AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 8 February 2024 at 9.00 am to 12.45 pm in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

No.	Agenda item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** Group Chair	Verbal	Information	**09:00**
1.2	**Patient Story - NLaG** Deputy Chief Nurse (NLaG)	Verbal	Discussion / Assurance	
1.3	**Declarations of Interest** Group Chair	Verbal	Assurance	
1.4	**Minutes of the Meeting held on Tuesday, 14 November 2023 (HUTH)** Group Chair	BIC(24)004 Attached	Approval	
1.5	**Minutes of the Meeting held on Tuesday, 5 December 2023 (NLaG)** Group Chair	BIC(24)005 Attached	Approval	
1.6	**Minutes of the Boards-in-Common Meeting held on Tuesday, 12 December 2023** Group Chair	BIC(24)006 Attached	Approval	
1.7	**Minutes of the Boards-in-Common Meeting held on Tuesday, 23 January 2024** Group Chair	BIC(24)007 Attached	Approval	
1.8	**Matters Arising** Group Chair	Verbal	Discussion / Assurance	
1.9	**Action Tracker – Public** Group Chair	BIC(24)008 Attached	Assurance	
1.10	**Chief Executive's Briefing** Group Chief Executive	BIC(24)009 Attached	Assurance	**09:25**
1.11	**Matters for Escalation from the NLaG Council of Governors January 2024 Business Meeting** Vice Chair (NLaG)	BIC(24)010 Attached	Assurance	**09:45**
2.	**GROUP DEVELOPMENT**			
2.1	**Group Development: Latest Update** Group Chief Executive	Verbal	Assurance	**09:50**
2.2	**Group Operating Model / Care Group Structure** Group Chief Delivery Officer	BIC(24)011 Attached	Approval	
2.3	**Group Data Sharing Agreement & Privacy Notice** Group Chief Strategy & Partnerships Officer	BIC(24)012 Attached	Approval	

3. STRATEGY				
3.1	**Engagement with External Stakeholders (Standing Item)** Group Chief Executive / All	Verbal	Assurance	**10:10**
3.1.1	**Formal Submission to Public Consultation – Humber Acute Services: Your Health, Your Hospitals** Group Chief Strategy & Partnerships Officer	BIC(24)013	Information	
BREAK – 10:20 – 10:35				
4. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS				
4.1	**Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge** Non-Executive Director Committee Chair	BIC(24)014 Attached	Assurance	**10:35**
4.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Interim Chief Nurse, Deputy Chief Nurse & Heads of Midwifery (NLaG & HUTH)	BIC(24)015 Attached	Assurance	**10:50**
4.1.3	**Maternity & Neonatal Safety: NED Safety Champions' Reports – NLaG and HUTH** NED Maternity & Neonatal Safety Champions	BIC(24)016 Attached	Assurance	
4.2	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge** Non-Executive Director Committee Chair	BIC(24)017 Attached	Assurance	**11:05**
4.3	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Non-Executive Director Committee Chair	BIC(24)018 Attached	Assurance	**11:20**
4.4	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Non-Executive Director Committee Chair	BIC(24)019 Attached	Assurance	**11:35**
4.4.1	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 3) – NLaG & HUTH** Group Chief People Officer & FTSU Guardians (NLaG & HUTH)	BIC(24)020 Attached	Assurance	**11:50**
4.5	**Health Tree Foundation Trustees' Committee Highlight / Escalation Report & Board Challenge - NLaG** Non-Executive Director	BIC(24)021 Attached	Assurance	**11:55**
4.5.1	**Chair of Health Tree Foundation Trustees' Committee – Extension of Tenure** Group Chair	BIC(24)022 Attached	Approval	
4.6	**Charitable Funds Committee Highlight / Escalation Report & Board Challenge** Non-Executive Director Committee Chair	BIC(24)046 Attached	Assurance	**12:00**
5. GOVERNANCE & ASSURANCE				
5.1	**Board Assurance Framework & Strategic Risk Register – NLaG and HUTH** Interim Governance Advisor	BIC(24)023 Attached	Assurance	**12:05**
5.2	**Trust Boards' Aligned Business Reporting Framework** Interim Governance Advisor	BIC(24)024 Attached	Approval	**12:15**

5.3	**Trust Boards & Committees Meeting Cycle** Interim Governance Advisor	BIC(24)025 Attached	Approval	**12:20**
6. OTHER ITEMS FOR APPROVAL				
6.1	No other items for approval	-	-	-
7. ITEMS FOR INFORMATION / SUPPORTING PAPERS				
7.1	**Items for Information / Supporting Papers (as per Appendix A)** Group Chair	Verbal	Information / Assurance	
8. ANY OTHER URGENT BUSINESS				
8.1	**Any Other Urgent Business** Group Chair / All	Verbal		**12:25**
9. QUESTIONS FROM THE PUBLIC AND GOVERNORS				
9.1	**Questions from the Public and Governors** 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** 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, 11 April 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 Committee – December 2023 (NLaG)** Non-Executive Director Committee Chair	BIC(24)026 Attached
7.1.2	**Quality – December 2023 (HUTH)** Non-Executive Director Committee Chair	BIC(24)027 Attached
7.2	**Audit, Risk & Governance Committees-in-Common**	
7.2.1	**Audit, Risk & Governance – November & December 2023 (NLaG)** Non-Executive Director Committee Chair	BIC(24)028 Attached
7.2.2	**Audit Committee – October 2023 (HUTH)** Non-Executive Director Committee Chair	BIC(24)029 Attached
7.2.3	**NLaG ARG Committee Annual Self-Assessment Exercise** Non-Executive Director Committee Chair	BIC(24)030 Attached
7.2.4	**HUTH Audit Committee Annual Self-Assessment Exercise** Non-Executive Director Committee Chair	BIC(24)031 Attached
7.3	**Performance, Estates & Finance Committees-in-Common**	
7.3.1	**Finance & Performance – December 2023 (NLaG)** Non-Executive Director Committee Chair	BIC(24)032 Attached
7.3.2	**Performance & Finance – December 2023 (HUTH)** Non-Executive Director Committee Chair	BIC(24)033 Attached
7.4	**Workforce, Education & Culture Committees in Common**	
7.4.1	**Workforce Committee – November 2023 (NLaG)** Non-Executive Director Committee Chair	BIC(24)034 Attached
7.4.2	**Workforce, Education & Culture – December 2023 (HUTH)** Non-Executive Director Committee Chair	BIC(24)035 Attached
7.5	**Charitable Funds**	
7.5.1	**Health Tree Foundation Trustees' – November 2023 (NLaG)** Committee Chair	BIC(24)036 Attached
7.5.2	**Charitable Funds (HUTH)** Non-Executive Director Committee Chair	BIC(24)037 Attached
7.6	**Other**	
7.6.1	**Integrated Performance Report** Group Chief Strategy & Partnerships Officer	BIC(24)038 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
Minutes of the Trust Board
Held 14 November 2023

Present:	Mr S Lyons	Group Chairman
	Mr S Hall	Vice Chair
	Mr M Robson	Non-Executive Director/Senior Independent Director
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mrs J Hawkard	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr J Lofthouse	Group Chief Executive Officer
	Mr L Bond	Group Chief Financial Officer
	Dr K Wood	Group Chief Medical Officer
	Mr S Stacey	Group Chief Delivery Officer
	Mr S Nearney	Group Chief People Officer
	Mr I McConnell	Group Director of Strategy and Partnerships
	Mrs J Ledger	Interim Chief Nurse
In Attendance:	Mrs L Cooper	Director of Midwifery
	Mr P Sedman	Deputy Chief Medical Officer
	Ms F Moverley	Head of Freedom to Speak Up
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Welcome and Apologies** Mr Lyons congratulated the newly appointed Group Executives and advised that it was the start of the new Group model. Mr Lyons advised that it was Mrs McMahon's last Board meeting and thanked her for all her hard work. Mrs McMahon wished the new Board the best success. Apologies were received by Mrs L Jackson, Associate Non-Executive Officer.	
2	**Declarations of Interest/Conflicts of interest with any agenda items** There were no declarations or conflicts raised.	
3	**Minutes of the meeting held September 2023** The minutes were approved as an accurate record of the meeting.	
4	**Action Tracker** Mr Lofthouse advised that since the patient story at the last Board meeting the Pain Team had developed a local action plan to improve the accessibility and contact information to practicing consultants. A Business Case relating to vascular access issues was also being developed and would be reviewed by the Executive Team. Mr Nearney advised that once the new Board Development programme was in place for 2024, the EDI Network Chairs would be invited to the relevant sessions.	

