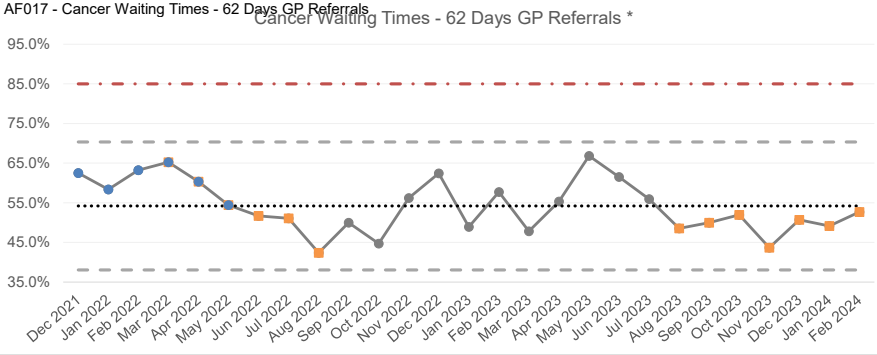
Actions:

• Within the GIRFT action plans a number of initiatives have been agreed including changes to pathways and consideration of PIFU in pathways where clinically appropriate. Work on delivery will continue for the remainder of the year (Oct - Mar 24)
• Patient Knows Best patient portal is being developed to support condition specific PIFU pathways, this will be developed throughout the course of 2024
• Work continues to encourage clinicians to utilise the various options available to manage follow-ups and prevent patients being added to the follow-up list. Focussed work has commenced within the Medicine specialties of Gastroenterology, Respiratory and Cardiology (ongoing)
• The organisation has completed the Further Faster GIRFT checklists, a gap analysis has been completed and work is being undertaken to consolidate with the GIRFT speciality outpatient plans to ensure actions are taken forward into 24/25.
• GIRFT plans will be mergerd and centralised with the aim to minimise the burden on operational teams for updating against all recommendations - June 2024
• Evaluation of CHN complete. Awaiting discussion and decision at cabinet (Mar 24)
• Data Packs have been developed to support specialties in reducing follow-up, highligting good/poor practice and showing inconsistencies across the specialty workforce. Gastroenterology is the first pilot area to use the pack. Urology, Max-fax and ENT will be complete by March 2024

Mitigations:

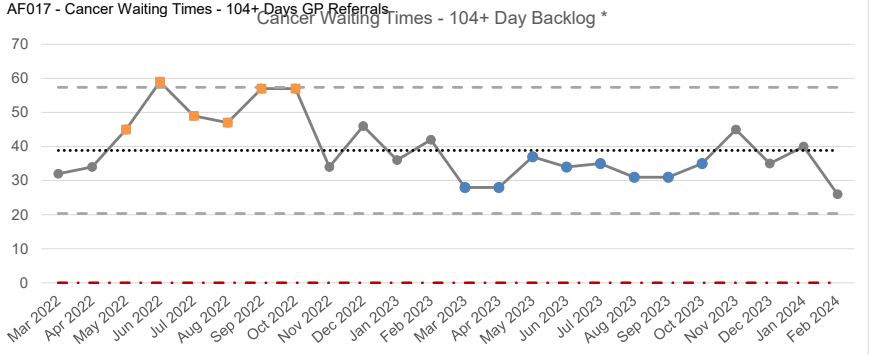
• Clinicians engaged through GIRFT to support PIFU adoption, discharge and OP Follow-up Patient Validation.
• Divisional Medical Directors engaged in discussions and proposals to validate follow-up patients (via direct correspondence)

AF017 - Cancer Waiting Times - 62 Days GP Referrals



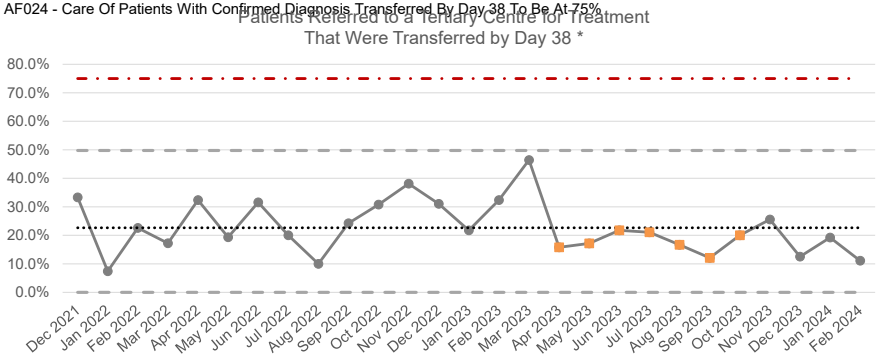
Feb 2024	Target	Variance	Assurance
52.7%	85.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



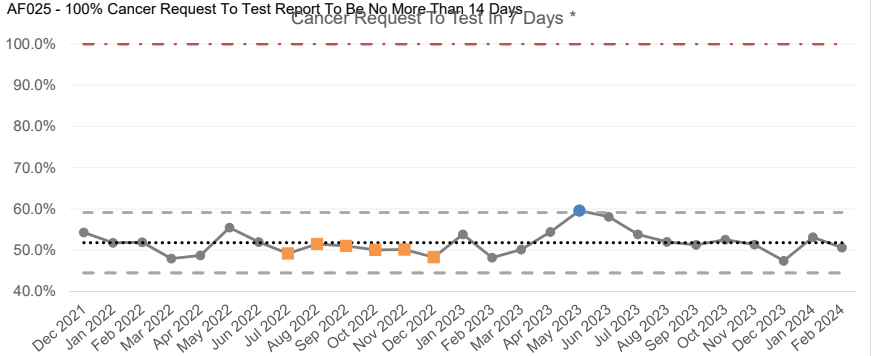
Feb 2024	Target	Variance	Assurance
26	0	Common cause - no significant change	Consistently falling short of the target

AF024 - Care Of Patients With Confirmed Diagnosis Transferred By Day 38 To Be At 75%



Feb 2024	Target	Variance	Assurance
11.1%	75.0%	Common cause - no significant change	Consistently falling short of the target

AF025 - 100% Cancer Request To Test Report To Be No More Than 14 Days



Feb 2024	Target	Variance	Assurance
50.6%	100.0%	Common cause - no significant change	Consistently falling short of the target

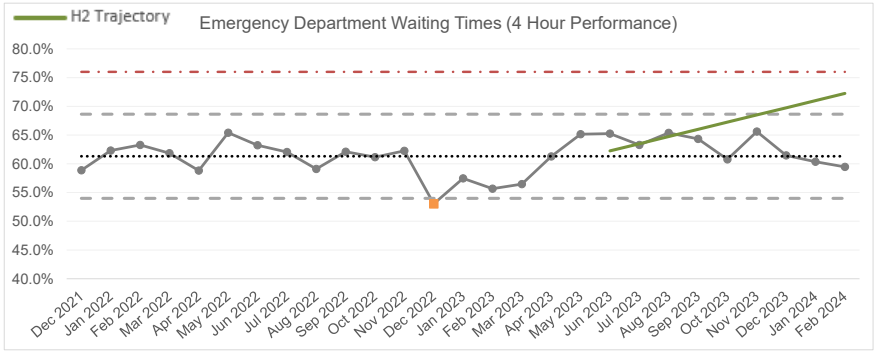
Comments
Performance below target for 62 day GP referrals and patients are still waiting for confirmation of a cancer diagnosis at 104 days. Whilst 50.6% of patients are having a request for test within 7 days this is not having a positive impact on transferring patients by day 38.

Challenges:
- All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62-day pathway)
- Management of complex unfit patients requiring significant work-up are causing delays
- Most tumour sites are unable to achieve 62-day standard due to multiple factors, including diagnostic and pathology turnaround times, patient choice
- Notable increase in Urological Cancer referrals over last 3 months and increase in 62 day breaches due to TURBT no longer being classed nationally as a first treatment
- Increase in Urology patients awaiting surgery at HUTH due to Urology Renal consultant vacancy
- Patient unavailability - patients not always aware they are on a suspected cancer pathway
- Increase in 104+ day patients due to a number of factors including access to diagnostics, surgery, oncology
- Request to test in 7 days performance has fallen - this impacts on 28 day Faster Diagnosis Standard, Best Practice timed Pathways and IPT by Day 38

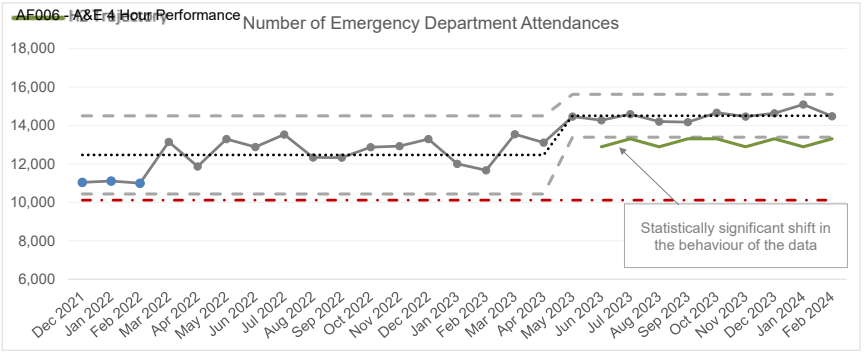
Key Risks:
- Request to Test (14 days) requires reduction to 7 calendar days to meet 28-day Faster Diagnosis Standard
- Upper GI pathway includes HUTH, currently significant delay due to demand on services
- There are issues related to visiting consultant services for Oncology referrals for tertiary based staging scans (EUS, PET CT) and associated wait for results affect the ability to transfer for treatment by Day 38 - when patients are transferring to Hull and/or other providers (e.g. Sheffield, Leeds, Brimingham)
- Shortfalls in establismmetnt results in difficulty in achieving faster diagnosis and 7 day first appointments for pateints in Lung

Actions:
- Timely removal of patients from cancer tracking once non-malignancy confirmed (Ongoing)
- Regular review with HUTH of demand and capacity for Oncology (Ongoing)
- Actions to take prostate biopsies out of theatre from Jan to ensure booking at 7 days instead of 14 days (ongoing).
- Working with Estates to refit 2 rooms at DPoW which will enable biopsy within 9 days (as set out in the prostate Best Practice Timed Pathway). Awaiting start date for the Estates work.
- Working with Diagnostics to increase ultrasound availability for FNA's (ongoing) and CT slots available within 72 hours for high risk patients (Lung) as per Best Practice Timed Pathway (ongoing)

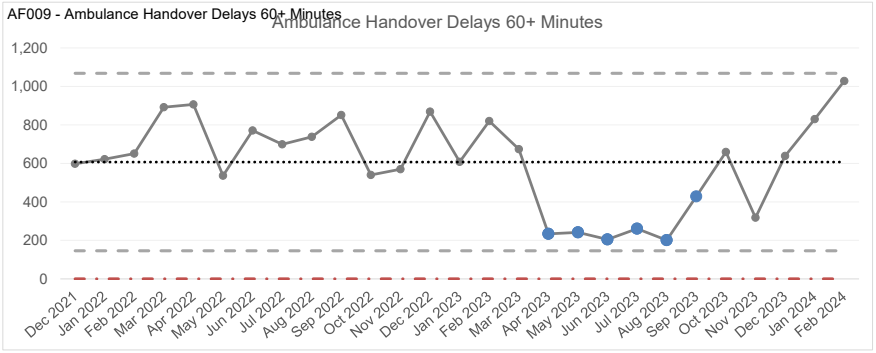
Mitigations:
- 62-day performance is being reviewed and managed weekly.
- Joint weekly PTL review between Medicine and Surgery Upper GI
- Cancer Improvement Plans developed for each cancer tumour site - undergoing revision Jan-March 24, based on impact of improvements to date.
- Micro-management of the completion of cancer packs with any incomplete after 5 working days is now being overseen at senior divisional level
- Funding now approved to recruit to administrative support roles
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLaG/ HUTH to identify areas where the pathway can be accelerated
- Review of all 104+ day patients on PTL by Divisions to remove where possible or chase up appointment times to eliminate any 104+ waiters
- Recruitment of Transformation Project Manager and support officer roles for cancer with Quality Improvement team (commence in post end Jan) to support cancer transformation work across pathways at both NLAG and cross-group services.



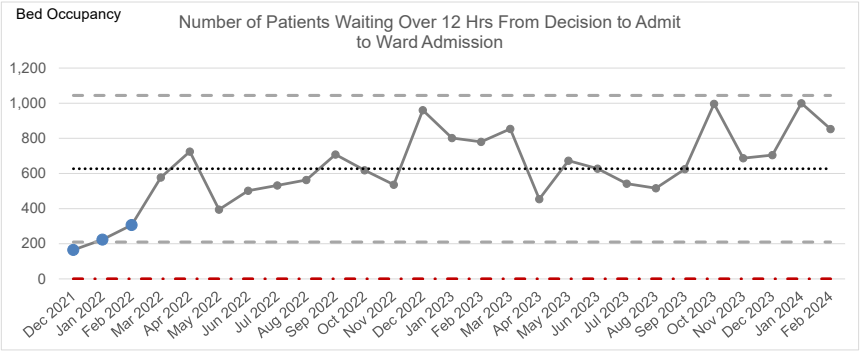
Feb 2024	Target	Variance	Assurance
59.5%	76%	Common cause - no significant change	Consistently falling short of the target



Feb 2024	Target	Variance	Assurance
14,485	10114	Common cause - no significant change	There is no target therefore target assurance is not relevant



Feb 2024	Target	Variance	Assurance
1,028	0	Common cause - no significant change	Consistently falling short of the target



Feb 2024	Target	Variance	Assurance
853	0	Common cause - no significant change	Consistently falling short of the target

Comments

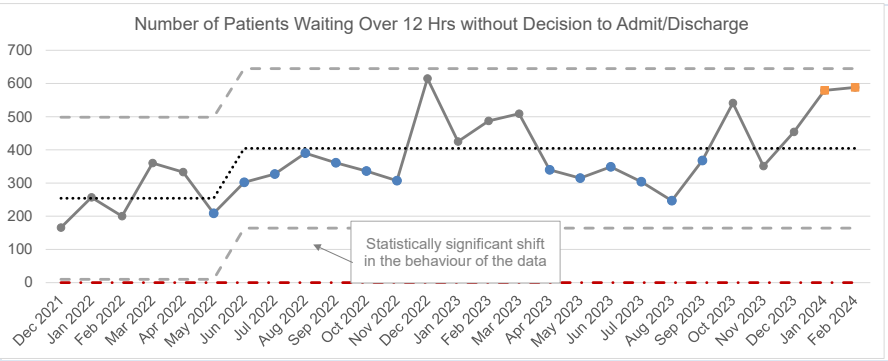
Attendances increasing, creating operational demand causing inability to meet 4hr and handover targets and delays in admitting patients.

Challenges:
- Pressure created within the community due to demand for ambulances which may be held up in hospital handover process
- Elevated level of acuity resulting in pressures within Resus and delays for walk in patients
- Same Day Emergency Care (SDEC) regularly running at full capacity
- Recruitment to support implementation of UCS 24/7 at SGH
- Demand on services impacts on hospital flow and delays in admission
- Continued rise in attendances at ED
- Available space to see patients in ED

Key Risks:
- Gaps in both medical and nurse staffing resulting in high levels of agency and locum staff
- Challenge to achieve Ambulance Handover targets due to lack of flow within the hospital - however progress being made against current targets set
- Inability to meet waiting times in Emergency department due to demand
- Staff burnout and maintaining morale through ongoing pressures - impacting on recruiting and retention

Actions:
- Opening of new SDEC/IAAU at DPoW (Jan 24) and SGH (Apr 24)
- Reiteration of the criteria to admit to all grades of clinicians within ED as part of the MADE Event (Mar 24)
- 45 minute Ambulance Handover zero tolerance protocol/pathway in place (Feb & Ongoing)

Mitigations:
- Work on-going with individual clinicians to highlight improvements in the 4 hour performance, flow and ambulance handovers
- Full review of the Consultant rota has taken place and was implemented from 08/01/24
- SDEC nurse-in-charge attends 08:00am ED board round to support identification of patients suitable for SDEC with Acute Care Phyisican in department from 0800-1700
- Direct electronic referrals to SDEC for GP/Ambulance Services via SPA now in place to support alternative pathways. Further work to be carried out to embed
- Virtual ward, Outpatient Parenteral Antimicrobial Therapy (OPAT) and Home first now implemented and work continues to embed
- Front door frailty model implemented
- Implementation of 24/7 in DPOW for UCS
- Move to 0800-0000 opening for SGH UCS



Feb 2024	588
Target	0
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Consistently falling short of the target

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Comments

Due to an increase in attendances there are delays in decision making which are exceeding 12 hours.

Challenges:

- Number of patients with a Decision to admit continues to rise - impacting on the ability to move patients from Emergency Department to Integrated Acute Assessment Unit (IAAU)
- Regularly running at capacity in SDEC, impacting Patient Flow within the department
- Use of urgent care service (UCS) rooms overnight to bed patients down resulting in a lack of rooms to see patients the following day

Key Risks:

- Lack of rooms to be able to see new patients that arrive within the department due to lack of flow out of ED
- Staff burnout and maintaining morale through ongoing pressures - impacting retention and recruitment
- Number of red flag (higher risk) patients in the Waiting Room
- Failure to meet triage targets
- Lack of flow through ED due to lack of timely discharges from all in-patient wards.
- Contiued rise in the number of patients attending ED with a rise of 25.74% for Jan 24 in comparison to Jan 23

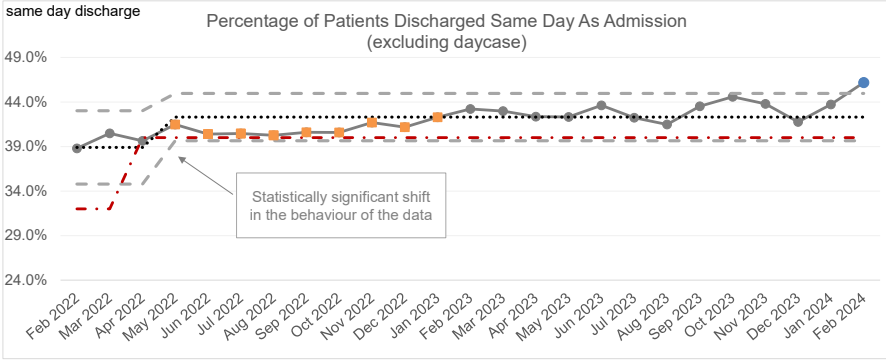
Actions:

- Progress the work to enable Live review and validation of 12 hour DTAs (Ongoing)
- New process to be introduced in relation to admissions to Medicine (led by Clinical Leads for UEC and Acute) whereby all admissions will be signed off by ED consultant 0800-0000 and Medicine Registrar 0000-0800 (ongoing)
- Live audit of patients in ED (ongoing)
- In-reach from other departments to review patients that have improved and can be discharged without admissions (ongoing)
- 45 minute Ambulance Handover zero tolerance protocol/pathway in place (Feb & Ongoing)

Mitigations:

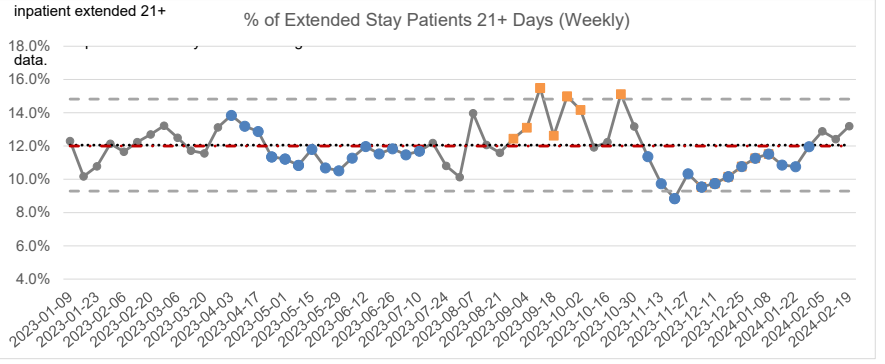
- Care standards are in place to ensure that the patients are reviewed regularly
- Two hourly Board Rounds in place and patients are reviewed where necessary
- Critical Medication Sheets are in place where required to ensure patients are receiving the medication they require whilst waiting for admission
- Position statements given at all Operational Meetings in relation to flow and bed status in ED
- In reach from relevant services is taking place daily
- Live monitoring of patients to ensure that there are no delays when there are available beds on the wards is in place
- Virtual ward, OPAT and Home First service now implemented
- Continued review of the patient numbers considering alternative pathways to ensure patients are seen and treated by the appropriate service
- Criteria to admit followed in ED to review appropriateness of admission and consideration of all alternative pathways

same day discharge

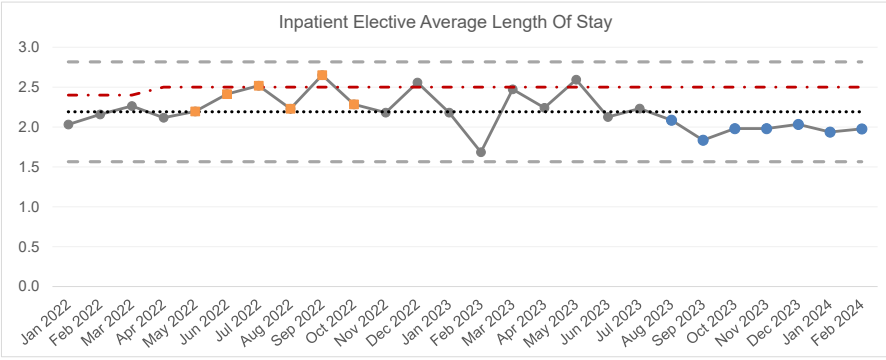


Feb 2024
46.2%
Target
40.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Inconsistently achieving and failing the target

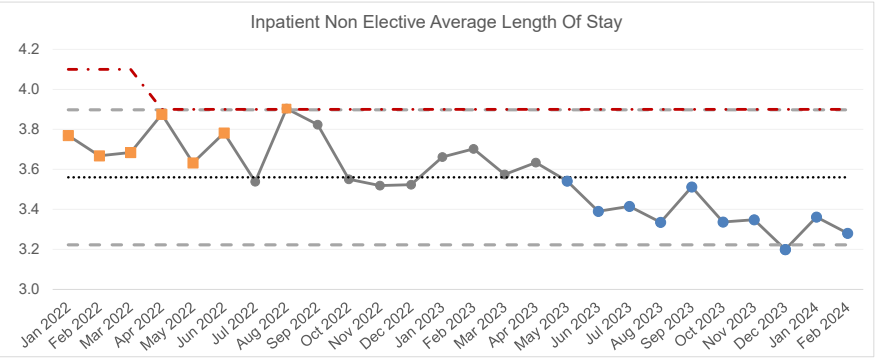
inpatient extended 21+



Feb 2024
13.2%
Target
12.0%
Variance
Common cause - no significant change
Assurance
Inconsistently achieving and failing the target



Feb 2024
2.0
Target
2.5
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently achieving and failing the target



Feb 2024
3.3
Target
3.9
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently passing the target

Comments
Please take note that the Trust implemented a new PAS system on 26th February 24. This may have affected data flow and resulted in some variance in the data results displayed above.
The April 24 publication will use data that has been extracted and updated from the new PAS system Lorenzo.

Challenges:
- Consultant vacancies impacting on service delivery
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself well to the creation of escalation beds
- Infection prevention constraints remain
- Increase in emergency attendances affecting capacity vs demand and patient flow

Key Risks:
- Space and capacity issues within SDEC/IAAU continues
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- High acuity levels and patients means more patients require further support on discharge
- Migration of PAS to Lorenzo has resulted in temporary loss/ corruption of data (Incomplete & unavailable data). This has negatively limited internal and external reporting.

Actions:
- Virtual Ward step up model from primary / community care (ongoing)
- System wide action plan in place to support patient flow (ongoing)
- Delivery of new IAAU/SDEC New Builds (DPoW Complete, 2024/25 Q1 SGH) with inclusion of Gynaecology services
- Development of General Internal Medicine / Geriatric Model to support improved patient discharges / flow (ongoing)
- Northern Lincs system No Criteria to Reside winter 5 high impact actions (ongoing)
- Planned Multi-Agency Discharge Event to commence for 7 days on Friday 22nd March 2024 (Ongoing)
- Failed Dscharge Audit completed with action plan to be developed (Ongoing)
- Audit of Estimated Discharge Date [EDD] commenced in March 2024. Action plan to be developed (Ongoing)
- Early identification of complex discharges and review of D2A referral process (Ongoing)

Mitigations:
- Admission avoidance/SPA developments continue to perform well
- Community Frailty team working within care homes and operating direct referral from UCS and SPA
- Homecare Team now fully established and providing homecare in North Lincs
- Single Point of Access available with 2-hour community response in place
- Community Response Team GP supporting Category 3 & 5 calls
- Daily meetings led by the Programme Director Home First Transformation weekdays and site senior team Sat and Sun's, who work with system partners to have a clear delayed discharge and escalation plan
- 7-Day Services for equipment provision to support discharge at both North and Northeast Lincolnshire
- Urgent Care Service and Single Point of Access to enable anticipatory/proactive management of frailty cases

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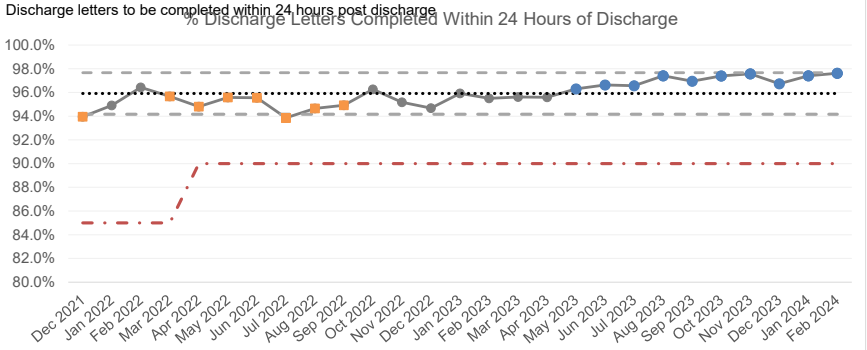
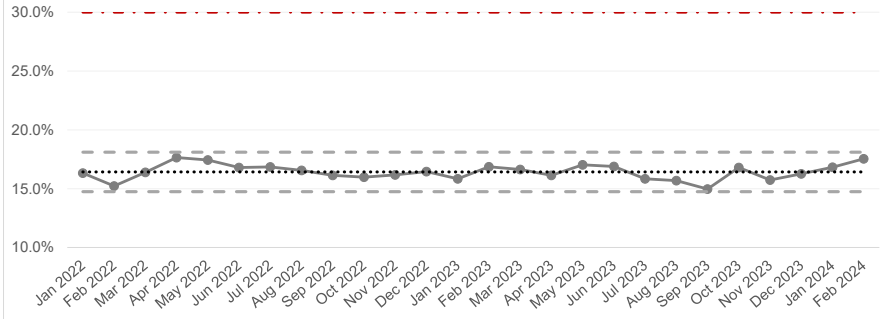
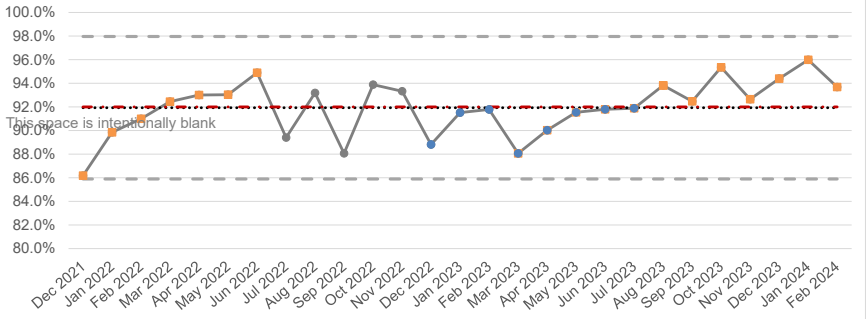
Discharge letters to be completed within 24 hours post discharge



Feb 2024
97.6%
Target
90.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently passing the target



Feb 2024
17.5%
Target
30.0%
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target



Feb 2024
93.7%
Target
92.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently achieving and failing the target

Comments

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Key Risks:

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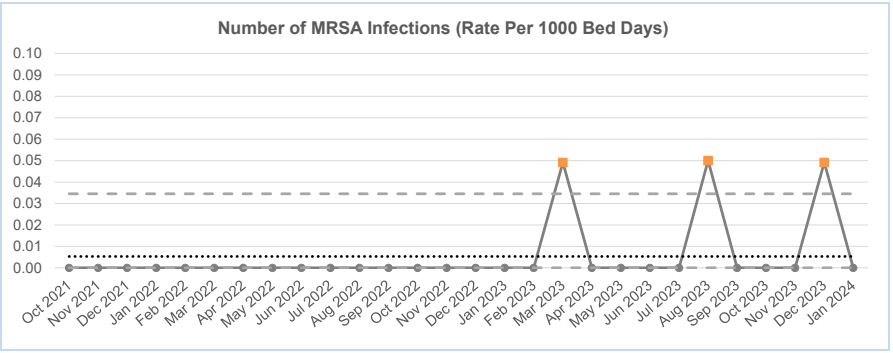
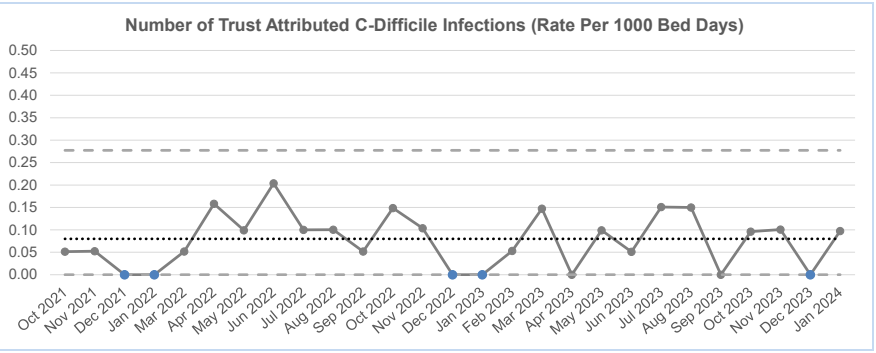
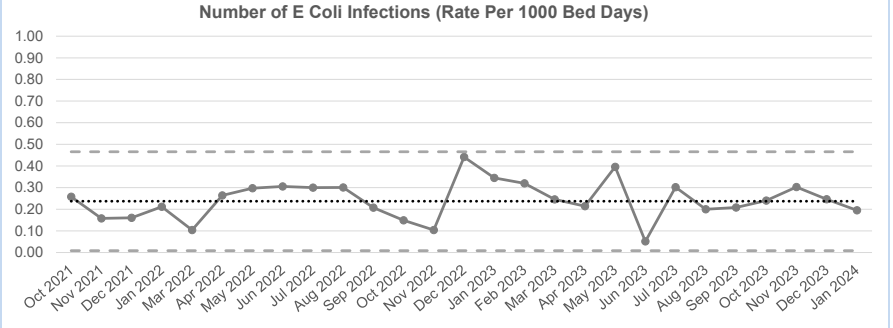


Jan 2024
0.00
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2024
0.10
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2024
0.20
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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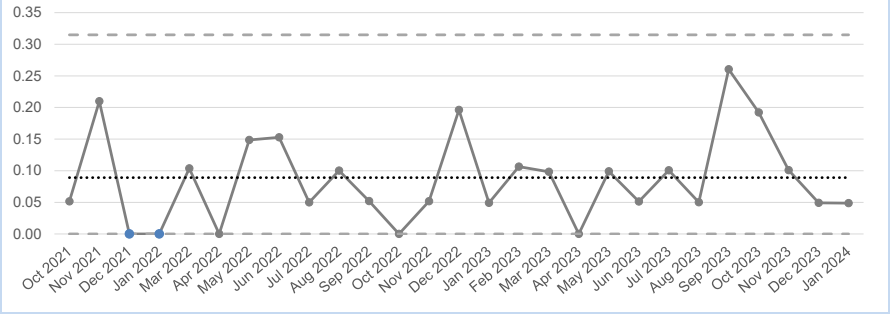
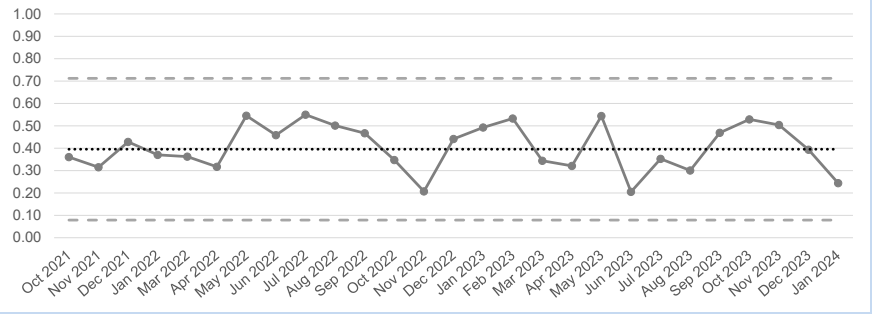
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 2 against an annual target of 1.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 17 against an annual target of 20.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 47 against an annual target of 46.

Commentary:
There has been a further MRSA bacteraemia case identified on Ward 24 at Scunthorpe. The review meeting is on 14/03/2024 and further update will be provided following the meeting. The C.Diff cases are within trajectory. Recent reported cases reviewed and deemed unavaiodable with no lapses in patient care. There has been some recent Flu outbreaks managed by the team. The areas were Ward 16 at SGH, C2 and Ward 3 at GDH. Outbreak reviews and meetings have taken place. Learning included: Timely testing, appropriate PPE and improvements in staff vaccination rates. The IPC team and the Trust Antimicrobial pharmacist took part in the National Healthcare associated Infection (HCAI) and Antimicrobial usage Points prevalence survey. The results have been provided in a summary report to the Trust and presented at IPC committee. The National report will be published by UKSHA in April 2024. There are Link worker meetings booked on all 3 sites in April Linkworkers have been invited to attend and this has been published on the HUB. There has been an iGAS outbreak within the community, the team have been working closely with Colleagues in UKSHA and the Trust Pathology team and a process has almost been completed screening community staff as a potential source of transmission. The IPC team has successfully recruited to the vacant Band 6 post and the recruitment process is progressing. The Trust are having a visit by IPC leads within the ICB to look at how as an organisation we use redirooms and the advantages this gives to improve patient safety. The team continue to meet with Divisional collegues in relation to Measles preparedness. This has been supported by CPD providing Train the trainer sessions for staff to attend.



Jan 2024
0.05
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2024
0.24
Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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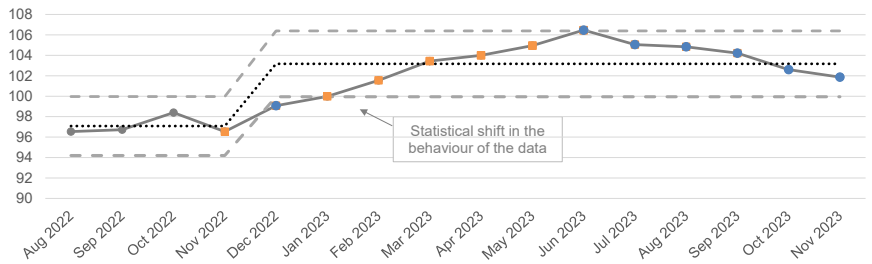
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 19, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 75 against an annual target of 75.

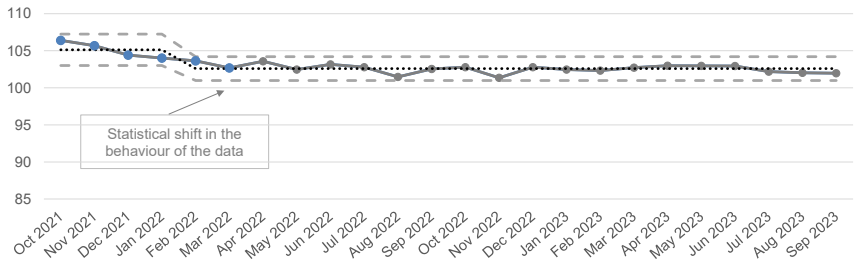
Commentary:

Hospital Standardised Mortality Ratio (HSMR)
Rolling 12 month position



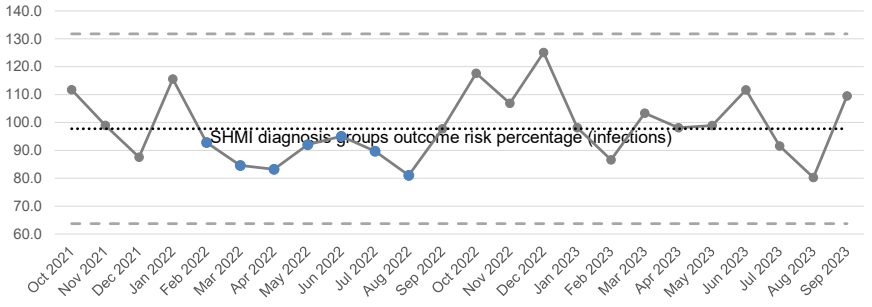
Nov 2023
101.9
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'as expected' range

Summary Hospital level Mortality Indicator (SHMI)
Rolling 12 month position
Note: The red dots indicate the expected range



Sep 2023
102.0
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'as expected' range

SHMI diagnosis groups outcome risk percentage (infections)



Sep 2023
109.5%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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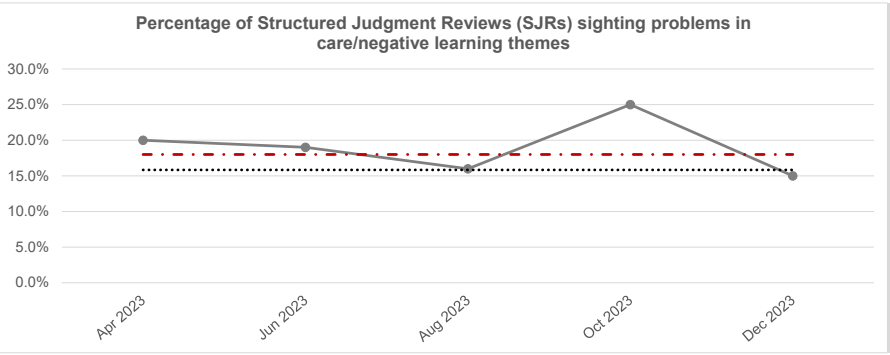
Data Analysis:
HSMR: From January 2023, performance increased steadily until May. From June to November, however, data shows improvement with a trend towards relative decline.
SHMI: Performance is stable and continues within the expected range. The data represents a rolling 12 month position.
SHMI diagnosis: Performance is stable and continues within the expected range.

Commentary:
The Trust has a SHMI value 100.28 for the latest period November 2022 – October 2023, which is in the 'as expected' banding.
There has been successive reduction in the rolling 12 month HSMR value to 101.9 over the past five months and has returned to common cause variation.
The infection related SHMI diagnosis groups continue to show common cause variation with a value of 109.5 in September 2023.