5 Board Work Programme

The Board reviewed the Work Programme. Mrs Thompson advised that there had been no changes and it would be superseded by the new Group Work Programme.

6 Board Development Framework

Mrs Thompson advised that the Board Development session in December 2023 would be a joint venture with NLAG.

7 Patient Story

Mr Sedman presented the patient story which related to a number of appointments and hospital attendances, gall bladder removal procedures being cancelled and resulted in gall bladder surgery that should have taken place much earlier.

The patient was a member of staff who understood the pressures on the hospital but her delayed surgery meant a long period of sickness and poor patient experience. The patient had nothing but praise for the staff that helped her during her stay in hospital.

Mr Sedman advised that NICE guideline (CG188 October 2024) states that the laparoscopic cholecystectomy should take place a week after diagnosis to patients with acute cholecystitis, as the earlier it is done the easier it is. He added that this was not a stand-alone case and highlighted 2 other patients that had also had poor patient experience. The procedure was seen as lower down on the priority list but quick responses would mean less attendance at the hospital.

Dr Wood thanked Mr Sedman and advised that the problem was not unique to HUTH and a review of the pathways was required to reduce the number of bed days taken up. Mr Stacey advised that a review of scheduling would be undertaken next week as well as looking at day case possibilities.

8 Report from the Group Chief Executive Officer

Mr Lofthouse advised that the Group Executive recruitment was on track and that the remaining vacancies were now out on the National market. The plan was to stabilise the top team by December and a number of interim roles had been appointed to give additional bandwidth during the transition.

The new Care Group structure had been presented to the Triumvirate Teams and the initial recruitment process would be concluded by January 2024.

Mrs Ledger updated the Board regarding VTE and Falls in relation to the Coroner concerns. She advised that good progress was being made with the Falls work and major harms were reducing. A task and finish group had been set up to address the Regulation 28 relating to VTE and Mrs Ledger added that she would also work with Dr Wood regarding this issue.

Mr Stacey advised that there was continued growth in the number of RTT patients and the number of elective pathways over 78 weeks was also increasing. There had been some improvement regarding the 65

week process. There were also challenges regarding cancer 62 day performance but the Trust had achieved the Faster Diagnosis Standard.

Mr Lofthouse advised that he had commissioned a piece of improvement work which would introduce a revised RTT management tool which had previously been used at Kings College.

Mr Bond advised that all Acute Trusts will be experiencing variation in the mid-year planning round as the financial deficit for NHS UK was growing. Both HUTH and NLAG would need to consider the variation and prepare actions for Board sign off before 22nd November 2023. The actions would include revised trajectories for the ED 4 hour performance, Ambulance handovers, 62 day cancer and faster diagnosis. The ICB would receive £17.3m to facilitate the actions and if 103% of activity was achieved it would be paid at full tariff.

Post meeting note: The updated plans have been circulated to both the ICB and NHS England on 22 November 2023 and accepted. Both Boards were made aware of this on 23 November 2023.

Mr Bond advised that there were 3 main drivers linked to the £10m issue which were; the cost of the strikes, unearned elective recovery funding and the unfunded element of the pay rise. He add that the £17.3m would go some way to cover the industrial action and some of the pay rise shortfall.

Mr Lofthouse asked for delegated responsibility from the Board to appoint a check and challenge group to review the revised position and report back to the centre. This group would consist of the Group CEO, Group Chairman, Group CFO, Group CDO and the Performance and Finance Committee Chairs from both Trusts. Board members discussed the significant risks in the organisation and the need for local partners to assist to provide the most appropriate care for patients in the right setting.

Mr Lofthouse advised that he was meeting with Mr Reading, CEO of YAS to discuss any Group opportunities to dissipate Ambulances more constructively.

Mr McConnell reported that the Acute Services review was under way and on track. The public consultation was ongoing and there had been 1910 responses so far.

Congratulations were given to the Nursing Workforce and Education Team who had won the award for workforce initiative of the year, for their work in retaining staff and reducing nurse vacancies. The team attended the RCN Nursing Awards to collect their award.

Mr Lofthouse mentioned the Staff Disability Conference and the range of excellent speakers that had attended. He added that the staff felt valued and understood the support mechanisms in place at the Trust.

Amanda Pritchard the CEO of NHS England had visited the Trust on her first visit to the region. During her time in Hull she visited the Jean

Bishop Centre, Rossmore, the Rehab 1 Unit at Castle Hill Hospital and the Interventional Radiology Team at HRI. The visit ended with a celebration of Jeanette, a House Keeper that had worked for the Trust for 51 years and was retiring.

Mr Lofthouse had met with a range of MPs over the last couple of weeks and would eventually meet with all of them.

9 Board Assurance Framework

Mrs Thompson presented the Quarter 2 Board Assurance Framework and advised that it had been received at all of the Board Committees previously.

The Board Assurance Framework was aligned to the assurance ratings decided by the Committees and to that end there had been no movement in any of the risks. BAF risk 3.2 had been increased in September 2023 to align with the ED crowding risk on the Corporate Risk Register and Mrs Thompson advised that there was still concern in the Emergency Medicine Health Group regarding crowding in ED. This had been discussed also at the Operation Risk and Compliance Sub-Committee.

Mrs Thompson reported that the only risk not to be discussed at any of the Committees was BAF risk 5 which related to partnerships and in particular the ICS partnership. She added that there was to be a new Risk and Assurance check and challenge meeting led by the Group CEO where this risk would be reviewed.

Mr Lofthouse advised that the first check and challenge meeting would take place in the first week of December 2023. This would be scheduled monthly thereafter.

Resolved: The Board approved the Quarter 2 risk ratings as set out in the report.

10.1 Escalation from the Quality Committee

Prof Macleod presented the report and advised that a stricter view of assurance was being sought and robust evidence seen before the rating could be increased to substantial.

Deep dives had been received relating to medication errors and a Board Development session focussing on Infection Prevention and Control received.

Mrs Hawkard asked whether any impact modelling had taken place on the new UTC building and Mr Bond advised that the pathways were still being agreed. Mr Lofthouse added that it would take patients from the ED who did not need to be there and would be a substantially larger space. Dr Ashok asked if there would be adequate workforce capacity to manage the UTC and Mr Bond advised that the planning assumptions assumed the facility would be built gradually in Q4 and would not massively impact the Acute pathways until after then.

Dr Wood advised that she was meeting with the Interim Director of Quality Governance to review ward to Board governance and that she

would also be meeting with Prof Macleod to touch base regarding other Quality issues.

Mrs Ledger advised that the 2 historic serious incidents would be completed by the end of November 2023, work was ongoing regarding device related pressure ulcer damage and medical staff were now on board with the Falls training. The assurance visits were still be carried out which gave good insight into the lived reality of patients and staff.

Mrs Cooper reported that there were still risks around the Maternity workforce, in particular maternity leave which was impacting on the delivery of the maternity incentive scheme. She added that there was no harm being caused, it was just the impact on patient experience.

10.1 Clinical Negligence Scheme for Trusts
Mrs Ledger introduced the item and advised that the Trust had declared 10/10 for compliance in January 2023, but following the CQC inspection there were 4 areas of concern raised so a further review of the standards was undertaken.

Mr Wright gave the presentation which highlighted the NHS Resolution scheme with 10 standards to declare against. Technical guidance is revised each year and the declaration must be approved by the Board.

If the Trust is meets the specified compliance a MIS Saving is released which in Year 4 is £467k. In the current year 5 the potential saving is £542k.

The Group CEO received a letter from NHS Resolution on 10/10/23 identifying areas of concern which appeared to contradict the January 2023 submission. Following this letter a full review of all 10 standards was undertaken to check compliance against them.

The process highlighted 4 areas that were not compliant but after checking this with NHS Resolution it was agreed that only 2 were non-compliant. These two areas related to neonatal staffing compliance not being referenced in the Board minutes and non-compliance with the moderate scanning pathway within the Saving Babies Lives V2 care bundle.

A number of recommendations were presented which included:

- Appointing 2 x Band 8A to oversee the delivery of the Saving Babies Lives Care Bundle.
- A separate CNST governance and assurance structure to be put into place
- Diligent annual review of the CNST technical guidance
- Care around minute taking at the Board and be clear on what is required.

Mr Lofthouse asked about NLAG resource and Dr Wood advised that there was a team of 2 a Band 8A and a Band 6 to do the compliance work. Mr Stacey added that there was also a Band 7 CNST co-ordinator due to the amount of work. The level of matrons had also been increased.

Mrs Hawkard asked if the Team were confident that the 10 risks were in hand for 2023/24 and Mrs Cooper advised that the main issue related to workforce vacancies and this was impacting on training requirements.

Resolved: The Board approved the re-submission of the template with an accompanying letter from the Group Chief Executive to inform: NHS Resolution, NHS England, Integrated Care Board and the CQC.

10.2 Escalation from the Performance and Finance Committee

Mr Robson presented the summary report and advised that the Committee had agreed limited assurance for ED performance although the Management Team were due to present the impact of improvement initiatives at the next meeting in November.

The Committee had discussed patients with no criteria to reside, the 13th Floor and Rossmore and the need for a system response to winter pressures. Limited assurance had been given in all areas with the exception of the Capital programme, this was given reasonable assurance. There was slippage in the capital programme but this was being managed.

Cancer performance was comparable with previous months and the Committee had requested a cancer trajectory as to when performance would improve.

The Committee had received a GIRFT presentation from Dr Davidson highlighting the genuine integration between GIRFT and the improvement plans.

The financial deficit in month was £5m with £3.8m being the Elective Recovery Funding shortfall. Mr Robson advised that even with the current pressures the Team was still forecasting achievement of the year-end target. There was still an underlying deficit of £52m which needed to be addressed.

Mr Bond advised that the £500k CNST payment, winter pressures, beds and the cost of the re-organisation of the Group were not included in the financial plan.

The Committee also received a presentation from the Group Procurement Director on progress against the procurement strategy across the ICB.

Mr Lofthouse advised that the risks in the ED relating to response and flow were being picked up by the Group Chief Delivery Officer and the new Interim Director of Performance to ensure patients were kept safe. He added that the new Interim Winter Director would also be providing support and a risk position statement would be presented to the Board the first week in December 2023.

10.3 Escalation from the Workforce Education and Culture Committee

Mr Curry presented the report from the Committee and advised that there was good assurance in a number of areas, but there was limited assurance regarding the Staff Survey.

Mr Curry added that the Freedom to Speak Up Guardian and the EDI leads had also presented at the meeting. The Committee had discussed equality and diversity issues for doctors and how this could be very different for a Band 5 nurse.

Great progress had been made on nursing staffing levels but there were still risks around retention and turnover.

Mr Nearney advised that the Trust was hosting an event at the University for 150 of the Trust's top leaders to give the key messages and gain reflections relating to the new Group model. This would be attended by Jim Mackey and would be repeated quarterly.

Mr Lyons asked about the response rate of the Staff Survey and Mr Nearney advised that HUTH was at 46% and NLAG a 40% with 2 weeks to go. He added that this year's was the best response rate the Trust's had ever had.

The Board discussed the two different appraisal processes on the North and South Banks and Mr Nearney advised that only one would be used going forward.

Mr Hall asked why the assurance rating was reasonable when the Trust had hit 77% for job planning. Mr Nearney advised that it would not turn green until the target had been met.

Dr Wood asked if the Responsible Officer report had been seen by the Board and Mrs Thompson assured her that it had and had been signed off by the CEO.

10.4 Escalation from the Audit Committee

Mrs Hawkard presented the report and highlighted the Annual Auditor's report which included the VFM audit. The VFM audit was not compliant due to the weaknesses around the CQC in Maternity and ED.

There had been 3 internal audit reports received relating to EPRR, E-Rostering and Learning from Serious Incidents. The Follow Up audit report was also received and an action to clear all follow up audits by the end of the year had been agreed.

The Audit Committee had also approve the Local Counter Fraud Policy and good progress was being made in relation to the Data Security and Protection Toolkit.

Mr Stacey advised that the EPRR National core standards had changed since the self-certification in October and this had resulted in a variation of what is being reported back to NHS E. All organisations had the same issue and action plans will be developed to ensure the evidence gathered is robust and correct reporting to the Board is in place.

Mrs McMahon advised that 35 audit follow up actions were linked to her and the IG Team and she had been working closely with the Auditors to reduce these actions.

11.1 Freedom to Speak Up Q2 Report

Mrs Moverley presented the Quarter 2 Freedom to Speak Up Report and highlighted that she had received 38 individual concerns of a varied nature. The only theme noted was inappropriate behaviour.

There had been an increase in Nursing and Midwifery staff concerns so Mrs Moverley and the Interim Chief Nurse had carried out drop in sessions to target specific areas.

Mrs Moverley advised that the Board would receive a letter from NHS England in January 2024 requesting assurance relating to the Freedom to Speak Up processes in place. She added that National Policy had been adopted and she was working closely with her NLAG counterpart to ensure processes were aligned.

Mr Hall asked how volunteers contacted the service and Mrs Moverley advised that they generally raised issues as and when they arose with their teams. Mr Hall added that it was good to see none of the concerns were raised anonymously and that the number of concerns were growing which showed staff new the correct routes to follow.

Mr Lofthouse added that he and Mrs Moverley met monthly to discuss the Guardian role and workload.

12.1 Use of the Trust Seal

Mrs Thompson asked the Board for retrospective approval for use of the Trust seal.

Resolved: The Board approved the use of the Trust seal.

12.2 Winter Plan

Mr Stacey presented the Winter Plan and advised that there were 3 comprehensive parts which included risks around the current flow issues, capacity and our partners to help provide appropriate care in the right setting.

Mr Stacey advised that the plan would be revised if any further winter monies were received or if any national standards changed. If any changes were made the plan would be re-submitted to the Board for approval. On-call would be provided at Gold level and there would be a substantive out of hours leadership provision.

Mr Robson advised that the plan as it stood now was approved by the Performance and Finance Committee but with a caveat that the system response to the issues was key.

Resolved: The Winter Plan presented was approved by the Board.

12.3 Emergency Preparedness, Resilience and Response Core Standards

Mr Stacey advised that the report presented to the Board in October had been correct, but since then new National Guidance had been received which had altered the standards so the Trust had further work to do to ensure compliance.

Mr Stacey added that this change was a National change and all Trusts would be in the same position.

Resolved: The Board approved the revised compliance levels stated in the report.

13 Any Other Business

There was no other business discussed.

14 Date and time of the next meeting:
Thursday 8 February 2024

BIC(24)000

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (MEETING IN PUBLIC)

Minutes of the Public Meeting held on Tuesday, 5 December 2023 at 10.15 am
In the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Linda Jackson	Vice Chair
Lee Bond	Group Chief Financial Officer
Jenny Hinchliffe	Deputy Chief Nurse (representing Ellie Monkhouse)
Shaun Stacey	Group Chief Delivery Officer
Dr Kate Wood	Group Chief Medical Officer
Fiona Osborne	Non-Executive Director
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director
Simon Parkes	Non-Executive Director

In Attendance:

Diana Barnes	Public Governor
Adrian Beddow	Associate Director of Communications
Wendy Booth	Interim Governance Advisor
Rachel Farmer	NHS Liaison
Nicola Foster	Associate Chief Nurse Midwifery (for item 10.1)
Karen Green	Public Governor
Stuart Hall	Associate Non-Executive Director
Liz Houchin	Freedom to Speak Up Guardian (for item 11.1)
Steve Leggett	System C Healthcare
Jo Loughborough	Senior Nurse Patient Experience (for item 7)
Ivan McConnell	Director of Strategic Development
Simon Nearney	Interim Director of People
Carla Ramsey	Chief of Staff
Simon Treacher	Patient Experience Lead (for item 7)
Kate Truscott	Associate Non-Executive Director
Suzanne Maclennan	Corporate Governance Officer (note taker)

Standing Items

1 Welcome and Apologies

Sean Lyons welcomed everyone to the meeting and declared it open at 10.15 am. The Board were asked to note this was the last Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) Board meeting alone with future meetings to be held 'in common' as a Group with Hull University Teaching Hospitals (HUTH) Trust.