Dec 2023
15.0%
Target
18.00%
Variance
There is insufficient data for variance and assurance
Assurance
There is insufficient data for variance and assurance

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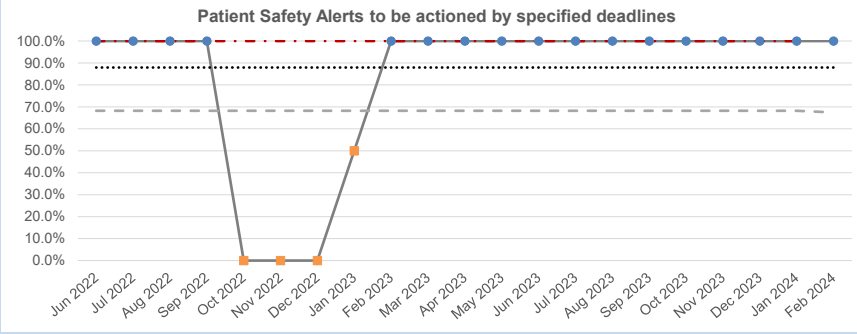
Data Analysis

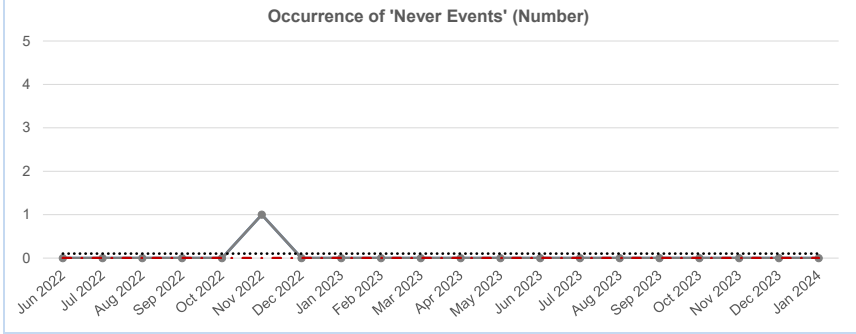
SJRs: This figure is not available every month. December 2023 is the most recent month for which data is available. The figures have ranged from 16% to 25%.

Commentary

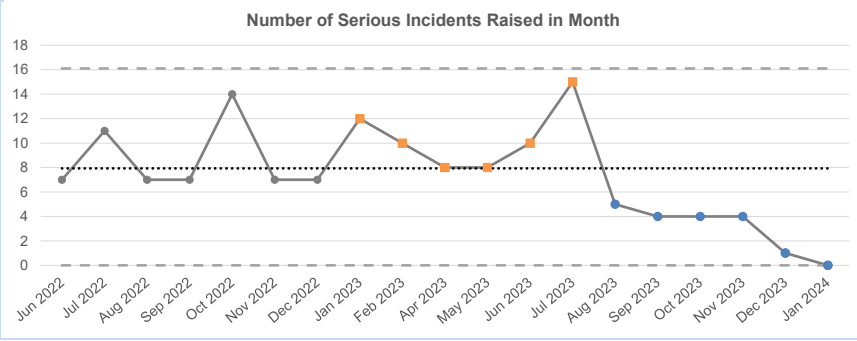
The percentage of SJRs sighting problems in care/negative learning associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation has reduced from 25% in October 2023 to 15% in December 2023. Recognition and care planning are included in training delivered by the specialist end of life team with different options of training delivery offered to improve compliance, including face to face, virtual training and targeted sessions. A questionaire for Medical staff has been launched to further understand the barriers to early recognition of End of Life and decision making to stop active treatment.



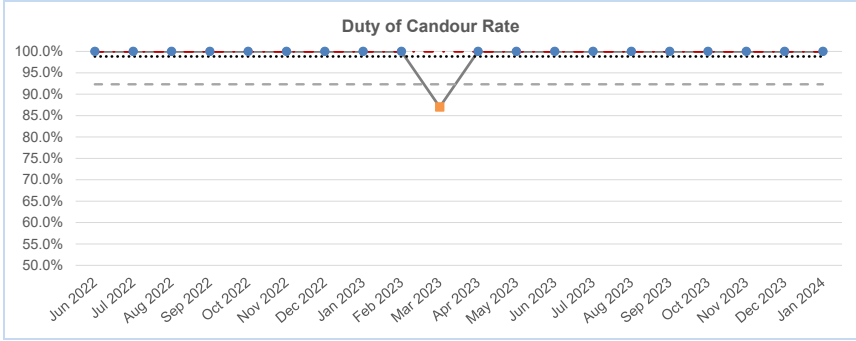
Feb 2024
100.0%
Target
100.00%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently achieving and failing the target



Jan 2024
0
Target
0
Variance
The data are not appropriate for an SPC chart, therefore varaince is not relevant
Assurance
The data are not appropriate for an SPC chart, therefore assurance is not relevant



Jan 2024
0
Target
8.7
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently achieving and failing the target

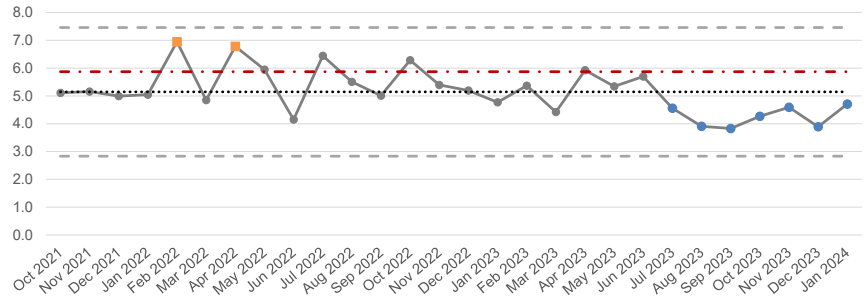


Jan 2024
100.0%
Target
100.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently achieving and failing the target

Data Analysis:
Patient Safety Alerts: Performance is within the expected range and registering improvement. The numbers involved are low.
Never Events: Due to the infrequency of never events an SPC is not appropriate. Never events data are a subset of the serious incidents data.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents. The data is showing improvement from August 23 to the current month.
Duty of Candour: Following a low figure in March the indicator has returned to regularly recording 100%.

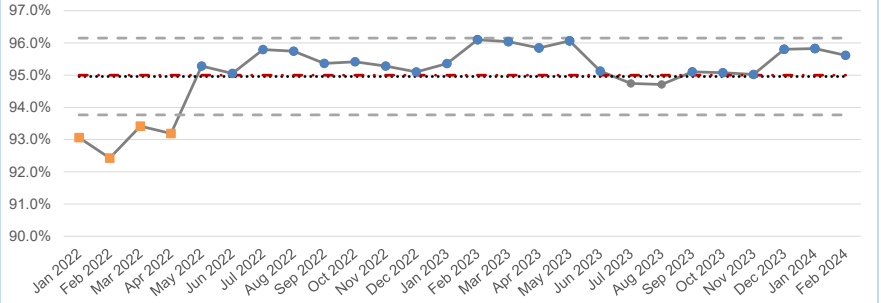
Commentary:
We continue to manage patient safety alerts, meeting national deadlines for the past 13 months.
Duty of candour rate is maintained at 100% and there has been zero never events reported over the past 14 months.
Individual audiology incident cases ceased to be reported on STEIS in August 2023 as agreed with the ICB. The Trust commenced transition to PSIRF on 1 December 2023 with one PSII declared in that month. 0 cases declared in January 2024.

Falls on Inpatient Wards (Rate Per 1000 Bed Days)



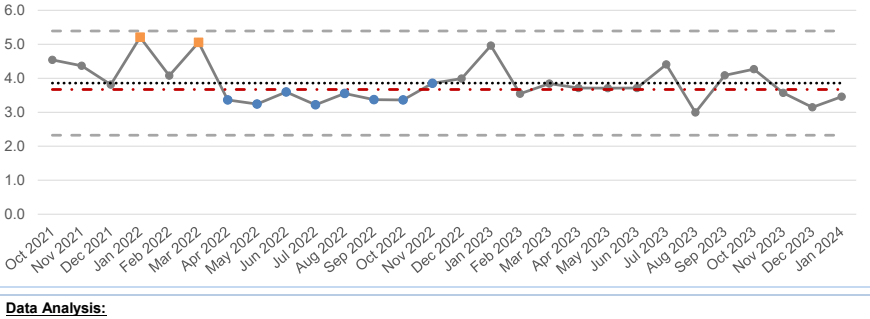
Jan 2024
4.7
Target
5.9
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently achieving and failing the target

Venous Thromboembolism (VTE) Risk Assessment Rate



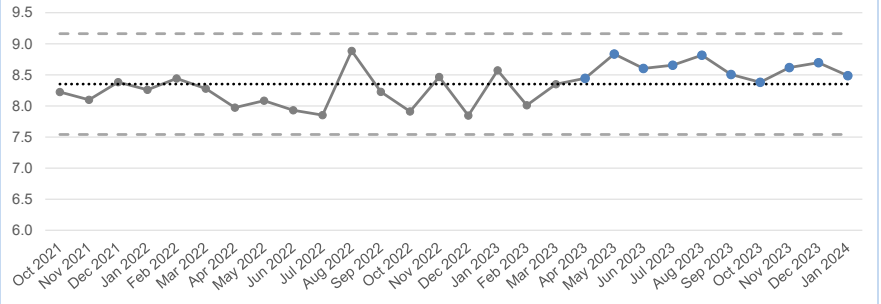
Feb 2024
95.6%
Target
95.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently achieving and failing the target

Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate Per 1000 Bed Days)



Jan 2024
3.5
Target
3.67
Variance
Common cause - no significant change
Assurance
Inconsistently achieving and failing the target

Care Hours Per Patient Day (CHPPD)



Jan 2024
8.5
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant

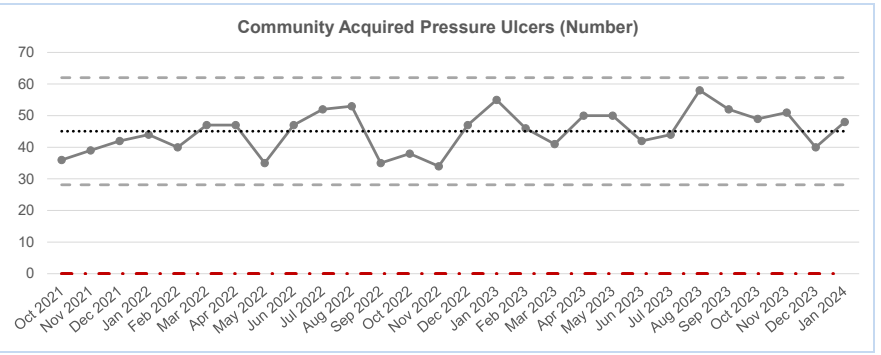
Data Analysis:

Falls on Inpatient Wards: Performance is stable and is showing improvement for the last 7 data points.
VTE Risk Assessment: Performance is within the expected range and is currently above the average, showing as improvement. The indicator can be expected to achieve and fail the target at random.
Hospital Acquired Pressure Ulcers: Performance is consistently within the expected range for the data.
Care Hours Per Patient Day: Performance is registering improvement due to the most recent ten months recording values higher than the average for the data.

Commentary:
VTE risk assessment shows special cause of improving nature achieving 95.6% in February 2024.

Falls on Inpatient Wards - the number of falls reported per 1000 Bed Days demonstrates an improving trend. Hospital Acquired Pressure Ulcers - the number of hospital acquired pressure ulcers contines to fall within the as excpected range. All moderate harms incidents reported in January have been reviewed at the weekly review meeting with no new learning idnetified.

Jan 2024	Target	Variance	Assurance
5	0	Special cause of improving nature or lower pressure due to lower values	Inconsistently achieving and failing the target



Jan 2024	Target	Variance	Assurance
48	0	Common cause - no significant change	Consistently failing the target

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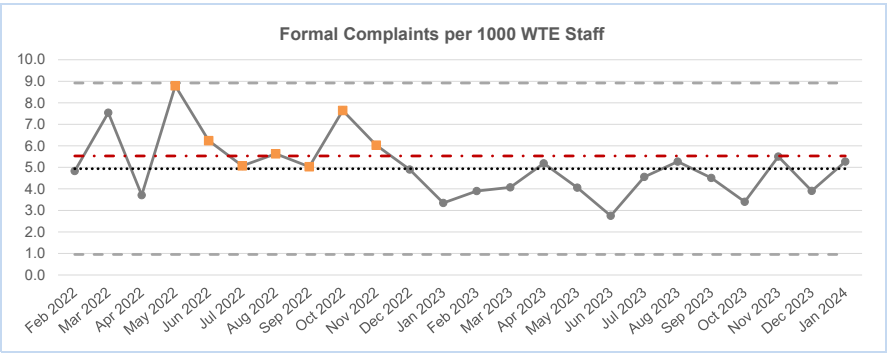
Data Analysis:

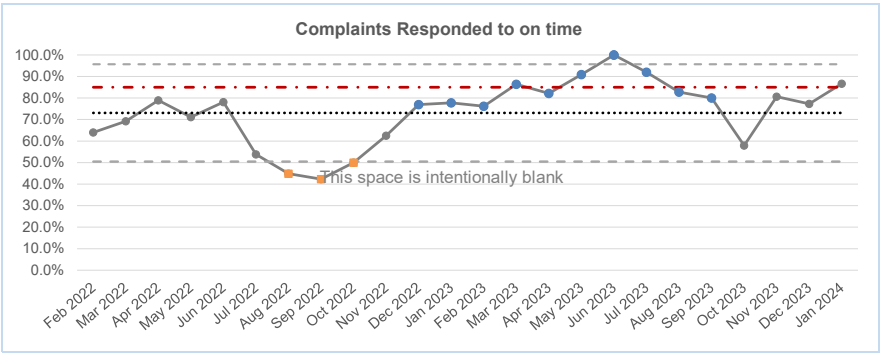
Mixed sex accommodation: Performance is within the data's expected range and will achieve and fail the target at random; the last eight months have shown improvement.

Community Acquired Pressure Ulcers (Number): Performance is within the expected range of the data. However, the target is unlikely to be met without action.

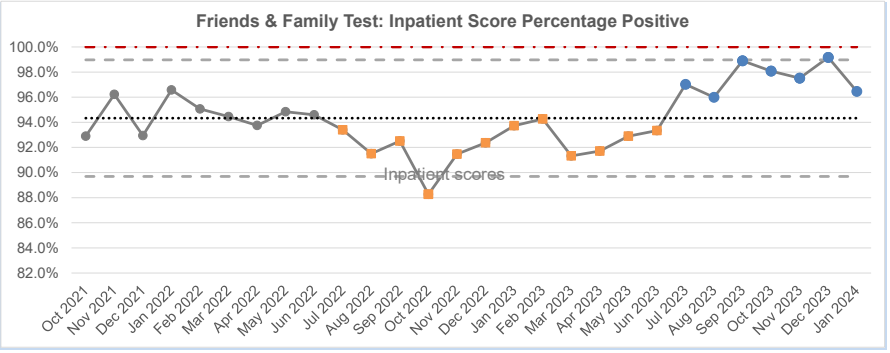
Commentary:



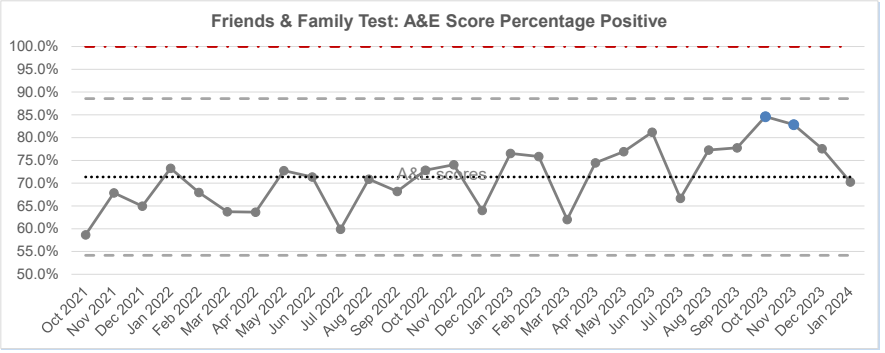
Jan 2024
5.3
Target
5.5
Variance
Common cause - no significant change
Assurance
Inconsistently achieving and failing the target



Jan 2024
86.7%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Inconsistently achieving and failing the target



Jan 2024
96.5%
Target
100.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Consistently failing the target



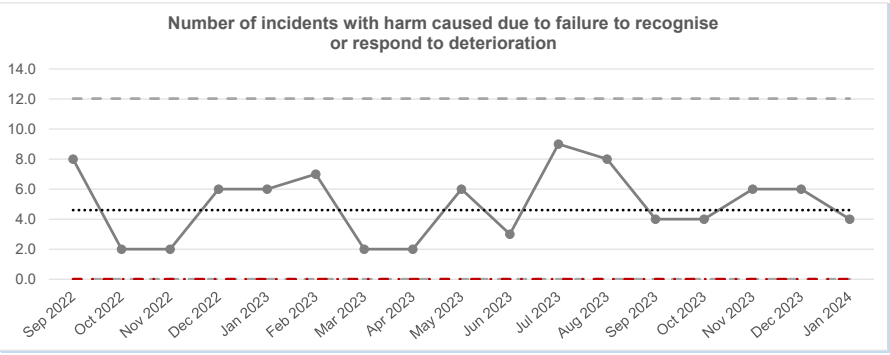
Jan 2024
70.3%
Target
100.0%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

Data Analysis:

Formal Complaints: Performance is stable and continues within the expected range of the data.
Complaints Responded to on time: Performance is stable and within the expected range of the data. The indicator will achieve and fail the target at random.
FFT Inpatient: Performance is stable and within the expected range of the data. The majority of respondents continue to provide positive feedback, the last seven data points indicate improvement.
FFT A&E: Performance is stable and within the expected range of the data.

Commentary:

85% of complaints closed within timescale of 60 working days. Formal complaints increased with 25 new complaints received
The new complaints continue to be complex in their nature across all Divisions.
For our Friends and Family Test we received 1665 FFT responses which is the highest number ever received.



Jan 2024
4.0

Target
0

Variance

Common cause - no significant change

Assurance

Inconsistently achieving and failing the target

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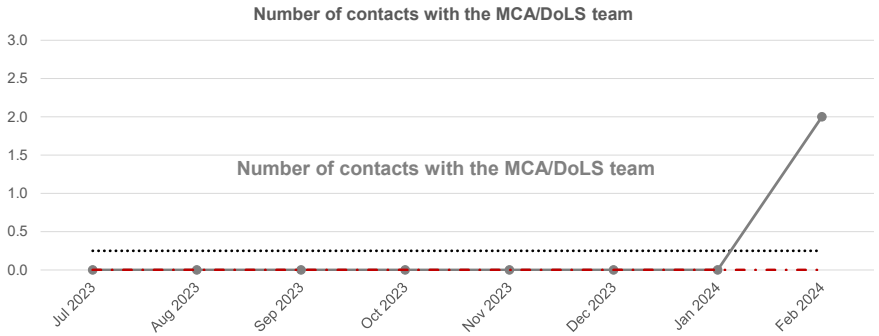
Data Analysis

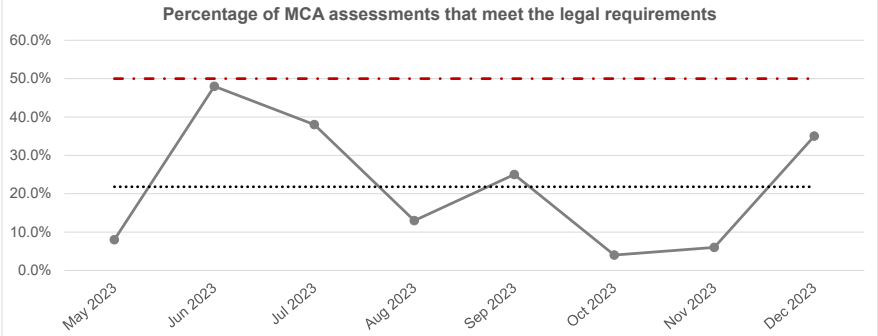
Harm caused deterioration: Performance is stable and within the expected range of the data.