Apologies were noted from Helen Harris and Ellie Monkhouse, represented by Wendy Booth and Jenny Hinchliffe respectively.

2 Declarations of Interest / Conflicts of Interest with any Agenda Items

Sean Lyons requested any declarations and conflicts of interest in respect of agenda items. No items were raised.

3 Minutes of the meeting held on Tuesday, 3 October 2023 – NLG(23)199

The minutes of the meeting held on the 3 October 2023 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments were made.

- Shaun Stacey referred to page 3, item 7, 4th paragraph regarding the comment made in respect of Complementary and Alternative Medicine (CAM) which required amending to read Child and Adolescent Mental Health Services (CAMHS)
- Simon Nearney referred to page 4, item 8, last two paragraphs to be re-written and submitted for inclusion.

It was agreed the minutes would be amended to reflect the proposed changes.

Post meeting note:
Simon Nearney submitted the following changes for inclusion in the October 2023 minutes
In respect of workforce Simon Nearney reported on the Covid and flu vaccination programme. It was explained the incentive scheme that staff would receive was an additional days leave if both vaccines had been received by the individual, however, this would only be rewarded if the 75% compliance was achieved across the Trust.

Simon Nearney also highlighted the work to reduce agency spend. That the Trust was going out to tender to invite three companies to bid for our contract to provide Group bank arrangements and reliable data to reduce agency and bank spend.

4 Action Log – Public – NLG(23)200

Sean Lyons referred to the action log and requested updates. The following updates were noted.

- Item 8, 3 October 2023 – Report from Group Chief Executive – Workforce. Simon Nearney advised a confirmation slip was required from the GP administering the vaccine. Alternatively, staff were to inform Occupational Health once the vaccine had been received and the Trust could port the information from the GP system to be included in the overall vaccine numbers.

- Item 9.5, 3 October 2023 – Health Tree Foundation Trustees' Committee Highlight Report – Installation costs of skylight windows. Jonathan Lofthouse confirmed a reduced retrospective skylight fit had been secured and funding agreed by the charity.

- Item 9.5, 3 October 2023 – Health Tree Foundation Trustees' Committee Highlight Report – Charity contributions. Gill Ponder confirmed the Committee Chair, Neil Gammon had written to Simon Nearney requesting evidence that other charities had not experienced a drop in donations during the cost of living crisis.

- Item 10.1, 3 October 2023 – Maternity & Neonatal Oversight Report – Conference regarding recognising 'smoke signals' from staff regarding concerns raised. Sean Lyons confirmed invites to the February 2024 session would be issued shortly. Stuart Hall advised that he was working with Sue Liburd to develop a Maternity Safety Champions report which would be submitted to the Quality & Safety Committees-in-Common and Boards-in-Common. The report would provide information on concerns raised with the Maternity Safety Champions as well as examples of best practice.

5 Matters Arising

There were no matters arising raised.

6 Board Reporting Framework – NLG(23)201

The Board Reporting Framework was noted. Wendy Booth advised work is underway to align the NLaG and HUTH Board Reporting Framework and the new version was due to be presented at the Group Board Development session on 12 December 2023. Sean Lyons thanked everyone involved and commended the spirit in which the work had been undertaken.

7 Patient Story

Sean Lyons thanked Jo Loughborough for all work completed during a long service with the Trust as this would be the last time presenting a Patient Story to the Board before retirement.

Jo Loughborough introduced Pat's story regarding a traumatic experience which had taken place on a Trust ward two years previous. The incident had severely affected Pat who had suffered shame, guilt and isolation since the incident. The staff had followed policy although had failed to ask Pat how she was. The result

was to create a module on the Incident Reporting System to ensure this question was asked.

In response to a query Jo Loughborough explained Pat was prepared to receive some counselling when the time was right.

A discussion ensued regarding the sadness felt by Board members and the frustration at the need to have processes in place once an incident had happened and queried how it could have been avoided when the process problem appeared to be basic humanity.

Dr Kate Wood explained the experience would have been harrowing for the staff at the time and was mortified to hear the doctor's response to the situation. It was highlighted these are not normal events and retrospectively creating a process to become ingrained in the workforce culture to ensure lessons were learnt was potentially the way forward initially. Dr Kate Wood thanked Jo Loughborough for the impactful story.

Jo Loughborough explained the challenging behaviour displayed by the gentleman in the story was not a rarity and that he had been managed by Navigo colleagues since the incident. It was hoped the story would raise awareness of trauma and confirmed the meeting regarding the complaint had not been required immediately and therefore sadly had become lost along the way. Jo Loughborough provided assurance this would not happen again due to a new process in complaints.

Gill Ponder suggested all locks on bathroom doors should be checked as a basic requirement although this could not have prevented the comment made during the incident.

Jenny Hinchliffe confirmed the Ulysses reporting would assist with the frequency of the trauma and other reporting in place included daily matron oversight and daily assurance of one-to-one supportive care for challenging patients from the Vulnerabilities Team.

Sue Liburd highlighted a piece of the work the Care Quality Commission (CQC) would be implementing in 2024 regarding care and harm beyond procedure.

Jonathan Lofthouse concluded the discussion and agreed a cultural transformation was required.

8 Report from the Group Chief Executive – NLG(23)202

Jonathan Lofthouse referred to the Group Chief Executive's Report and highlighted a few points. Assurance was provided in relation to substantive recruitment and Non-Executive Director (NED) colleagues were thanked for the support during the interview process.

Shaun Stacey confirmed 86 formal questions had been received and responded to since the beginning of the staff consultation for the operation Care Groups. In addition, one-to-one sessions had commenced along with weekly drop-in sessions

for staff directly affected and fortnightly for the remainder of the organisation. It was reported the response had been positive.

Dr Kate Wood explained the CQC had conducted a planned visit to the Maternity Services at Goole District Hospital (GDH) where there had been seven births in the last calendar year. It was reported the verbal feedback had been predominately positive along with the recently received feedback letter highlighting the key positives. There was further risk assessment work to be completed and the formal report was expected in the new year.

Lee Bond provided an overview of the national re-set exercise from a financial perspective which highlighted a little more money and a reduced elective target. Lee Bond had felt confident the financial plan could be delivered. The key areas in relation to the activity perspective were outlined as a revised trajectory on the Emergency Department (ED), ambulance handovers and cancer past the diagnosis target. It was confirmed the revisions had been submitted to the Integrated Care Board (ICB) and a draft letter of acceptance had been received.

Shaun Stacey highlighted that urgent care, time in the ED and ambulance handovers were three key points to focus on. It was confirmed ambulance handover target times had been reduced to 45 minutes to ensure vehicles were released for high priority patients. This had proved to be a vulnerability target for the Trust along with the 12 hours target within ED. It was reported the Trust was in a positive position although another risk was for cancer patients over 62 days in their journey without a diagnosis and focus work was underway to create a transformative change.

Ivan McConnell provided an update on the Humber Acute Services (HAS) midpoint review conducted by NHS England (NHSE) Gateway Assurance team who had advised the requirements of a consultation had been met. It was confirmed further HAS events had been planned within Scunthorpe and other sessions included children and families with long term conditions within deprived areas which had been well received. Planned session also included veterans and a session to be held in Gainsborough. Ivan McConnell reported that qualitative feedback had been good with 2500 responses received to date. Non statutory transport was highlighted as the main issue and good working progress with Stagecoach was ongoing.

With regards to the Devolution Scheme it was reported that North, North East and Lincolnshire Councils had been identified as a trailblazer resulting in the appointment of a mayor. Ivan McConnell reported the consultation was live and would generate £720 million into the system split into £24 million per year with a 50/50 split on revenue and capital. The key areas would be tourism, skills and workforce and regeneration. It was reported a motorway or road extension cost £1 million per mile. It was noted as the Trust was in interested party a supportive response was required from a health perspective.

In relation to queries Ivan McConnell confirmed a response was required from both NLaG and HUTH and subsequently a collective ICB response. The draft response would be shared with Board members along with the time and date of the Hull briefing session. Ivan McConnell added that discussions with United Lincolnshire Hospitals Trust (ULHT) were planned.