Commentary

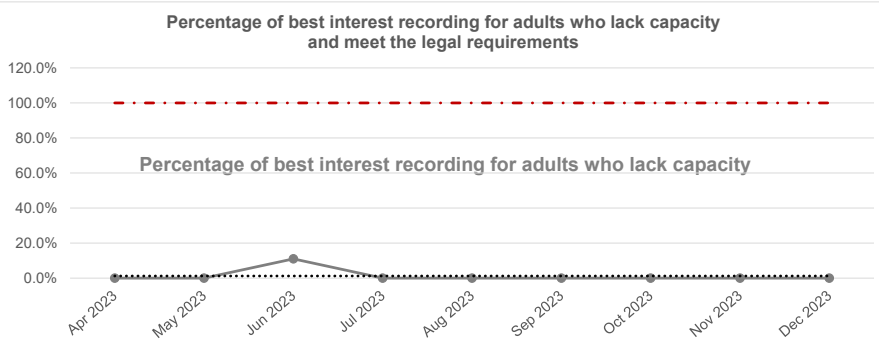
4 incidents with low/minor harm were reported in January 2024. The data is within the expected range with common cause variation. Deteriorating patient incidents continue to be monitored through the Deteriorating patient/sepsis group to identify themes and learning. All clinical sisters and ward managers are continuing to undertake applying QI training to focus on deteriorating patient and escalation. Stop and check continues to be embedded across all areas, encouraging use through night shifts.



Feb 2024
2
Target
0
Variance
There is insufficient data for variance and assurance
Assurance
There is insufficient data for variance and assurance



Dec 2023
35.0%
Target
50.0%
Variance
There is insufficient data for variance and assurance
Assurance
There is insufficient data for variance and assurance



Dec 2023
0.0%
Target
100.0%
Variance
There is insufficient data for variance and assurance
Assurance
There is insufficient data for variance and assurance

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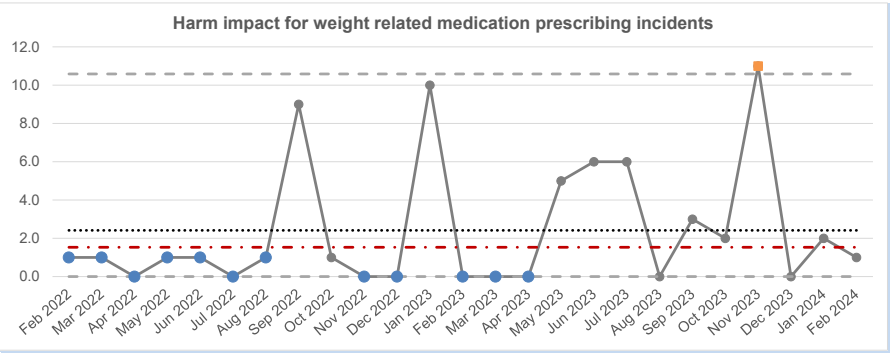
Data Analysis

MCA/DoLS contacts: Data is available for the most recent eight months. The only month with a number is February 2024; all other months have zero contacts.
MCA Assessments: Performance has varied from 4% to 48%.
Best interests: Data is available for nine months. For eight of these months the figure is 0%. In June a figure of 11% was recorded.

Commentary

The percentage of MCA assessments that meet the legal requirements has significantly improved from 6% in November 2023 to 35% in December 2023. We are starting to see improvements in the completion of some elements of the assessments. For example, 66% of assessments completed on Ward B6 in December 2023 had evidence that the patients had been supported to make a decision compared to 0% in May 2023. The MCA/DoLS Lead is continuing to provide targeted support to ward B6 staff and bespoke feedback forms for staff who have completed MCA assessment and best interest forms are shared for learning. Bitesize training sessions have been delivered to Ward B6. The MCA working group continue to meet to share learning and change ideas.



Feb 2024	1
Target	1.53
Variance	Common cause - no significant change
Assurance	Inconsistently achieving and failing the target

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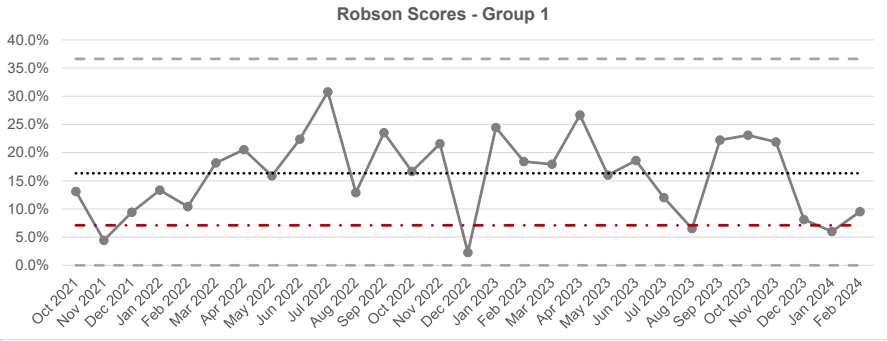
Data Analysis

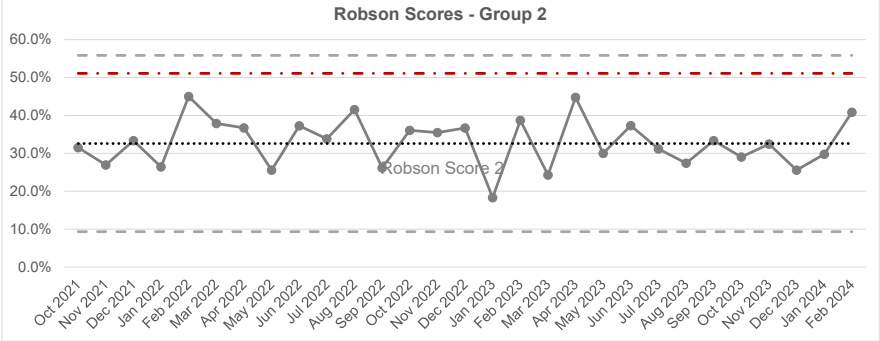
Harm impact: Performance continues to be sporadic ranging from zero to 11 over the past two years. The most recent figure is registering common cause however, due to the highly variable nature of this indicator this cannot be taken as indicative of any trend.

Commentary

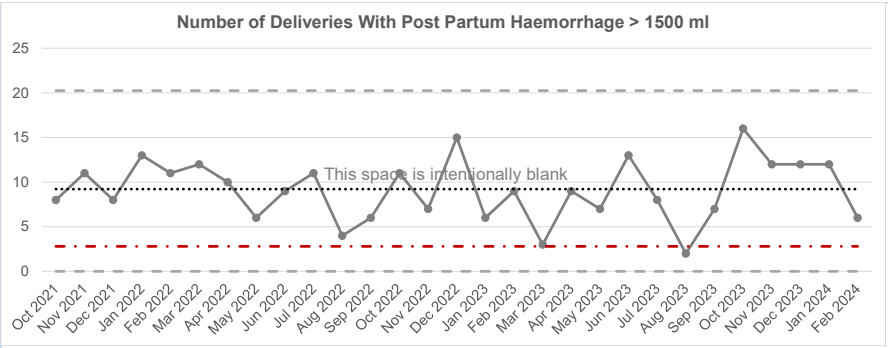
There was one no harm weight related prescribing incident reported in February 2024. All medication related incidents are discussed at the Safer Medication Group to raise awareness and share learning



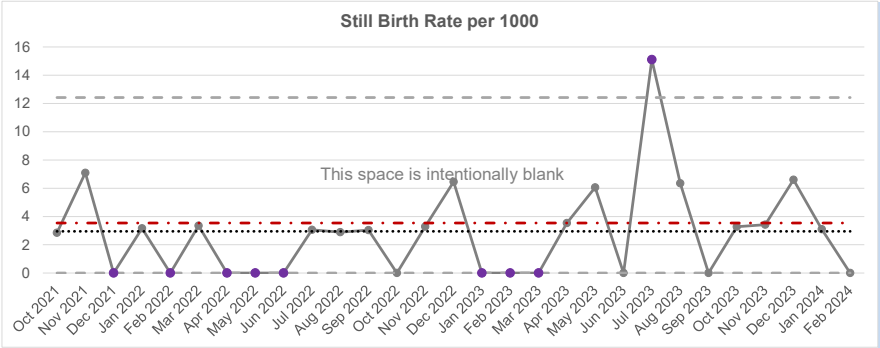
Feb 2024	Target	Variance	Assurance
9.5%	7.1%	Common cause - no significant change	Inconsistently achieving and failing the target



Feb 2024	Target	Variance	Assurance
40.8%	51.1%	Common cause - no significant change	Inconsistently achieving and failing the target



Feb 2024	Target	Variance	Assurance
6	2.80	Common cause - no significant change	Inconsistently achieving and failing the target



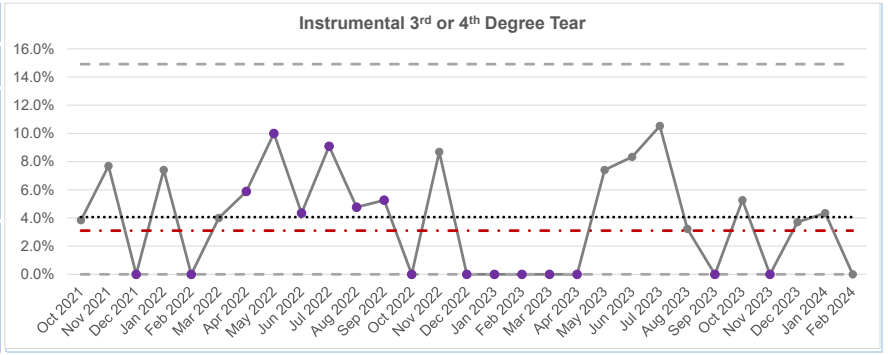
Feb 2024	Target	Variance	Assurance
0.0	3.54	Common cause - no significant change	Inconsistently achieving and failing the target

Data Analysis:

Robson Scores 1: Performance is within the expected range of the data.
Robson Scores 2: Performance is within the expected range of the data
PPH > 1500 ml: Performance is within the expected range of the data
Still birth rate per 1000: Although several months record a value of zero, performance continues to be sporadic ranging from zero to 15 over the past two years.

Commentary:

Feb 2024	Target	Variance	Assurance
1.2%	3.1%	Common cause - no significant change	Inconsistently achieving and failing the target



Feb 2024	Target	Variance	Assurance
0.0%	3.10%	Common cause - no significant change	Inconsistently achieving and failing the target

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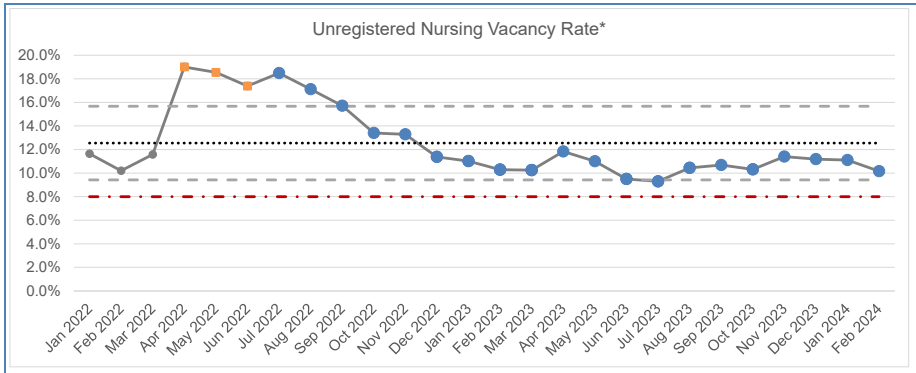
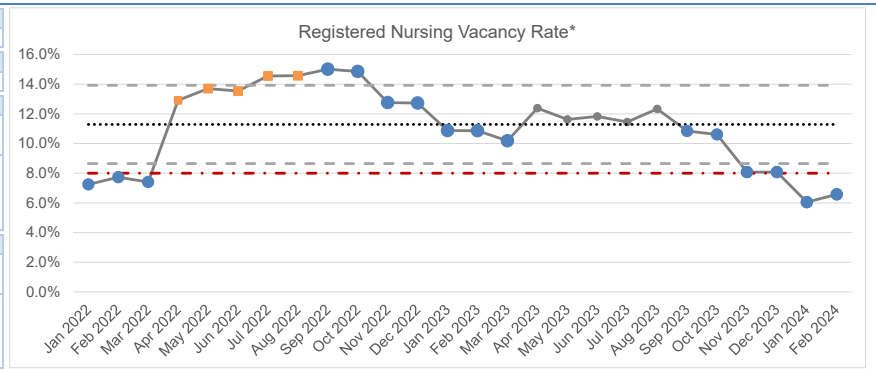
Data Analysis:
Spontaneous 3rd or 4th degree tear: Performance is stable and within the expected range.
Instrumental 3rd or 4th degree tear: Performance is stable and within the expected range.

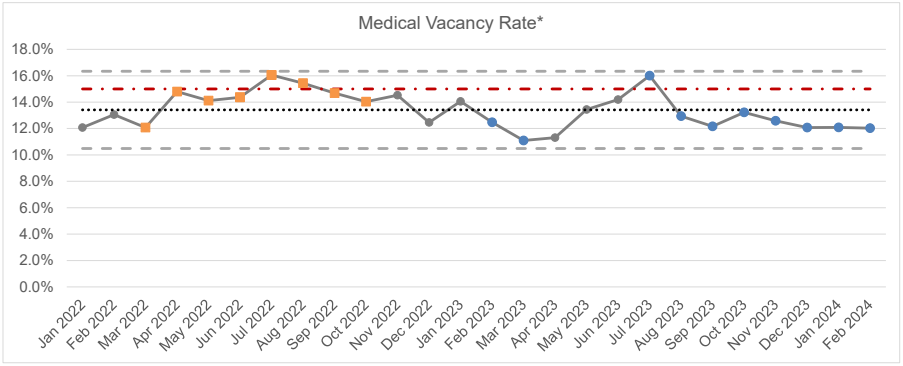
Commentary:



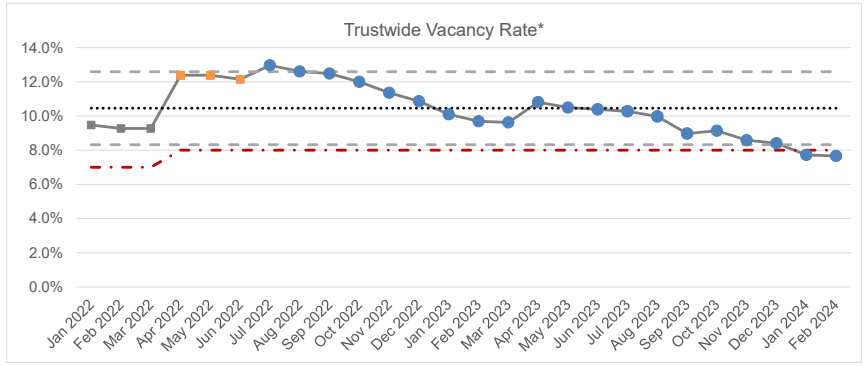
Feb 2024	10.2%
Target	8.0%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Consistently failing the target



Feb 2024	6.6%
Target	8.0%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Consistently failing the target



Feb 2024	12.0%
Target	15.0%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Inconsistently achieving and failing the target



Feb 2024	7.7%
Target	8.0%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Consistently failing the target

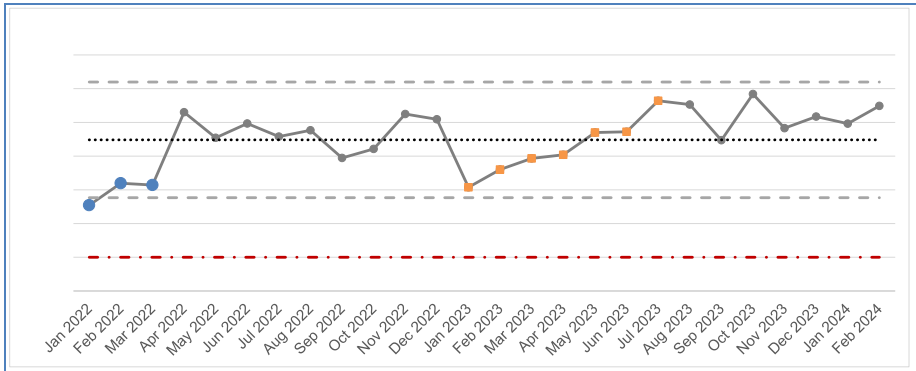
Data Analysis:
Unregistered Nursing Vacancies: Performance is as expected and registering improvement due to a long run of points lower than the average of the data. However, without continued improvement the indicator will continue to fail the target.
Registered Nursing Vacancies: Performance has improved since mid 2022 and the past six months have registered improvement. This improvement needs to continue in order to impact target assurance.
Medical Vacancy Rate: Performance is stable and registering improvement due to seven consecutive months of figures lower than the average. The target is within the process limits and may therefore be achieved at random.
Trustwide Vacancy Rate: Performance is as expected and registering improvement due to a long run of points lower than the average of the data. This improvement needs to continue in order to impact upon target assurance.

Commentary:
The vacancy position for Unregistered Nursing shows improvement in month. This is due to the effect of the revised process implemented in December now taking effect with starters with 38.51 WTE commencing during January and February.. 10 WTE are currently scheduled to start in March, with a further 36 WTE allocated going through pre-employment checks. Further pipeline is being established through regularly scheduled advertisements. The vacancy position is forecast to show an improvement in coming months. Regular meetings with the NHSI/E HCSW Programme Lead for support and accountability are ongoing.

The vacancy position for Registered Nurses remains within target. Engagement with international nurses sourced in Kerala is ongoing with the next cohort of 20 scheduled to commence in March. Longer term international pipelines have been developed to continue to meet need. NQN starts from the 2023/2024 recruitment round will see 4 WTE starting in the coming months. Recruitment for 2024/2025 continues and is currently exceeding target, with 89 Adult Nurses appointed, 13 Paediatric nurses appointed, and 14 to be interviewed in March. Adverts will continue to roll and further interviews are scheduled for April and May. Please note the vacancy position shown relates to registered nurses in all grades.

Commentary Vacancies Cont/d:
The overall medical vacancy position has shown a slight improvement in month and remains within target. A pipeline of 46 appointed medical staff is established, with 7 scheduled to start in March. Engagement with the existing pipeline is ongoing to facilitate starts as soon as possible. Additional schemes for sourcing and longer term staff development is are now undergoing internal ratification, including utilising GMC sponsorship, Fellowship roles and establishment of a wider Portfolio Pathway (CESR) programmes. An MOU between the HNY ICB and Aster DM Healthcare (Kerala, India) was agreed and formally signed in January which will facilitate sourcing of medics for training programmes at NLAG and other opportunities.

An improving Trustwide vacancy position is shown again in month with the vacancy position remaining within target. Various staff group specific projects are underway to impact Registered Nursing, Unregistered Nursing, and Medical Staff. Trustwide recruitment suppported by the recruitment team continuies with 199 offers in month and starting 171 new starters, 165 active vacancies being recruited to, and 4268 applications received and processed.



19.5%

15.0%

Common cause - no significant change

Consistently failing the target

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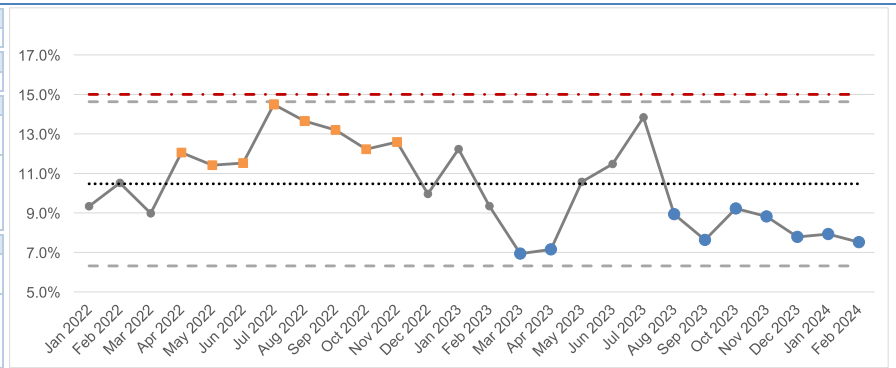

7.5%

15.0%

Special cause of improving nature or lower pressure due to lower values

Consistently passing the target

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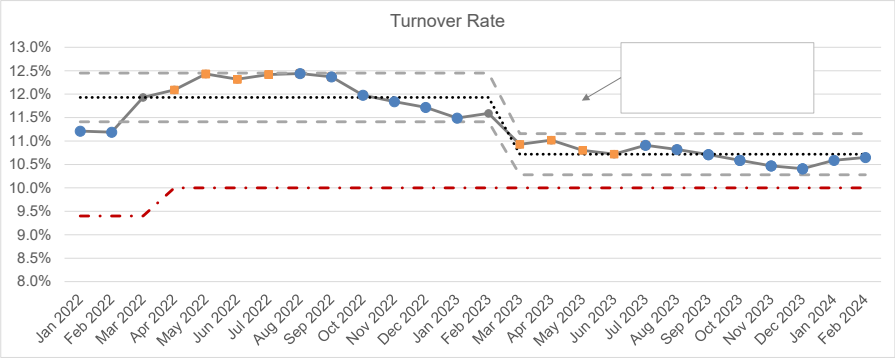
Data Analysis:
Medical Vacancy Rate - Consultants: Performance is currently registering common cause after seven consecutive months of concern. The target is unlikely to be met without action.
Medical Vacancy Rate - Other: Performance is registering improvement for the most recent seven months due to recording values lower than the average of the data. The indicator is expected to reliably achieve the target.

Commentary:
This month sees an increase in the vacancy factor. 2 Consultants are scheduled to start in March, with a further 5 appointed in the pipeline. A review of the Group's approach to sourcing Consultants to improve the process is underway, with the aim of increasing capacity focused on Consultant level recruitment. An amended AAC policy has been drafted and reviewed by JLNC and is currently undergoing further wider clinical engagement to create a Group AAC approach. In addition the use of resources within the recruitment team has been reviewed with changes in working practices underway, this includes a specific focus on sourcing via the Talent Acquisition team and allocation of a dedicated Recruitment Officer to focus on Consultant recruitment. The Group is exploring programmes to train and develop employees into Consultant roles, these include Training Fellowships and a Portfolio Pathway programme. Relationships have been developed overseas and an MOU signed at ICB level to facilitate sourcing of quality candidates into these roles for development. A Group-wide review of the branding and identity of the Group is also being developed to assist with domestic Consultant recruitment, to be included in various advertising platforms. A project plan is in place for development of these initiatives with a planned implementation date of 1st May 2024.

The vacancy position for other medical grades has improved in month and remains within target. 8 non-Consultant grades are confirmed to start in February, with a further 31 appointed in the pipeline awaiting start . The implementation of GMC sponsorship and proposed implementation of Training Fellowships, alongside the opportunities presented by the ICB MOU with Aster, is expected to positively impact upon the middle grade level in coming months



10.7%

10.0%

Special cause of improving nature or lower pressure due to lower values

Consistently failing the target

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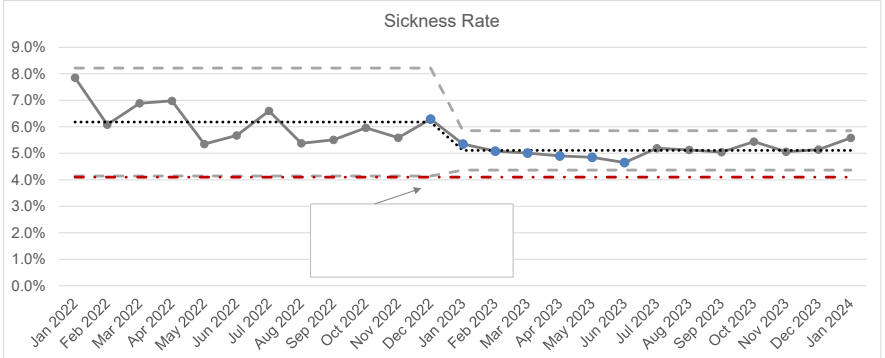

5.6%

4.1%

Common cause - no significant change

Consistently failing the target

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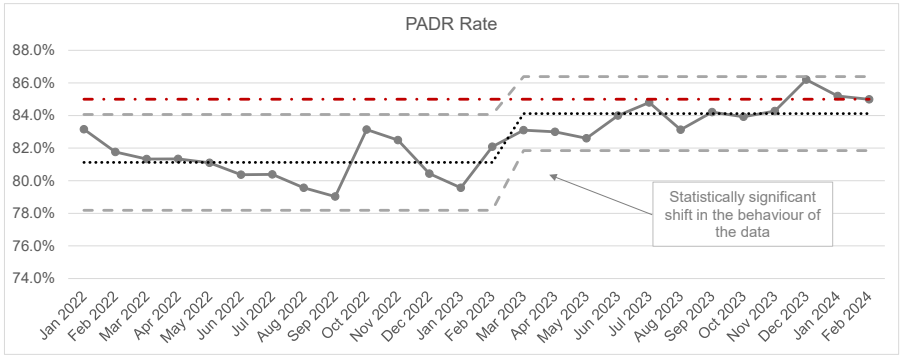
Data Analysis:
Turnover Rate: Performance is stable and as expected. However, the target is unlikely to be met without action.
Sickness Rate: Performance is stable and as expected. However, the target is unlikely to be met without action.

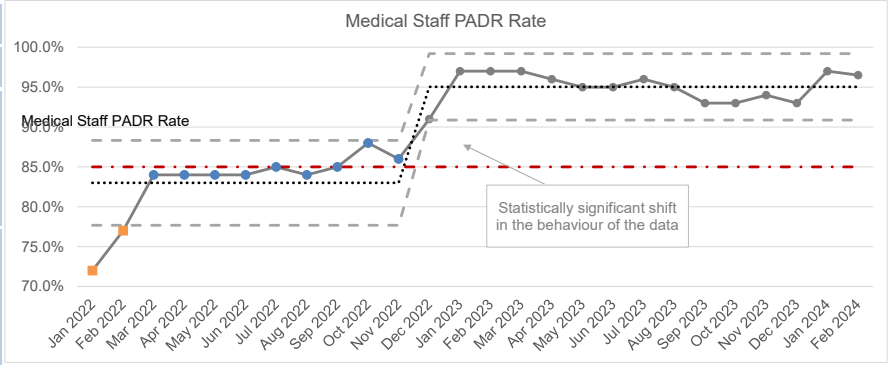
Commentary:

Turnover levels have increased by 0.06% which is 0.7% above target. Resignation guidance has been created to support managers to ensure all appropriate considerations are made when an employee advises their intention to leave their Job. The main aim of this guidance is to enable managers to have supportive retention conversations with staff to enable them to stay. Where this is not possible to highlight the importance of understanding why an individual wishes to leave, learning from their expertise, retaining valuable skills wherever possible and ensuring employee are appropriately supported. On further reivew of the data the main three reasons for leaving in February are Voluntrary Resignation for Work Life Balacnce, Promtion and Relocation.
Turnover rate for AHP has gone down from 12.56% to 12.01%
Midwifery sees fluctuating levels of turnover around the 6% mark for the past 6 months.
Reg nursing is still decreasing from 10.20% in dec, 9.90% in January and 9.68% in February, which means that our recruiting rate continues to exceed our leavers rate in the profession bringing good news for our staff and the support they are getting as well as better patient outcomes as a result of safer staffing levels.

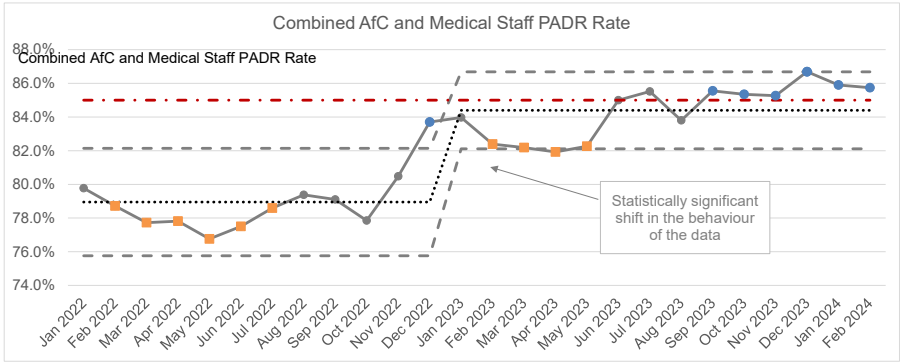
Sickness levels have increased in January 2023 which has peaked above this time last year. On further review of the data, short term absence has increased owing to an increase in absences related to cold/cough/flu. There are 3 divisions where absence levels have seen a sudden increase and therefore targeted work will be undertaken to review in detail and ensure appropriate support and advice. The HR team continue to provide monthly training on attendance management, which has recently been modified to increase interactivity and engagement, and ad hoc sessions where it is identified this is required.



Feb 2024
85.0%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Inconsistently achieving and failing the target



Feb 2024
96.5%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Consistently passing the target



Feb 2024
85.7%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Inconsistently achieving and failing the target

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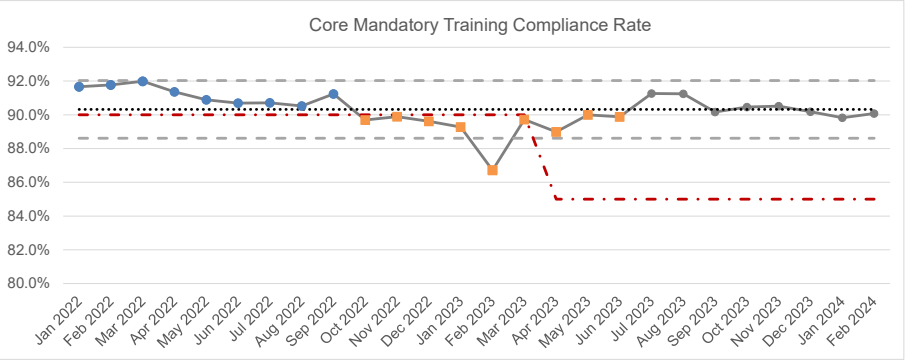
Data Analysis:
PADR Rate: Performance is stable and as expected. The indicator can be expected to achieve and fail the target at random.
Medical Staff PADR Rate: Performance is stable and within the expected range of the data. The indicator is expected to reliably achieve the target.
Combined AfC and Medical Staff PADR Rate: Performance is stable and within the expected range of the data. The target is expected to achieve and fail at random.

Commentary:

Between January and March there will no doctors with pre-scheduled appraisal months (doctors are allocated appraisal months which their appraisal is expected by, no doctor is allocated January, February or March as an appraisal month). Therefore the CMO office is working to ensure doctors who are delayed for their appraisal from 2023 have got an appraisal meeting booked and additional support is given.
Medical PADR consistently passes its target of 85%.

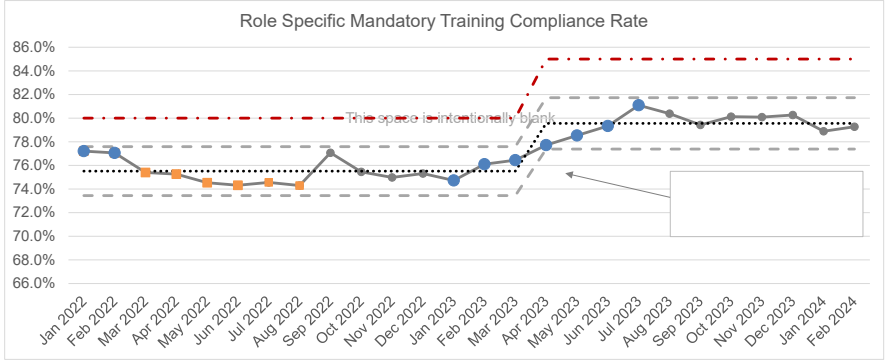


90.1%

85.0%

Common cause - no significant change

Consistently passing the target



79.3%

85.0%

Common cause - no significant change

Consistently failing the target

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Data Analysis:
Core Mandatory Training: Performance is stable and within the expected range of the data. The target will reliably be achieved.
Role Specific Mandatory Training: Performance is stable and within the expected range of the data. However current data indicates that the target will not be met without action.

Commentary:

Core Mandatory training compliance has seen a slight improvement (0.3%) since the previous report and has now returned above 90%. The following competencies remain below 80% compliance @ 5.3.24: Level 3 Safeguarding Children remains the lowerst compliance @ 71.63%, with 330 out of compliance at the time of reporting. There is no significant change in this data from the previous report though the DNA rate for this classroom-based provision continue to improve. February 2024 saw a 14% DNA rate compared to 19% the previous month. Further, Fire Safety continues to report low compliance @ 74.35%, with 1793 out of compliance at the time of reporting. This is a 1.13% improvement since the previous report and a reduction of 92 out of compliance. Fire Safety is now established within the Corporate Induction for new staff which is supporting this slight improvement although February still reported 136 staff not attending a Fire safety session they had booked on to. Finally, Level 3 Safeguarding Adults reported a compliance of 74.09%, with 178 out of compliance at the time of reporting. This has seen a slight decline from the previous month with only 16 members of staff completing this classroom-based session in February 2024. The Head of Learning and Development continues to attend the Vulnerabilities Group to report on compliance and DNA data, offering support from Learning and Development where required. Data has now been gathered from staff to determine barriers to attending / completing training and a meeting will be held on Tuesday 12th March to develop a plan to support improvements in accesibility of training provision.

Role Specific Mandatory training compliance has, also, seen a slight improvement in compliance (0.4%) since the previous report but remains 5.7% below the Trust target. Moving and Handling (all modules) and Resuscitation (all modules) compliance rates continue to be monitored closely, with the former improving by a further 1%, since the previous report, to 83%, and the latter maintaining 68% compliance. During February 2024, 259 staff enrolled onto a Moving and Handling module, with 127 completing. At 49% completion, this is a 12 % improvement from the previous report. No improvement, however, has been noted in the volume of DNAs across the month. Further, 508 staff enrolled onto a Resuscitation module during February 2024, with 345 completing. At 68% completion,this is a 5% improvement from the previous month and the % of DNAs reduced during the same time period. As in the previous report, Mental Capacity Act and DOLS compliance remains below 80% but has seen a 1.26% improvement, being 78.86% at the time of reporting. The number of staff out of compliance for this competency has reduced by 57 to 866 @ 5.3.24, following an improved completion rate to the classroom-based provision delivered in February 2024. Any eLearning with low compliance contiunues to be addressed via directed communication, with accessible links, to relevant staff who are out of compliance. During February 2024, Sepsis Training and NG Tube Displacement were focus areas and slight improvements have been seen in each, though they remain significantly below the 85% target so directed communication will continue throughout March 2024. Medical and Dental remains the lowest compliance in terms of staff groups though there has been a 8.37% improvement since the previous report, now at 61.71%. This staff group also reported a 65% completion rate for all classroom-based provision during February 2024, an improvement of 8% compared to January 2024. A full action plan to address barriers identified by Medical and Dental staff group will be developed at the meeting on 12.3.24 as indicated in the Core Mandatory trainining report across the page.

IPR Appendix A - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

Centiles from the Public View website have been provided where available (these are not available for all indicators in the IPR).

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisations. If NLAG's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than NLAG. The colour shading is intended to be a visual representation of the ranking of NLAG (red indicates most organisations are performing better than NLAG, green indicates NLAG is performing better than many organisations. Amber shows NLAG is in the mid range).

Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 13/03/2024

* Indicates the benchmarked centiles are from varying time periods to the data presented in the IPR and should be taken as indicative for this reason

^ Indicates the benchmarked centiles use a variation on methodology to the IPR and should be taken as indicative for this reason

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Feb 24	57.5%	92.0%	63	64 / 172	Dec 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Feb 24	977	353	57	74 / 169	Dec 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Feb 24	16.5%	1.0%	39	96 / 156	Dec 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Feb 24	52.7%	85.0%	21	108 / 136	Dec 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 24	59.5%	76.0%	20	115 / 143	Jan 24
	Urgent Care	Number Of Emergency Department Attendances	Feb 24	14,485	10,114	43	82 / 143	Jan 24
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Feb 24	853	0	7	140 / 151	Jan 24
	Flow	Bed Occupancy Rate (General & Acute)	Feb 24	93.7%	92.0%	45	85 / 155	Q3 23/24
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Feb 24	6.0%	5.0%	61	63 / 158	Dec 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Jan 24	0.00	No target	23	104 / 135	Dec 23
	Infection Control	Number of E Coli Infections	Jan 24	0.20	No target	68	44 / 135	Dec 23
	Infection Control	Number of Trust Attributed C-Difficile Infections	Jan 24	0.10	No target	96	6 / 135	Dec 23
	Infection Control	Number of MSSA Infections	Jan 24	0.05	No target	43	78 / 135	Dec 23
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Sep 23	102.0	As expected	47	64 / 119	Sep 23
	Safe Care	Number of Serious Incidents Raised in Month	Jan 24	0	8.7	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Jan 24	8.5	No target	45	102 / 186	Dec 23
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Feb 24	95.6%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Jan 24	5.3	5.5	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Percentage Positive Inpatient Scores	Jan 24	96.5%	100%	89	15 / 132	Dec 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Jan 24	5.6%	4.1%	51	104 / 213	Oct 23

Appendix B - Committee Scorecard

Scorecard - Access and Flow (F&P Committee)

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Feb 2024	57.5%	92.0%	**Alert**			Board
	Number of Incomplete RTT pathways 52 weeks*	Feb 2024	977	353	**Alert**			Board
	Total Inpatient Waiting List Size	Jan 2024	12,624	11,563	**Alert**			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Feb 2024	16.5%	1.0%	**Highlight**			Board
	Number of Incomplete RTT pathways 65 weeks	Feb 2024	170	0	**Alert**			Board
	Number of Incomplete RTT Pathways*	Feb 2024	40,711	25227	**Alert**			FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Feb 2024	13,076	15652				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Jan 2024	44.7%	37%	**Alert**			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Feb 2024	42,548	9,000	**Alert**			Board
	Outpatient Did Not Attend (DNA) Rate	Feb 2024	6.0%	5.0%	**Alert**			Board
	% Outpatient Non Face To Face Attendances	Feb 2024	19.3%	25.0%	**Alert**			Board
	% Outpatient summary letters with GPs within 7 days	Dec 2023	52.6%	50.0%				FPC
	Advice and Guidance as a Percentage of all Referrals	Jan 2024	9.3%	16.0%	**Alert**			FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Feb 2024	82.8%	99.0%	**Alert**			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Jan 2024	31.7%	23.0%	**Alert**			FPC
	Patient Initiated Follow Up	Feb 2024	4.1%	5.0%	**Highlight**			FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Feb 2024	52.7%	85.0%	**Alert**			Board
	Cancer Waiting Times - 104+ Days Backlog*	Feb 2024	26	0	**Alert**			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Feb 2024	11.1%	75.0%	**Alert**			Board
	Cancer Request To Test In 7 Days*	Feb 2024	50.6%	100.0%	**Alert**			Board
	Cancer Waiting Times - 2 Week Wait*	Feb 2024	90.8%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Feb 2024	64.2%	93.0%	**Alert**			FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Feb 2024	78.8%	75.0%				FPC
	Cancer Request To Test In 14 Days*	Feb 2024	85.1%	100.0%	**Alert**			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Feb 2024	95.7%	96.0%				FPC
	Cancer Waiting Times - Cancer 62-day backlog	Feb 2024	132	90	**Alert**			FPC
	Cancer Waiting Times - 62 day Screening*	Feb 2024	50.0%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2024	59.5%	76.0%	**Alert**			Board
	Number Of Emergency Department Attendances	Feb 2024	14,485	10,114	**Alert**			Board
	Ambulance Handover Delays - Number 60+ Minutes	Feb 2024	1028	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Feb 2024	853	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Feb 2024	588	0	**Alert**			Board
	Number of UCS Attendances	Feb 2024	5,833	5,000	**Alert**			FPC
	% UCS Waiting Times (4 Hour Performance)	Feb 2024	98.7%	92.0%				FPC
	Ambulance Handover Delays - Number 30-60 Minutes	Feb 2024	468	0				FPC
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Feb 2024	46.2%	40.0%				Board
	% of Extended Stay Patients 21+ days	Feb 2024	13.2%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Feb 2024	2.0	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Feb 2024	3.3	3.9	**Highlight**			Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Feb 2024	97.6%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Feb 2024	17.5%	30.0%	**Alert**			Board
	Bed Occupancy Rate (G&A)	Feb 2024	93.7%	92.0%	**Alert**			Board
	Percentage of patients re-admitted as an emergency within 30 days	Feb 2024	9.0%	7.5%				FPC
	Percentage of Daycase Spells From Elective Activity	Feb 2024	90.9%	85.0%				FPC
	% of Extended Stay Patients 7+ days	Feb 2024	50.8%	40.0%				FPC
	% of Extended Stay Patients 14+ days	Feb 2024	19.4%	18.0%				FPC
	% Inpatient Discharges Before 17:00	Feb 2024	68.3%	80.0%	**Alert**			FPC
Theatre	Theatre Session Utilisation (Core Capacity)	Feb 2024	91.7%	No Target			n/a	FPC
	Theatre In Session Capped Utilisation	Feb 2024	80.8%	85.0%				FPC
	Theatre In Session Non-Capped Utilisation	Feb 2024	81.9%	85.0%				FPC