Ivan McConnell confirmed the HAS Consultation finished in January 2024 to agree in principle along with business representation for example Associated British Ports (ABP). Secondary legislation was required and due in Parliament in March 2024 which should allow for implementation pre general election with the structure to be determined.

Jonathan Lofthouse invited Simon Nearney to provide an update on the commendable staff survey completion rates.

In relation to the staff survey Simon Nearney reported the completion rate target had been set at 60% with NLaG achieving 47.4% against HUTH's 49%. It was confirmed this was the best completion rate for the Trust in over 10 years which had resulted in 4000 responses. The data was embargoed until February 2024 following which a plan would be shared with the Board.

Simon Nearney provided an update of the Covid-19 and flu vaccination rates being 17% and 25% respectively which was reported as lower than other trusts. There had been a challenging start to the vaccination programme due to the resources required and suitable locations which was overcome. It was reported the feedback received from Occupational Health was staff do not want the vaccinations and were disapproving of the incentivisation which had been reported to the local newspaper.

Sean Lyons queried what had been done previously which had generated a greater uptake of vaccinations. In response Simon Nearney felt the slow start due to lack of resources had not helped and a reluctance in the workforce to receive the vaccination was proving difficult despite the link to protect their families and remain safe at work.

Simon Parkes highlighted a disconnect between junior staff and strong leadership which had been communicated through the 15 Step reviews. It was noted that staff felt permanent frustration and instead must feel valued and have a better sense of purpose. Simon Nearney agreed strong leadership was vital and hoped the new structure would help address this issue along with new Group values.

A discussion ensued regarding why the vaccinations rates were low and the key points highlighted were leadership, educational, personal choice and internal communications. Linda Jackson reminded the Board that pharmacies were also administering the vaccinations and felt the statistics were not a true reflection.

Board members were asked to note the video mentioned in 7.2 of the report was available via the Hub.

It was confirmed each Executive had an Equality, Diversity and Inclusion (EDI) support and objective set.

Jonathan Lofthouse concluded by thanking Charlie Grinhaff and the Communications team for organising the recent 'Our Stars' awards night which had been a huge success and thoroughly enjoyable for all who attended.

Sean Lyons thanked Jonathan Lofthouse for the update and highlighted that national recognition would bode well for the future of the Group to ensure staff were kept motivated.

9 Board Committees Highlight Reports

9.1 Escalation from the Quality & Safety Committee – NLG(23)203

Fiona Osborne provided an overview of the report which was taken as read.

Fiona Osborne asked the Board to note the Serious Incident Annual Report had been approved by the Quality & Safety Committee (Q&SC) on behalf of the Board following clarification of the process.

Linda Jackson queried whether the Governors had been involved in the consultation of the 2024/25 Quality Priorities. Following a discussion it was agreed the Quality Priorities 2024/25 would be added to the agenda for the Council of Governors (CoG) Business meeting in January 2024.

In response to a query Fiona Osborne assured the Board that Adam Creegan was undertaking a rapid review of data resources in the role of Interim Group Director of Performance.

Stuart Hall questioned whether the Trust was investing in point of contact Covid-19 testing. Jenny Hinchliffe advised that patients were not routinely tested unless they were symptomatic which was in line with national guidance. Shaun Stacey confirmed lateral flow tests were available in all departments for use by staff and patients showing symptoms of cold and flu which could be supported through Path Links with a rapid test for either Covid-19 or flu. Path Links continued to provide this facility for all Lincolnshire services. Shaun Stacey informed the Board funding was no longer received for Covid-19 or flu testing and was charged in the usual way.

Jonathan Lofthouse suggested Adam Creegan attend a Board Development session to present the new accountability framework and arrangements for improving data quality, comparisons and measures. Ivan McConnell confirmed initial work regarding data, data structures and governance had been completed and outlined business intelligence (BI) team and BI support as a vulnerability. It was suggested the multiple options were delivered to the Joint Board Development session and some skills sets had been identified a sparse.

Shaun Stacey highlighted the importance of the Mental Health Act (MHA) within the report and confirmed the Trust were compliant. Fiona Osborne reiterated the exceptional work by the team in delivering work relating to the MHA.

Fiona Osborne reported the Quality & Safety Committee were assured by the mitigations in place with regards to the 5 standards at risk within the deep dive of the Clinical Negligence Scheme for Trusts (CNST). In response to a query, it was confirmed the data for one of the standards was collected manually and the committee were assured it would be met in the timescale. Dr Kate Wood outlined NHS Resolution were comfortable with the work completed following a table top exercise which had examined data to ensure compliance. The importance of discussions at committees to make the time and provide the evidence was highlighted.

Sean Lyons requested further information in relation to lack of equipment mentioned in the Infection Prevention Control Annual Report. Jenny Hinchliffe confirmed there was no enhanced cleaning system used in the Trust. Jonathan Lofthouse agreed to discuss this further at the Group Executive Team Meeting.

Action: Jonathan Lofthouse

9.2 Escalation from the Finance & Performance Committee – NLG(23)204

The Finance and Performance report was taken as read and Gill Ponder highlighted a few key points.

It was confirmed there were plans in place to recover the current slippage on the capital plan.

In response to a query regarding funding for the backlog maintenance, Gill Ponder confirmed work was reviewed by the Capital Investment Board and the Executive team to determine the highest priority work as there was not enough funding to cover everything. Subject to other priorities roof replacement would potentially begin in 2024. Lee Bond had felt confident the funding would be granted and planning for the work could commence.

Linda Jackson queried whether the £123k penalty could be recovered. Lee Bond confirmed this rate to recovery had not been taken, it was an aggregate score and felt hopeful there would be an excess by the end of the year.

A discussion took place regarding the new National Cleaning standards and how these impacted the backlog maintenance issues. It was confirmed that structural changes were required to prevent spores and infections within the infrastructure of the Trust. Lee Bond highlighted that flooring and air conditioning across the organisations were also factors. Shaun Stacey reported that Q&SC were well sighted on a reoccurring problem within the maternity unit at DPoW and sadly there was no capital to clear the problem.

Stuart Hall raised a query in relation to 65 week waiters and what focus was placed on those patients who were in the middle of the two extremities being those in danger of contravening the standard and those with high levels of co-morbidity. Jonathan Lofthouse highlighted a huge political dynamic and national scrutiny as a result of multiple waves of Covid-19 impacting activity levels. Assurance was provided through 12 weekly cycles of validation for those patients waiting 16-64 weeks.

Sean Lyons questioned the impact of the multi agency MADE event to help discharge patients with stays over 21+ days referenced in the Integrated Performance Report (IPR). Shaun Stacey confirmed the MADE events take place every four month and which did have an impact and figures were not available during the meeting although could be provided. It was confirmed the Trust was in the upper quartile of the country for 7, 14 & 21 day stays and maintained this position. Shaun Stacey provided assurance the Board could be confident in the 21 day length of stay although a small number of patients had complex care needs. It was reported the MADE events were to remind the workforce of the best practice

ways of working. Jonathan Lofthouse requested a broadening of perspective in relation to MADE events within the planning for next year and would have expected one to be held week commencing 25th December.

Action: Shaun Stacey / Jonathan Lofthouse

9.3 Escalation from the Workforce Committee - NLG(23)205

Sean Lyons along with Board members congratulated Sue Liburd as the incoming High Sheriff of Lincolnshire in 2025.

In response to a query Sue Liburd provided assurance the recent trip to India had yielded good results for the full compliment of staff and was not restricted to those positions mentioned in the report. A discussion ensued regarding the level of vacancies and how the percentages translated into actual vacancy numbers. Simon Nearney confirmed there were 60 vacancies in terms of medics. It was reported the vacancies for registered nurses was under 50 following a cohort of nurses who had arrived during November 2023 and a further cohort due to arrive in January 2024. The focus was to recruit specialty doctors within anaesthetics and radiology with a two year Trust Certificate of Eligibility for Specialist Registration (CESR) programme.

Lee Bond queried the scale of improvement in recruitment with regards to the £36 million annual spend on bank and agency. In response Simon Nearney confirmed the consultant vacancy remained high and hoped the power of the Group could close the vacancy gaps although was unable to confirm the pace of improvement.

Simon Parkes remarked on the Government's recent announcement to cut net migration and restrict student dependents which had affected the January intake at Lincoln University which was down by 46%. Simon Nearney expected the impact to be similar to that seen within the education sector. Sean Lyons highlighted a response was needed in relation to deadlines, increased visa costs and right to remain.

Simon Parkes highlighted the review of the Board Assurance Framework (BAF) within the Audit, Risk and Governance (ARG) Committee and suggested a refocus on the Group BAF.

A further discussion took place regarding recruitment and the points discussed were consideration for new ways of working including shared joint appointments, new waves of staff created disruption for current staff and support for nurses arriving to assist with integration into the community and culture.

Linda Jackson requested that consultant recruitment and the CESR programme remained as an agenda item within Workforce Committee to ensure the Board were aware of any updates. It was reported the new Group Strategy was planned for July 2024 and the Group BAF would follow which meant the current BAF would continue for a few months.

Sean Lyons requested an update around retention for the next Board meeting.

Action: Simon Nearney

9.4 Escalation from the Audit, Risk & Governance Committee - NLG(23)206

Simon Parkes provided an overview of the report which was taken as read.

Sue Liburd questioned whether there was any data in relation to the demographic of staff working elsewhere whilst signed off sick and what the ramifications were if found guilty of this. Simon Parkes assured the Board the Counter Fraud Team investigate each case and take appropriate action although this had rarely led to dismissal. Specific data for the demographic was not available during the meeting. Jonathan Lofthouse was interested to know further details surrounding individual cases as it was classed as a dismissible fraudulent event. It was agreed this would be discussed further outside of the meeting between Simon Nearney and Jonathan Lofthouse.

Fiona Osborne queried whether there was a duty of care to inform the other employer that the member of staff was signed off sick from the Trust. Simon Nearney agreed although stated the Trust must discharge their responsibilities first and assess each case to determine whether contact with other organisations should be made.

Simon Parkes confirmed the financial statements had been finalised for sign off by the Group Chair and Group Chief Executive.

In response to a query Lee Bond confirmed there had been 3 or 4 losses of personal belongings every quarter which was affected by the number of patient moves and dentures and hearing aids would rarely be placed in a locker. Jenny Hinchliffe highlighted the new policy should improve the problem along with the lockers. The Board agreed that personalised care for each patient was required.

Action: Simon Nearney / Jonathan Lofthouse

9.5 Escalation from the Group Development Committee Committee-In-Common – NLG(23)207

Linda Jackson provided a summary of the report which was taken as read.

Linda Jackson highlighted the proposed transfer of responsibilities and planned reallocation from the Group Development Committee in Common (GDCiC). Sean Lyons sought approval from the Board that the GDCiC could be disbanded based on the proposal. It was agreed and approved by the Board.

9.6 Escalation from the Health Tree Foundation Trustees' Committee - NLG(23)208

Gill Ponder provided a brief overview of the report which was taken as read.

Jonathan Lofthouse asked the Board to note there was a national standard for signage and wayfinding using a specific format and therefore could not be tailored. Gill Ponder suggested there had been discussions around creating an app to be used on smartphones.

Sean Lyons reported feedback from Governors highlighting the difficulty in finding their way around SGH.

10 minute break at 12:40

Rachel Farmer left at 12:43

The meeting resumed at 12:50

10 Quality & Safety

10.1 Maternity & Neonatal Oversight Report – NLG(23)209

The Maternity and Neonatal Oversight Report was taken as read and Nicola Foster reported there were 27.54 midwife vacancies which had previously been reported at 36. Assurance was provided in relation to submission for compliance of the Clinical Negligence Scheme for Trusts (CNST). It was reported the maternity triage service had received over 10k calls during the last year which ensured patients were seen appropriately.

Kate Truscott confirmed the Maternity Safety Champions actions were taking place as they had not been annotated as actioned previously.

In response to a query regarding the maternity triage service Nicola Foster confirmed the criteria was electronic and all women were provided the same advice. Calls received were personal queries rather than generic questions in relation to maternity journeys.

Jonathan Lofthouse requested an update on the estates changes which had been costed following a recent walk around. Nicola Foster reported the project had been completed and was very grateful.

Linda Jackson requested the statistics within the report were more up to date in the next iteration. Nicola Foster outlined the pastoral support in place for recruitment and retention which was having a positive effect.

Stuart Hall noted the number of triage calls as a positive outcome as it could be preventing unnecessary journeys into hospitals particularly in the latter stages of pregnancy.

In reference to the Maternity Safety Support Programme (MSSP) Stuart Hall outlined the two key exit criteria as a formal paper for the Oversight Committee for approval and maternity services to have improved by one Care Quality Commission (CQC) rating. Nicola Foster confirmed the report was approved by the Board in August 2023 and that it was the national team who had agreed the

sign off of the increased effective rating in last CQC report and not safe and well led.

Gill Ponder requested an explanation why the Ward Assurance Surveys had not been completed as referenced on page 6 of the report. It was confirmed that Jasmine Ward had been a building site at the time and in addition the Matron was on sick leave. Discussions had taken place to ensure the data was submitted. Jenny Hinchliffe outlined the compliance data had been noted within the monthly nursing metrics and would be monitored.

Nicola Foster confirmed work with the Complaints Department was also ongoing to improve the complaints closure statistics which had previously been 100% and dropped to 33% during September 2023.

Fiona Osborne assured the Board the number of smoking patients attending through Maternity Services had reduced although smoking cessation was outlined as a contributory factor in not achieving some targets.

Sean Lyons requested the Maternity Safety Champions action log was reviewed and conclusions finalised for the next update as it appeared some actions were simple issues. Nicola Foster confirmed discussion with Shaun Stacey had taken place.

Action: Jenny Hinchliffe

11 Workforce

11.1 Freedom to Speak up Guardian (FTSU) Report – Quarter Two – NLG(23)210

Liz Houchin delivered a brief overview of the key points within the report and confirmed a Group FTSU Strategy would be written.

Kate Truscott queried whether there had been a decrease in the number of grievances submitted since the introduction of the FTSU Guardian role. Simon Nearney confirmed a huge reduction in case work within the last eighteen months following the implementation of the 'Just Culture' although was unable to translate this to a reduction in grievances.

Stuart Hall welcomed reflections from Liz Houchin in relation to the Letby case. In response it was reported the FTSU role was not in place at the time of the Letby case and the Trust and respective board in question were protective of their reputation. Liz Houchin confirmed that would not be the case at NLaG as there had been no hesitation with involving outside organisations where necessary.

12 Finance & Performance

12.1 Winter Plan – NLG(23)211

Shaun Stacey outlined the extensive review the Winter Plan had been subject to which had been built with the Trust's partners to ensure a level of safety was maintained during the winter period. No questions or comments were received.

13 Governance & Assurance

13.1 Board Assurance Framework (BAF) - NLG(23)212

Wendy Booth asked Board members to note the BAF was for information at this stage, at an appropriate moment the BAF would be aligned with HUTH and consequently strengthen how the framework was used.

Simon Parkes welcomed the update and highlighted the BAF must drive the agenda and could be very helpful in navigating the governance framework.

14 Items for Approval

14.1 Emergency Preparedness.

Emergency Preparedness, Resilience & Response (EPRR) Annual Report – NLG(23)213 and Northern Lincolnshire & Goole NHS Foundation (NLaG) Trust Compliance with the NHS England Core Standards for EPRR 2023/24 - NLG(23)214

Shaun Stacey confirmed the standards and compliance had changed and an action plan was in place.

The Board approved both the EPRR Annual Report and Trust Compliance with NHS England Core Standards for EPRR.

15 Other Business

There were no items of any other business raised at the meeting.

Sean Lyons informed the Board that Fiona Osborne would be resigning from the Non-Executive Director role and expressed sincere thanks for all the work completed.