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Jan 2024	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jan 2024	0.20	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jan 2024	0.10	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jan 2024	0.05	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jan 2024	0.24	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Nov 2023	101.9	As expected	**Highlight**	L	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Sep 2023	102.0	As expected			As expected	Board
	SHMI diagnosis groups outcome risk percentage (infections)	Sep 2023	109.5%	No target			n/a	Board
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Dec 2023	15.0%	18.0%		n/a	n/a	Board
	Percentage of in hospital deaths with anticipatory medication prescribed	Mar 2023	10.7%	33.0%		L	?	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Feb 2024	100.0%	100%		H	?	Board
	Number of Serious Incidents raised in month	Jan 2024	0	8.7		L	?	Board
	Occurrence of 'Never Events' *(Number)*	Jan 2024	0	0		n/a	n/a	Board
	Duty of Candour Rate	Jan 2024	100.0%	100.0%		H	?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2024	4.7	5.87		L	?	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2024	3.5	367%			?	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Feb 2024	95.6%	95.0%	**Highlight**	H	?	Board
	Care Hours Per Patient Day (CHPPD)	Jan 2024	8.5	No target		H	n/a	Board
	Mixed Sex Accommodation Breaches	Jan 2024	5	0		L	?	Board
	Community Acquired Pressure Ulcers (Number)	Jan 2024	48.0	0	**Alert**		F	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Jan 2024	5.3	5.5			?	Board
	Complaints Responded to on time	Jan 2024	86.7%	85.0%			?	Board
	Friends & Family Test: Inpatient Score Percentage Positive	Jan 2024	96.5%	100%	**Highlight**	H	F	Board
	Friends & Family Test: A&E Score Percentage Positive	Jan 2024	70.3%	100%	**Alert**		F	Board
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Jan 2024	4.0	0.0%			?	Board
	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Jan 2024	92.3%	90.0%		H	P	Q&S
	Recording of and response to NEWS2 score for unplanned critical care admissions	Dec 2023	73.1%	30.0%		n/a	n/a	Q&S
Mental Capacity	Number of contacts with the MCA/DoLS team	Feb 2024	2.0	0.0%		n/a	n/a	Board
	Percentage of MCA assessments that meet the legal requirements	Dec 2023	35.0%	50.0%		n/a	n/a	Board
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Dec 2023	0.0%	100.0%		n/a	n/a	Board
Sepsis	Percentage of paediatric primary sepsis screenings using national risk stratification criteria	Feb 2024	98.8%	No target		n/a	n/a	Q&S
	Percentage of Adult Sepsis screening completed within 15 minutes in response to elevated NEWS2 score	Feb 2024	26.8%	90.0%	**Alert**	H	F	Q&S
Prescribing	Harm impact for weight related medication prescribing incidents	Feb 2024	1	1.53			?	Board
	Actual weight recorded on Web V within 24 hours of admission	Feb 2024	No Data	No target		n/a	n/a	Q&S
	Weight recorded on EPMA matches actual weight recorded in Web V	Feb 2024	No Data	No target		n/a	n/a	Q&S
Maternity	Robson Scores - Group 1	Feb 2024	9.5%	7.1%			?	Board
	Robson Scores - Group 2	Feb 2024	40.8%	51.1%			?	Board
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Feb 2024	6	2.80			?	Board
	Still Birth Rate per 1000	Feb 2024	0.0	3.54			?	Board
	Spontaneous 3rd or 4th Degree Tear	Feb 2024	1.2%	3.1%			?	Board
	Instrumental 3rd or 4th Degree Tear	Feb 2024	0.0%	3.1%			?	Board

Scorecard - Workforce

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

Vacancies	Unregistered Nurse Vacancy Rate*	Feb 2024	10.2%	8.0%	**Alert**			Board
	Registered Nurse Vacancy Rate*	Feb 2024	6.6%	8.0%	**Alert**			Board
	Medical Vacancy Rate*	Feb 2024	12.0%	15.0%				Board
	Trustwide Vacancy Rate*	Feb 2024	7.7%	8.0%	**Alert**			Board
	Medical Vacancy Rate - Consultants*	Feb 2024	19.5%	15.0%	**Alert**			Board
	Medical Vacancy Rate - Other*	Feb 2024	7.5%	15.0%				Board
Staffing Levels	Turnover Rate	Feb 2024	10.7%	10.0%	**Highlight**			Board
	Sickness Rate	Jan 2024	5.6%	4.1%	**Alert**			Board
Staff Development	PADR Rate	Feb 2024	85.0%	85.0%				Board
	Medical Staff PADR Rate	Feb 2024	96.5%	85.0%				Board
	Combined AfC and Medical Staff PADR Rate	Feb 2024	85.7%	85.0%	**Highlight**			Board
	Core Mandatory Training Compliance Rate	Feb 2024	90.1%	85.0%				Board
	Role Specific Mandatory Training Compliance Rate	Feb 2024	79.3%	85.0%	**Alert**			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Feb 2024	7	5	**Alert**			WFC
	Average Length of Disciplinary Process Concluded in Month (Weeks)	Feb 2024	2	12				WFC
	Number of Suspensions Live in Month	Feb 2024	2	3				WFC
	Average Length of Suspension Concluded in Month (Weeks)	Feb 2024	0	8				WFC
Culture	Staff Survey - Advocacy	Jul 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Involvement	Jul 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Motivation	Jul 2023	6.6	7.0		n/a	n/a	WFC

Appendix C - Glossary

A&E	Accident and Emergency
A&F	Access and Flow
ACN	Associate Chief Nurse
ADQG	Associate Director Quality Governance
AfC	Agenda for Change
CDI	Clostridioides difficile infection
CESR	Certificate of Eligibility for Specialist
CHPPD	Care hours per patient day
CMO	Chief Medical Officer
DM01	Diagnostic Waiting Times and Activity
DNA	Did not attend
DOLS	Deprivation Of Liberty Safeguards
DPOW	Diana Princess of Wales Hospital
DWP	Department of Work and Pension
ED	Emergency Department
EMAS	East Midlands Ambulance Service
EPIC	Emergency Physician in Charge
EPMA	Electronic Prescribing and Medicines
FFT	Friends and Family Test
GMC	General Medical Council
GP	General Practitioner
HCSW	Health Care Support Worker
HEE	Health Education England
HIT	High Intensity Theatre
HR	Human Resources
HSMR	Hospital Standardised Mortality Ratio
HUTH	Hull University Teaching Hospital
IAAU	Integrated Acute Assessment Units
ICS	Integrated Care Systems
IPC	Infection Prevention and Control
KPI	Key Performance Indicators
LOS	Length of Stay
MCA	Mental Capacity Act
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NEWS	National Early Warning System
NG	National Guidance
NHSE/I	NHS England and Improvement
NL	North Lincolnshire
NLAG	Northern Lincolnshire and Goole NHS Trust
OD	Organisational Development
OOH	Out of Hospital
OP	Outpatient
OPAT	Outpatient Parenteral Antimicrobial Therapy
OPEL	Operational Pressures Escalation Levels
PADR	Performance Appraisal and Development
PALS	Patient Advice and Liaison Service
PBI	Power BI, a Microsoft software
PE	Patient Experience
PIFU	Patient Initiated Follow Ups
PTL	Patient Tracking List
Q&S	Quality and Safety
QI	Quality Improvement
RDC	Rapid Diagnostics Centre
RTT	Referral to Treatment
SAS	Specialist and Specialty
SGH	Scunthorpe General Hospital
SHMI	Summary Hospital Mortality Index
SJR	Structured Judgement Reviews
SPA	Single Point of Access
SPC	Statistical Process Charts
T&D	Training and Development
UCS	Urgent Care Centre
VTE	Venous Thromboembolism
WLIs	Waiting List Initiative's
WTE	Whole Time Equivalent
YTD	Year to Date

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)076

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	As Above
Title of Report	Documents Signed Under Seal
Executive Summary	The report below provides details of documents signed under Seal since the date of the last report provided in December 2023. The Seal was used five times, #279 to #283 with no gaps.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Not directly
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:

Use of Trust Seal – April 2024

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal at NLaG has been used on the following occasions:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
279	Renewal of Lease for Cottage Beck Road Clinic, Scunthorpe	Ivan McConnell & Lee Bond	12.12.2023
280	NELC & NLaG Early Access Licence for Site Investigation – 25 Baxtergate, Freshney Place, Grimsby	Lee Bond	13.12.2023
281	NLC & NLaG Lindum Street Car Park	Jonathan Lofthouse & Lee Bond	13.12.2023
282	CDC Freshney Place Lease of Part / Licence to Alter Phase 01 – Strip Out	Jonathan Lofthouse	01.02.2024
283	Goole Ambulance Station Lease Engrossment	Jonathan Lofthouse	29.02.2024

Action Required

The Trust Boards-in-Common are asked to note the report.

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)077

Name of the Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday, 11 April 2024
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Dr Elizabeth Evans, Guardian of Safe Working, NLaG Dr Wajiha Arshad, Guardian of Safe Working, HUTH
Title of the Report	Guardian of Safe Working Hours – Quarter 3 Reports, NLaG and HUTH
Executive Summary	NLaG: Exception reporting data from 01 October 2023 to 31 December 2023, including reasons for any immediate safety concerns. There has been a decrease in the number of reports received compared to the last quarter. This is an expected finding in the second quarter of the academic year (commencing in August). The majority of reports concerned working hours breeches, with a smaller number due to missed educational opportunities. HUTH: Highest number of exception reports by DME (33), Acute Medicine (32) and Neurology (11). Five fines were issued in total: one for Chest Medicine, two for Plastic Surgery and two for Paediatric Surgery. Fines by Plastic Surgery and Paediatric Surgery departments are due to high numbers of hours worked during non-resident shifts. The Plastic Surgery rota has been redesigned, but there has been no review of the Paediatric Surgery Registrars rota since Covid. This will need review with the support of Health Group Finance Manager and Human Resources Business Partner who are pulling together a business case.
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: Exception reporting software, last QBR
Prior Approval Process	Workforce, Education and Culture Committees-in-Common: NLaG on 30 January 2024 and HUTH on 29 February 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 ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Dr Liz Evans
Guardian of Safe Working
1st January 2024

Contents

1. Executive Summary

Exception reports for the quarter 1st October 2023 to 31st December 2023 saw a decrease from 61 to 40 exception reports. The majority of the exception reports submitted were in connection with working hours, with a smaller number submitted around service support, educational opportunities and work patterns, which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant divisions/directorates.

There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out for the Educational Supervisors, the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	319
Number of Doctors/Dentists in Training (WTE)	284
Number of Less than full time (LTFT) Trainees (Headcount)	27
Number of Training post vacancies (WTE)	35

Source Finance data

During the period of this quarterly report (1st October 2023 to 31st December 2023) there have been a total of 40 exception reports submitted through the allocate exception reporting system.

This showed a decrease of 21 reports from the last quarter (1st July 2023 to 30th September 2023).

Of the 40 exception reports submitted, 28 were linked to hours. This showed a decrease of 23 reports from the previous quarter.

The exception reports for this quarter relating to hours have been compensated by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL). They have mostly been closed successfully. We have provided more payment than usual

during this quarter as there have been problems with opportunities to take TOIL owing to the ongoing strike action.

The below table is a breakdown of the exception reports over the last quarter (October 2023 – December 2023)

Exception Reports Open (ER) between 1st October 2023 – 31st December 2023	
Total number of exception reports received	40
Number relating to hours of work	28
Number relating to pattern of work	3
Number relating to educational opportunities	5
Number relating to service support available to the Doctor	4
Number initially relating to immediate patient safety concerns	1

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support have the option of specifying whether the report constitutes an immediate safety concerns (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st October 2023 and 31st December 2023	
Total number of exception reports resolved as at 31/12/2023*	31
Total number of exception reports unresolved as at 31/12/2023**	7
Total number of exception reports where TOIL was granted	17
Total number of exception reports where overtime was paid	14
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	6
Total number of exception reports resulting in fines	0

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

2. Immediate Safety Concerns

During this quarter there was 1 exception report submitted where a Doctor raised an immediate safety concern in addition to a concern around working hours and clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

This quarter there was only one Immediate Safety Concern, the same number as in the previous quarter. This concern was received from Obstetrics and Gynaecology in Scunthorpe and concerned a doctor who was unable to go home at the end of an on

call shift as the doctor who was relieving them was two hours late and they were too tired to make safe decisions. TOIL was granted for this incident, but as it is unlikely to recur it has not been escalated further.

3. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

4. Trend in Exception Reporting

There has been a decrease in exception reporting this quarter. This is to be expected- there is always an increase in the number of reports received in the first part of the academic year which tends to settle as the doctors become more familiar with their working environment. It is pleasing to see that the amount of exception reporting for excess hours has decreased even with the added winter pressures, coupled with the affect of the Junior Doctor and Consultant strikes. The number of reports for excess hours outstrips the other reasons for exception reporting, which is a consistent finding throughout the year. Improved engagement with the doctors during induction has embedded a culture of exception reporting well among the doctors in training, particularly at a foundation level..

5. Fines Levied against Departments this quarter

There have been no fines this quarter.

6. Communication and Engagement

Work continues regarding communication and engagement with our Doctors in Training.

The Junior Doctors Forum has been up and running now for several years, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF is re-discussed at the first JDF of the new academic year to confirm that this time is convenient for the Doctors in Training, and a survey sent out to the doctors to ensure that the time is appropriate.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. This is usually run by the guardian of safe working, but several times a year is a joint session with PGME or the Freedom to Speak Up Guardian. There is also a joint drop in session in the canteen run by both the Guardian of Safe Working and the Freedom to Speak up Guardian to raise awareness of the role and to promote the culture of open reporting, the most recent of which took place in Grimsby on the 5th of December. A range of information including the fatigue charter and information on the junior doctors contract is available at this session, which is run in both Scunthorpe and Grimsby.

In addition there is a regular quarterly newsletter which is circulated via e-mail. Information pertaining to the guardians office is available on the HUB, and there is a leaflet which is provided to all doctors in training on joining the trust containing details of the support available. There is also now a regular meeting between the Guardian of Safe Working, the Freedom to Speak up Guardian, and a representative of PGME. This enables the support mechanism for Doctors in Training to establish any common themes and co-ordinate an approach to finding solutions. An exit survey for doctors leaving the

trust has been circulated, with good response. Finally a screen saver has been implemented across the trust to remind the Doctors in Training of the exception reporting system.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Chief Medical Officers Directorate.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, commenced in this role in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated a decrease compared with the previous quarter. This is what we would expect for this time of year. There has been an minimal number of immediate safety concerns, which is reassuring. Concerns raised have been escalated appropriately and actions taken to prevent recurrence where appropriate.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise. We will ensure that we continue with this work, as it provides real-time information about the situation on the wards, in addition to being a contractual obligation.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one.

Dr Liz Evans - Guardian of Safe Working

Date: 1st January 2024

Hull University Teaching Hospitals NHS Trust

Workforce, Education and Culture Committee

Thursday 29th February 2024

Agenda Item		**Meeting**	Workforce, Education and Culture Committee	**Meeting Date**	29/2/24
Title	Quarterly Report on Safe Working Hours (Doctors and Dentists in Training) 1st October 2023 to 31st December 2023				
Lead Director	Dr Kate Wood, Group Chief Medical Officer				
Author	Dr Wajiha Arshad, Guardian of Safe Working				
Report previously considered by (date)	This report has not been considered by any other Committee				

Purpose of the Reportv		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2022/23**	
Trust Board Approval		Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	Y
Assurance	Y	Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
The Guardian Report for this Workforce, Education and Culture Committee meeting covers the quarter from 1st October – 31st December 2023. The Workforce, Education and Culture and committee meeting is requested to review the full contents of the report. Key points summarised as below: 1. The Guardian of Safe Working continues to work with Medical Staffing on the roll out of e-roster across all rotas within the organisation. The standard of rota is determined by the below categories.

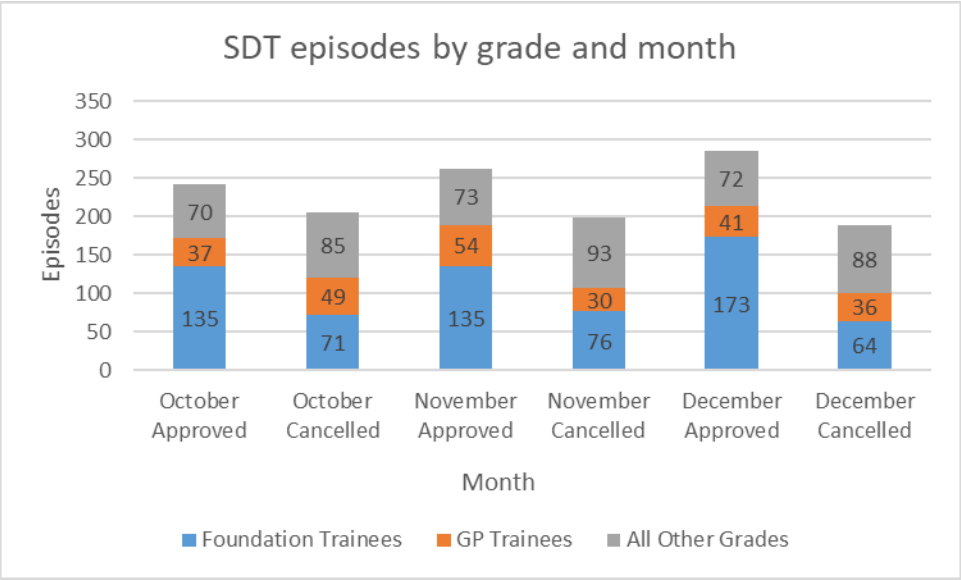
Gold	Fully Operational (Fully on eRoster and e-Roster main point of truth)
Green	Fully functional
Blue	Partially Functional
Red	Not functional

Below table summarises by Health Group current utilisation of e-Roster as at end December 2023, this table shows that 89% of HUTH rotas are now live on eRoster compared to 83% in the previous quarter (July – September 2023).

	Red	Blue	Green	Gold
Surgery	2	2	9	6
Clinical Support	0	3	4	2
Family and Womens	3	5	4	0
Medicine	2	7	10	0
Emergency Medicine	0	0	5	0
Total	**7 (11%)**	**17 (26.5%)**	**32 (50%)**	**8 (12.5%)**

2. Influx of large number of exception reports in October with issues relating to SDT in DME. However after further clarification at this point, there have been no further issues with GP trainees SDT which is very encouraging.