16 Date and time of next meeting:

Date: Thursday, 8 February 2024
Time: 9.00 am
Venue: Boardroom, Hull Royal Infirmary

17 Supporting Documents

The following items were shared at the December 2023 meeting:

- Q&SC Minutes – August & September 2023
- Nursing & Midwifery Assurance Report
- Faculty of Medical Leadership & Management – Affiliated Organisation Report
- Infection Prevention Control Annual Report
- Safeguarding & Vulnerabilities Annual Report

- Annual Medicines Optimisation Report 2022-2023 Annual Report
- Annual Patient Reported Outcome Measures (PROMs) Report
- Serious Incident (SI) Annual Report 2022-2023
- Workforce Committee Minutes – September 2023
- Guardian of Safe Working Hours Report – Quarter Two
- F&PC Minutes – September & October 2023
- ARG Committee Minutes – July 2023
- HTFTC – November 2023
- Health Tree Foundation's Annual Report 2022-2023
- Trust Board & Board Committee Meetings Timetable
- Communications Report
- Integrated Performance Report (IPR)
- Documents Signed Under Seal

Cumulative Record of Board Director's Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	5	5	Shauna McMahon	4	4
Jonathan Lofthouse	2	2	Ellie Monkhouse	5	4
Dr Peter Reading	1	0	Simon Nearney	5	4
Lee Bond	5	4	Fiona Osborne	5	5
Stuart Hall	5	3	Simon Parkes	5	4
Helen Harris	5	4	Gillian Ponder	5	5
Linda Jackson	5	4	Shaun Stacey	5	5
Jug Johal	4	4	Kate Truscott	5	4
Sue Liburd	5	5	Dr Kate Wood	5	5
Ivan McConnell	5	5			

NHS
Hull University Teaching Hospitals NHS Trust

NHS
Northern Lincolnshire and Goole NHS Foundation Trust

Joint Board Development Meeting
held on Tuesday, 12 December 2023 in the Board Room, Hull Royal Infirmary

Present:	Mr S Lyons	Group Chairman
	Mr S Hall	Vice Chair, HUTH
	Mr M Robson	Non-Executive Director/SID, HUTH
	Mrs L Jackson	Vice Chair NLaG
	Mrs G Ponder	Non-Executive Director, NLaG
	Mr J Lofthouse	Group Chief Executive Officer
	Dr K Wood	Group Chief Medical Officer
	Mr L Bond	Group Chief Finance Officer
	Mr S Stacey	Group Chief Delivery Officer
	Mr S Nearney	Group Chief People Officer
	Mr I McConnell	Group Chief of Strategy and Partnerships
	Mrs S Liburd	Non-Executive Director, NLaG
	Mr S Parkes	Non-Executive Director, NLaG
	Mr T Curry	Non-Executive Director, HUTH
In Attendance:	Mrs W Booth	Interim Governance Advisor
	Mr A Creegan	Interim Director of Performance
	Mrs R Thompson	Head of Corporate Affairs HUTH (Minutes)

1 Apologies for Absence

Professor U Macleod, Non-Executive Director HUTH, Dr A Pathak, Associate Non-Executive Director, HUTH, Mrs J Hawkard, Non-Executive Director HUTH, Mrs J Ledger, Interim Chief Nurse, HUTH, Mrs K Trustcott, Associate Non-Executive Director, NLaG, Mrs F Osbourne, Non-Executive Director

Boards-in-Common: Joint Business Items

2 Group Model – Latest Developments

2.1 Group Executive Recruitment Update

Mr Lofthouse provided an update on the group executive recruitment exercise, as follows:

The substantive post of Group Director of Quality Governance has not yet been appointed to, but Mr Chidlow is providing cover and staying with the Trust until April 2024 and will be covering the Group rather than just HUTH.

Mr Lofthouse also advised that the Group Director of Assurance had been appointed and Mr Sharif will be joining the Trust in early 2024, following his 12 weeks' notice period.

The North Triumvirate team had been appointed to with Dr Hibbert, Mr Rogers and Mrs Campbell as the medical, managing and nursing directors. The South Triumvirate team remains vacant, and a head-hunting exercise will commence shortly.

The Chief Information Officer stakeholder session had taken place and there are four applicants for interview. There are three candidates for the Transformation Director post and interviews will take place on 18th December 2023.

The interviews for the Group Chief Nurse will be held at the end of January 2024.

2.2 Care Group Structure Update

Mr Stacey presented Version 19 of the of the Care Group structure and added that, as part of the consultation, he had responded to eighty-five questions and had undertaken a number of group sessions.

Mr Bond highlighted the financial implications of the structure changes and advised that that the costs would be reviewed through the executive cabinet meetings.

Mr Nearney advised that the trusts are following the Organisational Change Process Policy and that NHS England have asked for information regarding the changes and how they are being managed.

2.3 Group Branding Update

Mr Lofthouse advised that a group name and branding was being developed and that an engagement exercise would be undertaken involving staff and governors being asked to vote on the options. He added that this exercise will follow the Values re-set in late January 2024.

2.4 Aligned governance and decision-making arrangements for the Group

2.4.1 Approval of Boards and Committees-in-Common Principles Framework

Mrs Booth presented the Boards and Committees-in-Common Principles Framework which outlines how the Boards and Committees-in-Common will work in practice.

Resolved:

The HUTH Trust Board approved the Boards and Committees-in-Common Principles Framework

The NLaG Trust Board approved the Boards and Committees-in-Common Principles Framework

2.4.2 Approval of Aligned Board Reporting Framework

Mrs Booth presented the aligned Board Reporting Framework which she advised incorporates both NLaG and HUTH requirements.

Mr Parks stated that the Board Assurance Framework and the Corporate Risk Register was not yet driving the boards' agenda. Mrs Booth agreed

and advised that that there was still a piece of work to complete to align the two Board Assurance Frameworks once strategic objectives for the group have been agreed. Once that work is complete the aligned Board Assurance Framework for the group would inform the boards' agenda.

Resolved:

The HUTH Trust Board approved the aligned Board Reporting Framework

The NLaG Trust Board approved the aligned Board Reporting Framework

2.4.3 Approval of final proposals for alignment of Board Committees

Mrs Booth presented the paper which set out the final proposals for the alignment of the board committees to work 'in-common'. She added that the paper had been discussed in various forums but now required board approval.

Resolved:

The HUTH Trust Board approved the final proposals for the alignment of the board committees

The NLAG Trust Board approved the final proposals for the alignment of the board committees

2.4.4 Approval of Board Committee Terms of Reference and Work Plans:

- **Quality and Safety Committees-in-Common**
- **Performance, Estates and Finance Committees-in-Common**
- **Capital and Major Projects Committees-in-Common**
- **Workforce, Education and Culture Committees-in-Common**
- **Audit, Risk and Governance Committees-in-Common**
- **Remuneration Committees-in-Common**

Mrs Booth presented the committees-in-common terms of reference and work plans for approval. She advised that the terms of reference and work plans for the committees would be reviewed after the initial three-month transition period, but the version presented would enable the committees to commence. She further advised that each set of terms of reference provides a schedule of the decisions delegated to each committee and those decision reserved to the trust boards. This was based on each trust's existing scheme of delegation. The schedules would also therefore be reviewed against the new group scheme of delegation once developed and approved. Finally, Mrs Booth stated that the next phase of work would include a review of reporting from the sub-group below the board committees.

Mrs Ponder asked about oversight of procurement. Following discussion it was agreed that performance against procurement KPIs e.g. waiver of standing orders would be discussed in the Audit, Risk & Governance

Committees-in-Common, whereas procurement strategy, improvement plan, processes and controls would be discussed in the Performance, Estates & Finance Committees-in-Common.

Mr Lofthouse advised that he and the Group Chair could attend any meeting at any time if they chose to do so. This had been written into the terms of reference.

Mr Lofthouse advised under this item that Mr Chidlow would be carrying out the initial scoping of the quality governance review and then it would be tested by an external organisation.

Resolved:

The HUTH Trust Board approved the committees-in-common terms of reference and workplans with the caveat that they would be subject to refinement after the initial three-month transition period

The NLaG Trust Board approved the committees-in-common terms of reference and workplans with the caveat that they would be subject to refinement after the initial three-month transition period

2.4.5 Approval of Board Committees Highlight/Escalation Report

Mrs Booth presented the new board committees highlight / escalation report which included confirm and challenge of the BAF and some hopefully helpful prompts for the committee chairs completing the reports.