3. In the month of October there were a total of 447 episodes requested, 242 approved (55%) and 205 (45%) cancelled. In November there were 461 requested, 262 approved (56%) and 199 (44%) cancelled. For December there were 474 episodes requested, 286 approved (60%) and 188 (40%) cancelled. The statistics are analysed from eRoster, it can be seen that as an increased amount of rotas become fully functional on eRoster more SDT episodes are requested.



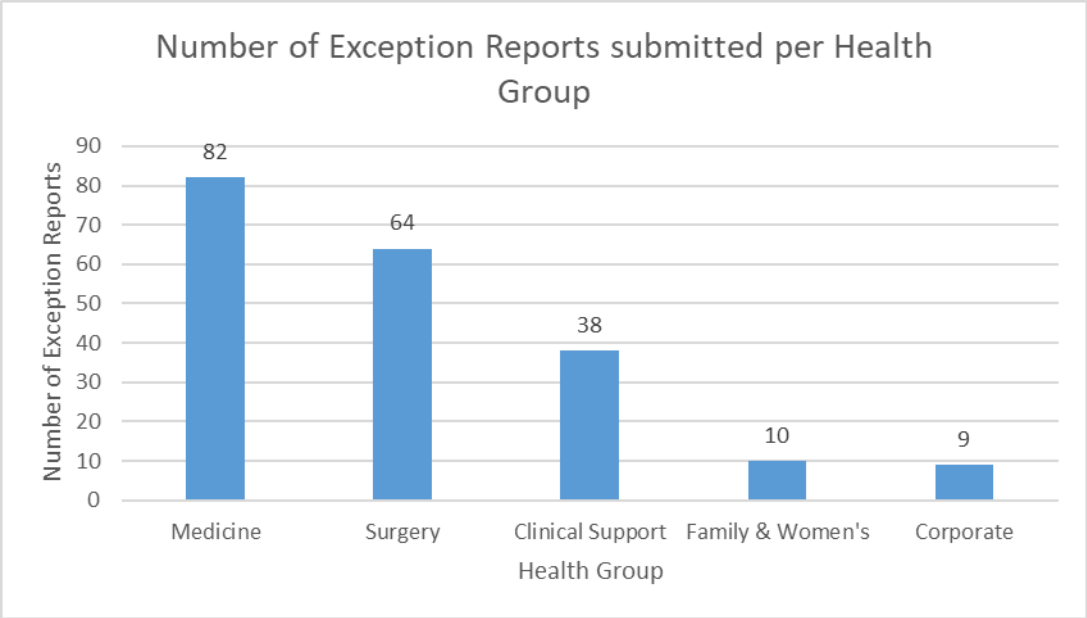
4. No further issues with ECGs have been documented on exception reports. There have however been issues with inconsistent phlebotomy cover. This has been raised at the recent JDF and will be investigated further by Mr Sedman and Dr Hibbert.

5. It is important to note that there were a number of periods of Junior Doctor Industrial Action across the quarter summarised in this report so some of the data presented may have been affected by this action eg Self-Development Time being cancelled.

Exception Reporting patterns and responses

There were a total of 203 exception reports (203 episodes) reported by doctors in training and locally employed doctors for this quarter. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

In this quarter the following number of episodes of exceptions reported per Health Group.



Exception Report trends:
The Medicine health group have received the highest number of exception reports submitted for this quarter. These were mostly accumulated from DME, Neurology, and Acute Medicine. This report details exploration into the quantity of submission by health group, grade and department.

Appendix 1

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st October – 31st Decemer 2023

1. Purpose of this Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from April to June 2023.

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	624
(establishment)	699
Number of doctors / dentists in training on 2016 TCS (total FTE's):	624
Amount of time available in job plan for guardian to do the role:	1 PA (4 hours per week)
Admin support provided to the guardian (if any):	1 WTE
Amount of job-planned time for educational supervisors:	1 WTE 0.25 PAs per trainee (max; varies between health groups)

Information on exception reporting is detailed within the junior doctor's contract (pages 37-39)

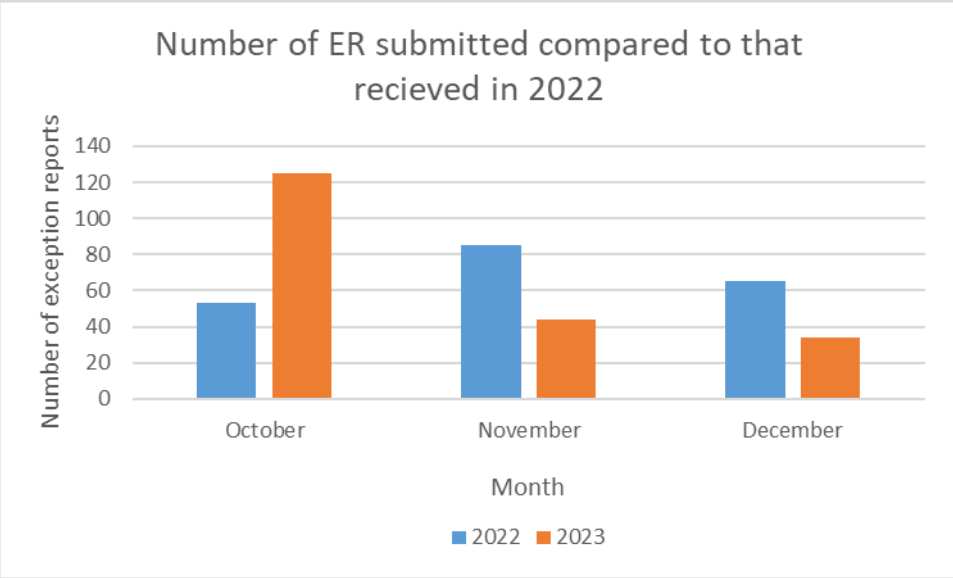
3. Doctors In Training Working Hours

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of NHS England, data will continue to be presented in this way to allow comparison to be made between Trusts across the region.
In all cases the data below is presented in relation to exception report episodes, since a single exception report may contain a number of episodes of concern.

There were 203 exception report episodes submitted between 1st October and 31st December 2023.

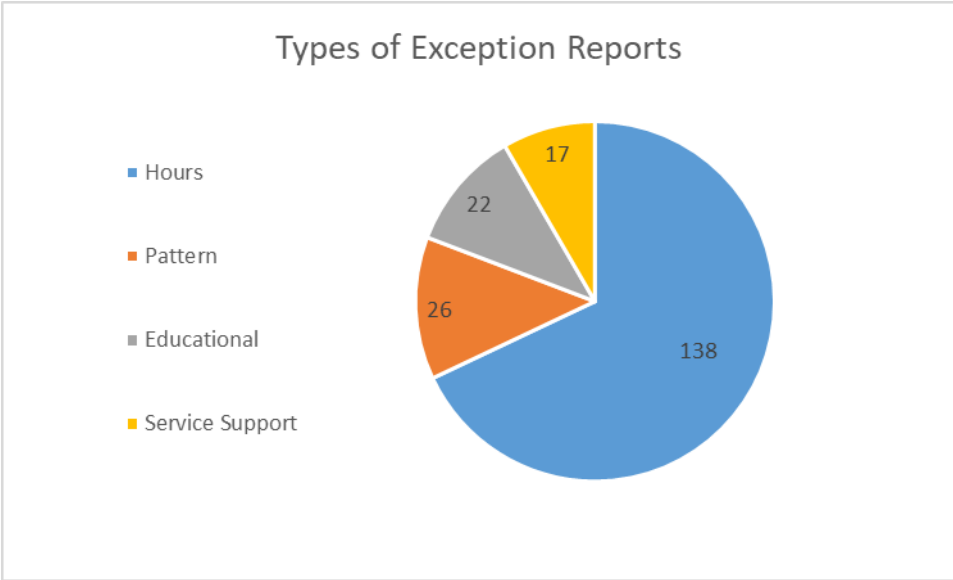
Exception reports from 2022 in comparison to 2023

The graph above shows the number of exception reports from October to December in comparison to that received in 2022. On average fewer exception reports received than that in 2022 per month. There were varied reasons for submission including sickness absence resulting in additional hours worked and missed SDT.



Types of exception reports received 1st October – 31st December 2023

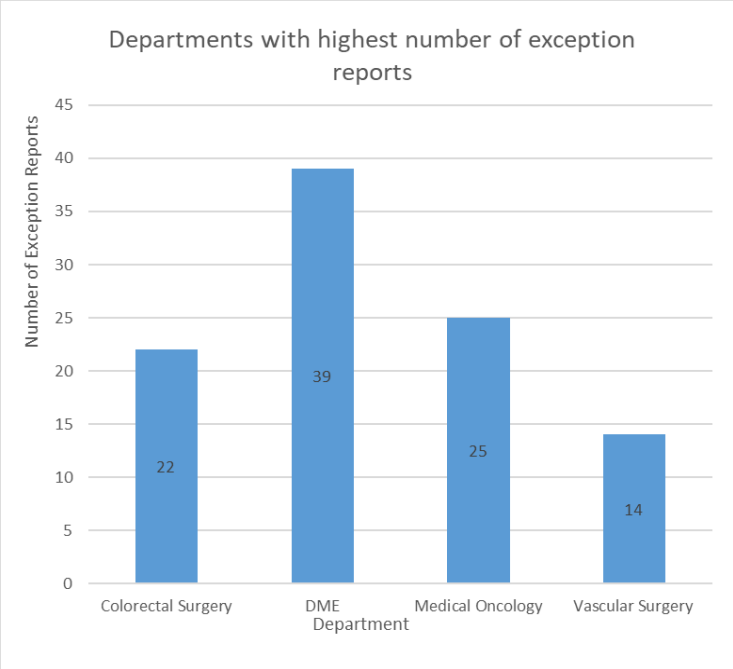
Harmonious with the data graphs below, a difference in hours continues to be the most common reason for submission of exception reports. The Guardian continues to encourage exception reporting when any variance from work schedules is completed. As a high number of rotas are reviewed due to the e-Roster roll out more juniors become aware of their working pattern and what should be exception reported.



Exception reports (episodes) by specialty 1st October – 31st December 2023

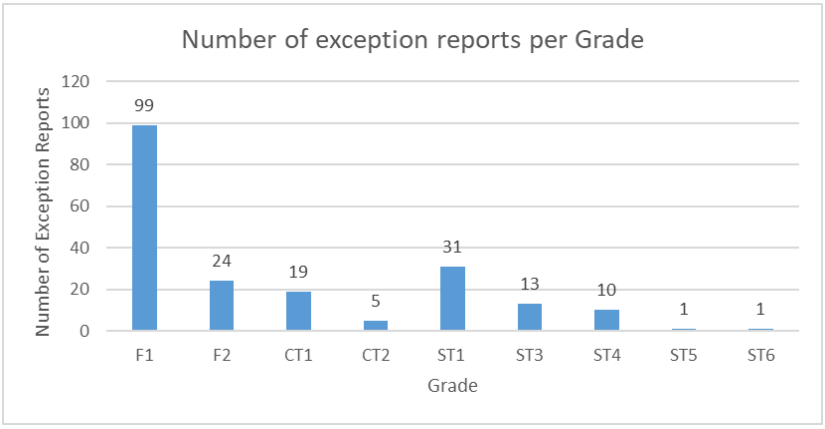
The following graph shows the top 6 departments with the highest number of exception reports submitted.

It can be seen that DME (Elderly Medicine) received the highest number of exception reports for this quarter. Many were in relation to SDT approval, everyone has been educated on protected self-development time for Foundation and GP trainees and how it differs from study leave. It is hoped that we will see an increase in numbers of DME trainees taking SDT. The trainee management and rota co-ordination role has been distributed to multiple individual's enabling the work to be completed in a timely manner. Other departments with high levels of exception reports were mostly due to additional hours being worked.



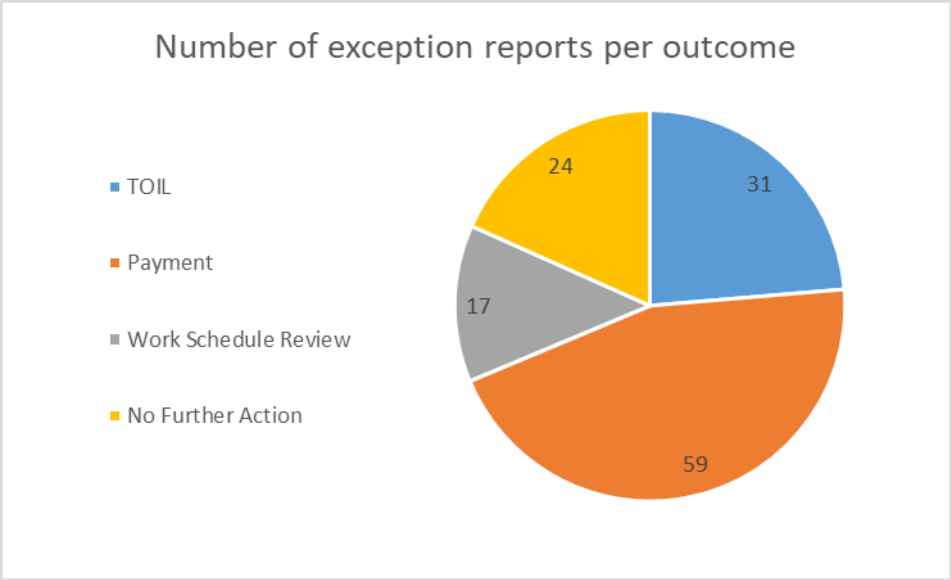
Exception reports (episodes) by grade 1st October – 31st December 2023

As previously experienced foundation doctors in training continue to submit the highest amount of exception reports. The common themes are working additional hours due to service demand and maintaining patient safety and missed self-development time. There has been an increase across all other grades as the e-roster roll out continues many offline rotas are being explored and redesigned to a more accurate version of their average working pattern. In order to ensure it is updated accurately doctors in training and locally employed doctors are encouraged to exception reports each instance they work outside of their work schedule enabling us gather as much data as possible.



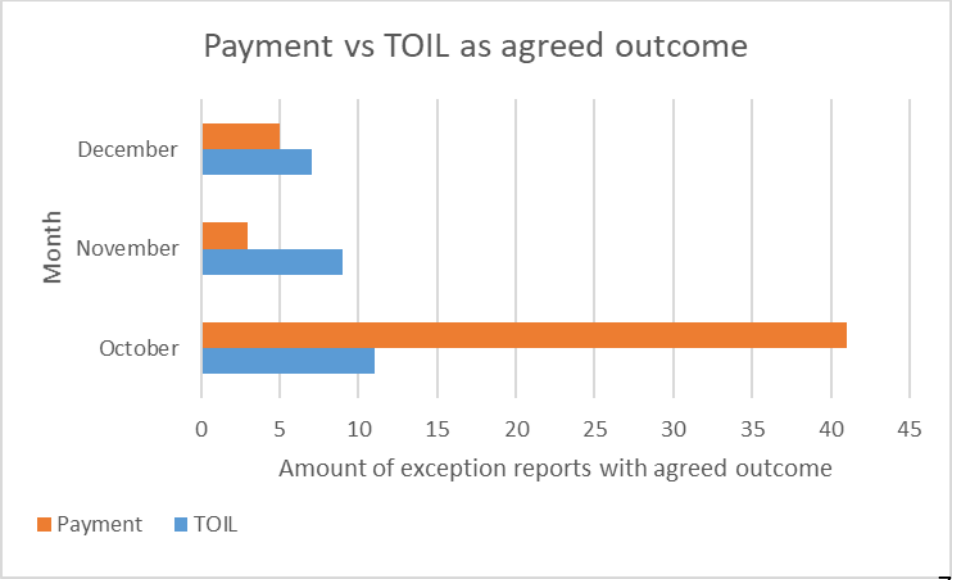
Outcomes of completed exception reports 1st October – 31st December.

As majority of exception reports received are in relation to a difference in hours worked the agreed outcome must be payment or TOIL. Due to high service pressures and backlogs it makes it challenging for TOIL to be taken therefore payment is offered as compensation. TOIL is encouraged however as some rotas are managed departmentally it can be challenging to advise if it can be taken while minimum staffing levels are maintained. A number of exception reports progressed to a level 1 review which then had no further action as the initial review outcome was upheld.



Payment and TOIL trends by month 1st October – 31st December.

The review of exception reports continues to pose a challenge as the contractual deadline of 7 days is not adhered to. A number of exception reports are pending review approval by the doctor meaning they cannot progress to complete. The Guardian has distributed multiple communications through different avenues to trainees reminding of the contractual 7 day deadline with applies to supervisors and trainees.



Fines
The 2016 Medical and Dental T&C's contract states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.
- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

When an exception report has been submitted for the difference in hours of work, e-roster is manually updated to reflect the actual hours worked, the system then automatically highlights any breaches.

Fines will be issued at four times the basic / enhanced rate of pay applicable at the time of the breach. The doctors will be paid 1.5 times the rate and the remaining amount will be paid to the Guardian of Safe Working who uses the fines to support Junior Doctor Initiatives through the Junior Doctors Forum.

Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine at the rate of twice the relevant hourly rate for the time in which the break was not taken.

Summary of fines issued 1st October – 31st December 2023

5 fines were issued in total. 1 for Chest Medicine, 2 for Plastic Surgery and 2 for Paediatric Surgery .

Reason for breaches incurring in fine:
All fines relate to non-resident on-call shifts, in Paediatric Surgery the Registrars are required to attend on-site as the General Surgery SHO on-call is often required in other specialties as they cover Vascular Surgery, Upper GI, Colorectal Surgery as well as Paediatrics Surgery. The above rota rules in relation to rest are then breached incurring in a financial penalty.

Similarly in Plastic Surgery due to the busy nature of the department the Registrars are required to attend onsite overnight again breaching rota rules on multiple occasions.

The fine applied to Chest Medicine related to short notice absence and a doctor having to cover multiple workloads. To ensure that all tasks were completed, the doctor stayed late breaching the maximum 13 hour rule on shift length.

Steps taken to resolve issues:
The clinical lead in Paediatric Surgery has produced several business cases to combat this issue, the most recent case is still pending financial approval.

The Plastic Surgery rota has been redesigned, since implementation there has only been 2 further exception reports causing breaches which were deemed to be exception circumstances. The correct mechanism through exception reporting was followed, the Guardian continues to observe the rota and action any concerns.
Multiple fines are issued for multiple breaches.

GOSW Funds Expenditure:

- Doctors Mess Summer/Winter Ball 2023 £1,500.00
- Dr Mess Noticeboard x2 £112.60
- Dr Mess Whiteboard x2 £216.52
- Dr Mess Whiteboard Pens x2 £24.66
- Dr Mess Pen Holder x2 £9.70
- Dr Mess Cutlery x2 + Coat Hooks £35.64
- Dr Mess Personalised Mugs x14 £130.15

All expenditure from the GOSW Funds is agreed at the Junior Doctors' Forum.

Further information can be found on the following:
Appendix A: Exception reports per specialty
Appendix B: Exception reports by grade
Appendix C: Exception reports by rota
Appendix D: Response time of exception reports

Rota/work schedule reviews

The following rotas were under review between October and December 2023, all relevant health groups are aware.

- Rota 59 Paediatrics
- Rota 42 Urology
- Rota 37 Oral & Maxillofacial Surgery
- Rota 16 Infectious Diseases

a) Locum bookings 1st October – 31st December

i) Bank 1st October – 31st December

The Trust has a number of avenues to fill rota gaps with post gaps filled by doctors working within the Trust initially either as overtime or via our Medical Bank. The bank data below details bookings made with doctors working through the Trust's 'Remarkable Bank' and does not include data on any rotational doctors working additional hours/overtime above their base working hours.

The information in this table covers shifts that have been booked by the Medical Staffing Team, Emergency Department and Anesthetics. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps. As the use of e-Roster is expanded across the Trust and the bookings of Bank Doctors managed centrally by Medical staffing, increased use of Bank Doctors is anticipated.

Locum Bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	124	1	912.62	12.5
F2	1945	490	18522.00	4785.32
CT/GPSTR/ST1-2	446	49	3789.00	506.17
ST3+	900	143	7743.00	1298.00
Total	**3415**	**670**	**30969.62**	**6468.49**

Locum Bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	752	296	7040.75	2781.5
Anaesthetics	28	0	155.5	0
Breast Surgery	4	0	40.5	0
Cardiology	79	3	536	26
Cardio-thoracic Surgery	74	0	591	0
Colorectal Surgery	35	0	326	0
Dermatology	3	0	16.5	0
Elderly Medicine	58	6	489.87	58.25
Emergency Medicine	943	178	8885	1723.74
Endocrinology	17	1	126.75	12.25
ENT	162	0	1661.5	0
Gastroenterology	72	1	560.5	8
General Surgery	151	68	1507.5	664
Haematology	25	0	232	0
Infectious Diseases	79	1	523.5	12.5
NCTR/Winter Wards	101	0	776	0

Neonatology	5	2	60	21
Neurology	43	5	370	50
Neurosurgery	164	12	1651	123.5
Obs & Gynae	25	1	295	12
Oncology	195	15	1703	150
Oral and Maxillofacial Surgery	88	52	825.5	560.5
Ophthalmology	1	0	24	0
Paediatric Surgery	45	9	359	92.5
Paediatrics	13	0	98.5	0
Plastic Surgery	14	1	168	13.25
Renal Medicine	6	6	45.5	45.5
Respiratory Medicine	23	0	197	0
Rheumatology	67	10	530.25	85.5
Trauma & Orthopaedics	96	0	829.5	0
Upper GI Surgery	14	0	72	0
Urology	14	0	120.5	0
Vascular Surgery	19	3	152	28.5
Total	**3415**	**670**	**30969.62**	**6468.49**

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Additional Resource	327	9	877.5	91.5
Annual leave	56	14	450	123.25
Compassionate Leave and Special Leave	18	3	159.5	37.5
Covid-19 Self Isolation and Sickness	330	38	3210.5	427.5
Maternity/Paternity Leave	13	0	103.5	0
Study Leave	6	0	44	0
Vacancy, Covid-19 Pressures and Strike Action	2661	602	26120.62	5784.74
Crem Fees	4	4	4	4
Total	**3415**	**670**	**30969.62**	**6468.49**

ii) Agency 1st October – 31st December 2023

Locum Bookings (Agency) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	124	0	912.62	0
F2	1945	589	18522	5293.9
CT/GPSTR/ST1-2	446	28	3789	299
ST3+	900	41	7743	437
Total	**3415**	**658**	**30969.62**	**6029.9**

Locum Bookings (Agency) by Department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	761	0	6947	0
Anaesthetics	28	0	155.5	0
Breast Surgery	4	0	40.5	0
Cardiology	102	5	733	53.5
Cardio-thoracic Surgery	33	16	332.5	149
Colorectal Surgery	35	0	326	0
CT Surgery	41	0	258.5	0
Dermatology	3	0	16.5	0
Elderly Medicine	58	0	489.87	0

Emergency Medicine	943	424	8885	3723.9
Endocrinology	17	0	126.75	0
Endoscopy	1	0	12	0
ENT	162	31	1661.5	312
Gastroenterology	72	50	560.5	384
General Surgery	159	18	1495.5	240.5
Gynaecology	0	0	0	0
Haematology	25	0	232	0
Infectious Diseases	79	0	523.5	0
NCTR/Winter Wards	101	0	776	0
Neonatal Medicine	5	0	60	0
Neurology	43	0	370	0
Neurosurgery	164	56	1705.75	565.5
Obs & Gynae	25	0	295	0
Oncology	195	36	1703	385
Oral and Maxillofacial Surgery	88	0	825.5	0
Ophthalmology	1	0	24	0
Paediatric Surgery	45	0	359	0

Paediatrics	13	0	137.5	0
Plastic Surgery	14	0	168	0
Renal Medicine	6	0	45.5	0
Respiratory Medicine	0	0	0	0
Rheumatology	49	0	530.25	0
Trauma & Orthopaedics	96	22	829.5	216.5
Upper GI Surgery	14	0	72	0
Urology	14	0	120.5	0
Vascular Surgery	19	0	152	0
Total	**3415**	**658**	**30969.62**	**6029.9**

Locum Bookings (Agency) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Additional Resource	327	50	877.5	384
Annual leave	56	35	450	252.00
Compassionate Leave and Special Leave	18	0	159.5	0.00
Sickness	330	27	3210.5	432.00
Maternity/Paternity Leave	13	0	103.5	0.00
Study Leave	6	0	44	0.00
Vacancy	2661	532	26120.62	4961.90
Crem Fees	4	0	4	0.00
Total	**3415**	**658**	**30969.62**	**6029.90**

Locum work carried out by doctors in training 1st October – 31st December.

This data is collected to help assess whether individual doctors in training are in breach of the WTR and the 2016 TCS, or at significant risk of breaching.

The table below represents the top 10 doctors in training that have worked the most extra hours and whether they have opted out of the WTD.

Base Specialty	Grade	Number of hours worked	Number of hours rostered per week	Opted out of WTD
Anaesthetics	ST3+	144.00	46:30	Yes
General Practice	ST3+	138.00	40:00	No
Chest Medicine	FY1	116.50	44:15	No
General Practice	ST3+	116.00	40:00	Yes
General Practice	ST3+	114.50	40:00	Yes
General Practice	ST3+	101.25	40:00	No
Infectious Diseases	ST3+	84.50	42:15	Yes
Haematology	ST3+	80.00	42:45	Yes
Cardiology	ST3+	79.00	47:30	Yes
Gastroenterology	ST3+	78.50	44:00	No

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

Doctors in training who opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be checked when doctors in training request additional hours.

e-Rostering is the key tool to making sure that all doctors working additional hours at HUTH are working within safety limits. With the continued roll out of e-Rostering across the Trust, assurance will be gained on safe working for all doctors as the system is embedded and is used as the single point of truth on working patterns and hours.

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 - Junior Doctor Trainee Establishment October to December 2023

	Trainee Establishment						Trainee In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Filled Dec 2023**	% Filled Sept 2023
Academic, GP, Psych & Community	9	29	0	110	0	148	9	28.4	0	98	0	135.4	**91.5%**	91.2%
Acute Medicine	5	7	8	0	9	29	4	7	7.8	0	7.4	26.2	**90.3%**	80.0%
Anaesthetics	5	4	25	0	30	64	5	4	20.3	0	29.8	59.1	**92.3%**	93.6%
Breast Surgery	2	0	1	0	2	5	2	0	0	0	1	3	**60.0%**	40.0%
Cardiology	3	1	3	1	11	19	3	1	3	1	10	18	**94.7%**	89.5%
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	8	0	2	0	3	13	8	0	2	0	3	13	**100.0%**	92.3%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	**100.0%**	100.0%
Elderly Medicine	6	3	5	7	6	27	6	3	6	7	4.2	26.2	**97.0%**	101.5%
Emergency Medicine	0	12	12	6	18	48	0	11.5	9.9	6	12.8	40.2	**83.8%**	84.8%
Endocrinology	3	0	2	0	4	9	3	0	1.8	0	4	8.8	**97.8%**	88.0%
ENT	2	1	2	2	5	12	2	1	2	2	3.6	10.6	**88.3%**	96.4%
Gastroenterology	3	0	2	0	6	11	3	0	2	0	5.2	10.2	**92.7%**	92.7%
General Surgery	0	1	0	0	0	1	0	0	0	0	0	0	**0.0%**	100.0%
Haematology	2	2	2	0	4	10	1	2	2	0	4.2	9.2	**92.0%**	92.0%
Histopathology	0	0	0	0	7	7	0	0	0	0	7	7	**100.0%**	100.0%
Immunology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Infectious Diseases/Neuro-Rehab	2	1	1	4	6	14	2	1	1	4	6.3	14.3	**102.1%**	102.1%
Neurology	4	3	3	0	5	15	4	3	2	0	3.5	12.5	**83.3%**	76.7%
Neurosurgery	1	1	2	0	4	8	1	0	1	0	4	6	**75.0%**	75.0%
Obstetrics & Gynaecology	0	3	7	4	13	27	0	3	5	2.8	12.8	23.6	**87.4%**	85.6%
Oncology	3	0	2	4	12	21	2	0	1	3	12	18	**85.7%**	90.5%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	5.8	7.8	**97.5%**	85.0%
Oral & Maxillofacial Surgery	0	0	10	0	1	11	0	0	2	0	1	3	**27.3%**	27.3%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	5.8	0	6.5	12.3	**87.9%**	87.9%
Paediatric Surgery	0	0	2	0	0	2	0	0	1.8	0	0	1.8	**90.0%**	90.0%
Palliative Care	0	0	0	2	0	2	0	0	0	2.4	0	2.4	**120.0%**	120.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	5	8	**88.9%**	97.8%
Paediatrics	3	4	5	2	9	23	3	3	4.2	2	5.5	17.7	**77.0%**	81.3%
Radiology	0	1	0	0	37	38	0	0	0	0	35.8	35.8	**94.2%**	96.8%
Renal Medicine	2	1	2	0	6	11	2	0	1	0	5	8	**72.7%**	81.8%
Respiratory Medicine	6	2	2	2	8	20	5	2	2	2	8.3	19.3	**96.5%**	94.5%
Rheumatology	0	0	1	2	3	6	0	0	1	1.8	2.8	5.6	**93.3%**	93.3%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Trauma & Orthopaedics	0	5	3	1	9	18	0	5	2	1	9	17	**94.4%**	72.2%
Upper GI	9	0	2	0	4	15	9	0	0	0	4	13	**86.7%**	86.7%
Urology	1	3	2	0	3	9	1	3	2	0	3	9	**100.0%**	102.2%
Vascular Surgery	7	0	1	0	5	13	6	0	1	0	4	11	**84.6%**	73.3%
TOTAL	**88**	**88**	**119**	**148**	**256**	**699**	**83**	**81.9**	**92.6**	**134**	**232.5**	**624**	**89.3%**	88.3%

Appendix A: Exception reports episodes per specialty 1st October – 31st December 2023

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No. exceptions outstanding (episodes)
Accident and Emergency	1	0	0	1
Acute Medicine	1	6	0	7
Cardio-thoracic surgery	1	0	0	1
Clinical Oncology	0	1	0	1
Diabetes and Endocrinology	0	2	0	2
General Medicine	66	94	80	80
General Practice	2	0	2	0
General Surgery	12	32	11	33
Geriatric Medicine	0	2	1	1
Haematology	0	6	6	0
Medical oncology	25	26	23	28
Neurology	8	4	0	12
Neurosurgery	2	0	0	2
OMFS	1	0	0	1
Paediatric Surgery	0	6	6	0
Paediatrics	1	3	1	3
Plastic Surgery	13	0	4	9
Psychiatry	1	9	0	10
Radiology	0	1	0	1

Respiratory Medicine	0	1	0	1
Surgical Specialties	12	9	4	17
Trauma and Orthopaedics	3	4	0	7
Urology	6	0	0	6
Vascular Surgery	7	14	3	18

Appendix B: Exception reports (episodes) by grade 1st October – 31st December 2023

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	77	103	62	118
F2	15	27	15	27
CT1	15	23	19	19
CT2	3	7	0	10
CT3	1	0	0	1
ST1	18	34	24	28
ST2	2	0	2	0
ST3	3	13	12	4
ST4	16	11	6	21
ST5	2	1	1	2
ST6	5	1	0	6
ST7	2	0	0	2
ST8	3	0	0	3

Appendix C: Exception reports (episodes) by rota 1st October – 31st December 2023

Rota	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Rota 9 – Chest/Renal (Blp 575)	3	2	1
Rota 23 - Surgery F1	14	2	12
Rota 124a - General Surgery, Acute & Elective	4	0	4
Rota 124b – General Surgery	2	0	2
Rota 19 – AAU SHO	5	0	5
Rota 4 – Gastro/DME/Acute Med/Neurology	25	13	12
Rota 8 – Oncology & Haematology	9	1	8
Rota 27 – Acute & Elective Surgery	1	0	1
Rota 130 – NCTR & General Medicine (F2+)	1	1	0
Rota 66 – Paediatric Surgery	6	6	0
Rota 131 – NCTR & General medicine (F1)	2	2	0
Rota 18 – Medicine F1	21	8	13
Rota 18b – Medicine F1	2	0	2
Rota 13 – Acute & General Med IMT	3	0	3
Rota 14 – DME (Blp 431)	31	25	6
Rota 5 – Neuro/DME/Derm (Blp 215)	2	1	1
Rota 25 – Acute/Elective F1	29	5	24
Rota 7 - Neurology	4	0	4

Rota 12 – Medical Oncology SpR	1	9	6
Rota 15 – Medicine SHO (Blp 450)	0	0	3
Rota 77 – Radiology	0	0	1
Rota 137 – Psychiatry SHO	0	0	9
Rota 59 – Paediatrics SpR	0	0	1
Rota 58 – Paediatrics SHO	1	0	1
Rota 134 – Orthopaedic/Orthogeriatric	0	0	4

Appendix D: Exception reports (episodes) - response time 1st October – 31st December 2023

The 2016 TCS require that the trainer meets with the doctor in training to discuss an exception report within seven days. This is a very difficult timescale to achieve, because of trainers and doctors in training often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

There is difficulty with supervisors completing exception report reviews within the contractual time frame, the T&C's have been updated enabling the Guardian to intervene should it be required. We are working with the software provider on automatic reminders which will help to reduce length of time taken to complete the reviews. Until the software updates are implemented we strive to have all exception reports addressed within the 7 day contractual time frame.

This is shown in the table below:

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Outstanding
F1	8	4	18	69
F2	3	2	5	14
CT1	2	2	6	9
CT2	0	0	0	5
ST1	1	0	11	19
ST3	5	0	7	1
ST4	1	0	2	7
ST5	1	0	0	0
ST6	0	0	0	1

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)078

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	As above
Title of the Report	Trust Boards-in-Common & Committees-in-Common Meeting Cycle

Executive Summary	The report provides the planned dates and times of trust boards & committees meetings. Where changes have been made diary invites have been sent or updated.
	Changes have been highlighted in red in the attached meeting cycle and highlight the new meeting date and time for the:
	• Audit, Risk & Governance Committee in:
	  ○ June (now the 21 June @ 9:00 to 10:30am) and
	  ○ August (now 6 August @ 9:00 to 10:30am)
	• Appointments & Remuneration Committee in May (30 May @ 2:30 to 4:00pm)

Background Information and/or Supporting Document(s) (if applicable)	This is 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 - 2024 - V13

	Quarter 4 (23/24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 1 (24/25)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Trust Board															
Public & Private (Thursdays - 9.00 am - 5.00 pm)		08.02.24		11.04.24		13.06.24		08.08.24		10.10.24		12.12.24		13.02.25	
Board Development (Tuesdays - 9.00 am - 5.00 pm)	02.01.24		05.03.24		14.05.24		02.07.24				05.11.24		07.01.25		04.03.25
Committees in Common															
Performance, Estates & Finance (Wednesdays - 9.00 am - 12.30 pm)	24.01.24	28.02.24	27.03.24	24.04.24	29.05.24	26.06.24	24.07.24	28.08.24	25.09.24	30.10.24	27.11.24	18.12.24	29.01.25	26.02.25	26.03.25
Capital & Major Projects (Tuesdays - 9.00 am - 12.00 pm)		20.02.24		23.04.24		25.06.24		27.08.24		29.10.24	26.11.24				
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24 (1.30 pm - 5.00 pm)	29.02.24	28.03.24	25.04.24 (1.30 pm - 5.00 pm)	23.05.24	27.06.24	31.07.24 (Wednesday)	29.08.24	26.09.24	24.10.24	28.11.24	17.12.24 (Tuesday)	30.01.25	27.02.25	27.03.25
Remuneration (Thursdays - 9.00 am - 11.30 am)	11.01.24			04.04.24	22.05.24		11.07.24			03.10.24			09.01.25		
Workforce, Education & Culture (Thursdays - 1.30 pm - 5.00 pm with exceptions as stated)	30.01.24 (Tuesday - 9.00 am - 12.30 pm)	29.02.24	28.03.24	30.04.24 (Tuesday - 9.00 am - 12.30 pm)	23.05.24	27.06.24	25.07.24	29.08.24	26.09.24	24.10.24	28.11.24		30.01.25	27.02.25	27.03.25
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24			25.04.24		21.06.24 (Friday - 9.00 am - 10.30 am) **HUTH ONLY**	25.07.24	06.08.24 (Tuesday - 9.00 am - 10.30 am) **NLAG ONLY**		31.10.24			23.01.25		
Charitable Funds															
NLAG (9.00 am - 12.00 pm)	10.01.24			03.04.24			04.07.24			09.10.24			22.01.25		
HUTH (9.00 am - 12.00 pm)		21.02.24			30.05.24			22.08.24			13.11.24			06.02.25	
Executive Team Meetings															
Executive Team (Tuesdays - 2.00 pm - 5.00 pm)	09.01.24 16.01.24 23.01.24 30.01.24	06.02.24 13.02.24 20.02.24 27.02.24	12.03.24 19.03.24 26.03.24	02.04.24 09.04.24 16.04.24 23.04.24 30.04.24	14.05.24 21.05.24 28.05.24	04.06.24 11.06.24 18.06.24 25.06.24	09.07.24 16.07.24 23.07.24 30.07.24	06.08.24 13.08.24 20.08.24 27.08.24	10.09.24 17.09.24 24.09.24	01.10.24 08.10.24 15.10.24 22.10.24 29.10.24	12.11.24 19.11.24 26.11.24	03.12.24 10.12.24 17.12.24 24.12.24	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
Governors															
Council of Governors (Thursdays - Business Meetings - 2.00 pm - 5.00 pm, with exceptions as stated)	11.01.24			18.04.24 (9.30 am - 12.30 pm)		18.06.24 **Business Meeting** 9.00 am - 12.00 pm **Annual Review Meeting** 1.00 pm - 3.00 pm		22.08.24	**Annual Members Meeting** 12.09.24	31.10.24			09.01.25		
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm with exceptions as stated)		15.02.24 (Thursday)			21.05.24		16.07.24		24.09.24						
Appointments & Remuneration Committee (Thursdays - 1.30 pm - 3.00 pm)			14.03.24		30.05.2024 (2.30 pm - 4.00 pm)					03.10.24					06.03.25
NED & CEO Meetings															
NED & CEO Meetings (Thursdays - 2.00 pm - 4.00 pm - with exceptions as stated)	09.01.24 (Tuesday - 10.00 am-12.00 pm)	15.02.24	14.03.24 (10.00 am-12.00 pm)		16.05.24	19.06.24 (Wednesday)	09.07.24 (Tuesday - 10.00 am - 12.00 pm)	15.08.24	10.09.24 (Tuesday - 10.00 am - 12.00 pm)	17.10.24	14.11.24	19.12.24	14.01.25 (Tuesday - 10.00 am - 12.00 pm)	20.02.25	13.03.25
Union Meetings															
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	15.01.24	19.02.24	18.03.24	15.04.24	20.05.24	17.06.24	15.07.24	19.08.24	16.09.24	21.10.24	18.11.24	16.12.24	20.01.25	17.02.25	17.03.25
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	04.01.24		07.03.24		02.05.24		04.07.24		05.09.24		07.11.24		02.01.25		06.03.25
Consultant Meetings															
JLNC - NLAG (Tuesdays - 1.00 pm - 3.00 pm)	16.01.24	20.02.24	19.03.24	16.04.24	21.05.24	18.06.24	16.07.24	20.08.24	17.09.24	15.10.24	19.11.24	17.12.24	21.01.25	18.02.25	18.03.25
LNC - HUTH (Wednesdays - 10.00 am - 12.00 pm)	17.01.24		20.03.24		15.05.24		17.07.24		18.09.24		20.11.24		15.01.25		19.03.25