Resolved:

The HUTH Trust Board approved the new board committees highlight / escalation report

The NLaG Trust Board approved the new board committees highlight / escalation report

Joint Board Development Session

2.5 HUTH Emergency Department Improvement Plan

Mr Stacey presented the ED improvement plan, which he advised outlines the areas for improvement, proposed actions and the trajectory to be achieved by April 2024.

Action: Mr Stacey agreed to circulate the presentation and the information behind the figures to all Board members

2.6 Accountability Framework – Emerging Work

Mr Creegan provided a comprehensive presentation of the new Performance & Accountability Reporting Framework for the group, which he advised sets out the Care Groups and trust / site teams will be held to account for the delivery of performance and improvements and the plans for aligning the Integrated Performance Report and KPIs.

Mr Lofthouse added that the processes which Mr Creegan had outlined, and the new performance reporting tools and regime would be updated and then built into the sequencing of the corporate meeting structure.

2.7 Patient Engagement/Service User Voice

Mr Lyons advised that the forums and arrangements for ensuring the patient and public voice is heard would need to be reviewed and strengthened as part of the development of the operating model and governance arrangements for the new group. He added that he anticipated this topic being an item for discussion on the boards' agenda in future.

2.8 Group Executive Development Programme Update

Mr Lofthouse advised that an external facilitator would be facilitating the Executive Development Programme which would consist of ½ day per month. He added that the programme would commence with reviewing behaviours and setting expectations and then move on to setting clear objectives and would, in turn, form part of the wider Board Development Programme.

2.9 Board Development – Next Steps

Mr Lyons thanked the Board for their contribution throughout the year and their support with regards to the group development work. He added that the programme was only at the start and looked forward to the New Year.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BOARDS IN COMMON MEETING

Minutes of the meeting held on Tuesday, 23 January 2024 at 1.00 pm by MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Stuart Hall	Vice Chair (HUTH) (Chair)
Jonathan Lofthouse	Group Chief Executive
Lee Bond	Group Chief Financial Officer
Jo Ledger	Interim Chief Nurse (HUTH)
Shaun Stacey	Group Chief Delivery Officer
Tony Curry	Non-Executive Director (HUTH)
Linda Jackson	Vice Chair (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Una Macleod	Non-Executive Director (HUTH)
Simon Parkes	Non-Executive Director (NLaG)
Gill Ponder	Non-Executive Director (NLaG)
Mike Robson	Non-Executive Director (HUTH)

In Attendance:

Adrian Beddow	Associate Director of Communications (NLaG)
Julia Chambers	Lead Midwife (HUTH)
Robert Chidlow	Interim Director of Governance
Nicola Foster	Associate Chief Nurse Midwifery (NLaG)
Caroline Hibbert	North Site Medical Director (HUTH)
Jenny Hinchliffe	Deputy Chief Nurse (NLaG)
Ivan McConnell	Group Director of Strategy & Partnerships Officer
Simon Nearney	Group Chief People Officer
Ashok Pathak	Associate Non-Executive Director (HUTH)
Rebecca Thompson	Head of Corporate Affairs (HUTH)
Sarah Meggitt	Personal Assistant to the 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

Stuart Hall welcomed those present to the meeting and declared it open at 1.00 pm. The following apologies for absence were noted:

Sean Lyons	Group Trust Chair

Ivan McConnell	Group Chief Strategy & Partnerships
Dr Kate Wood	Group Chief Medical Officer
Kate Truscott	Non-Executive Director (NLaG)

1.2 **Declarations of Interest**

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

2. ITEMS FOR DISCUSSION – QUALITY & SAFETY: CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST): MATERNITY INCENTIVE SCHEME – YEAR 5 SAFETY ACTIONS

2.1 **Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)001**

Stuart Hall referred to the highlight report and noted key points from the meeting. NLaG had declared compliance for ten out of the ten safety action for submission. HUTH had declared compliance for five out of the ten safety actions for submission. It was confirmed that details / evidence in support of both submissions was provided within the papers shared at the meeting. It had been agreed both submissions should be escalated for approval by the Trust Boards in Common and then to be signed prior to submission by the Group Chief Executive.

In respect of the HUTH submission it was advised action plans were in place to ensure non-compliance was addressed and monitored into year six. BIC(External consultancy and Integrated Care Board (ICB) peer review support was in place. It was noted the Maternity Safety Support Programme (MSSP) oversight would also provide further assurance and scrutiny.

In respect of the NLaG submission it was advised the Local Maternity & Neonatal System (LMNS) would undertake a review of the supporting evidence through a confirm and challenge meeting later that week.

Sue Liburd highlighted the reporting period for CNST was December to December hence why an Extra-Ordinary Quality & Safety Committees-in-Common meeting and Trust Boards in Common meeting had taken place.

The recommendations from the Quality & Safety Committees-in-Common to endorse the submission was noted.

2.1.1 **HUTH CNST Submission – BIC(24)002**

Julia Chambers advised Trusts that demonstrated standards being achieved would recover the element of Trust contribution relating to the CNST maternity incentive fund along with a share of any unallocated funds. Trusts that did not meet the threshold would not recover the contribution, however, may be eligible for a small discretionary payment to help progress those actions not achieved.

Julia Chambers referred to the presentation shared and highlighted the compliance met within the standards at HUTH as detailed below.

SA1 (PMRT)	Compliant	SA4 (Medical Staffing)	Non-Compliant
SA2 (MSDS)	Complaint	SA6 (SBLV3)	Non-Compliant
SA3 (ATAIN/TC)	Compliant	SA8 (Training)	Non-Compliant
SA5 (Midwifery Staffing)	Compliant	SA9 (Safety Champions)	Non-Compliant
SA7 (Listening to Women)	Compliant	SA10 (HSIB/ENS/Legal)	Non-Compliant

As only five out of the ten standards had been met HUTH would be non-compliant overall. Julia Chambers went through the presentation and explained the actions in place against those standards where compliance had not been achieved. Action plans were in place to provide assurance for non-compliance as detailed within the presentation. It was reported those actions would be monitored through the relevant groups with assurance being provided to the Quality & Safety Committees-in-Common and, in turn, to the board.

Mike Robson referred to the non-compliant action that detailed non-reporting to the board and queried what improvements had been made to provide assurance in the future. Julia Chambers advised although papers had been shared with the board previously no detailed documentation was available in respect of minutes regarding discussions. The technical guidance in respect of the standards were quite specific on what was required, plans were now in place to ensure the required standard was met going forward.

Jane Hawkard queried how the team would ensure the standards were achieved the following year and whether these were currently on track. A second query raised by Jane Hawkard related to the loss of £600,000 with HUTH not meeting the standards and queried how that would be managed. Julia Chambers advised year six had not been published in terms of the standards, however, the team would continue to work towards the year five standards to ensure those were met. Those processes were now embedded and could be changed as required for year six once it was published.

Robert Chidlow referred to the training standard not being met and advised assurance had been provided to the Quality & Safety Committees-in-Common that protected time had been built into rosters to ensure training compliance. In respect of the capacity issue the midwifery and consultant establishment had also been increased and performance had reported above target in January. Any additional actions and assurances required for the four remaining actions would be implemented quickly to provide assurance at the Quality & Safety Committees-in-Common and the Boards in Common.

Lee Bond confirmed the funds related to the next financial year so would need to be accommodated within future financial plans. Lee Bond felt Robert Chidlow's explanation had provided assurance that the required actions would be in place. There was concern raised as it appeared there had been some digress from the previous submission and members of the board expressed disappointed that the failure to achieve the standards were due to technical issues.

Mike Robson referred to the Key Performance Indicators (KPIs) noted by Robert Chidlow and queried whether they should be included within the Integrated Performance Report (IPR) shared at relevant Committees-in-Common meetings. Shaun Stacey advised CNST would be one of the objectives for the new Care Groups going forward including monitoring through the relevant Performance Review meetings.

Sue Liburd highlighted that although HUTH had not achieved overall compliance it would be allowed to seek a discretionary amount to support future development. Lee Bond advised those monies would only be supported for specific spending including maternity posts and would not be a contribution to the Trust.

Stuart Hall recognised robust processes would need to be implemented to ensure evidence was in place for actions to be completed and sought assurance of this. Una Macleod queried whether there were any general learning points from this in respect of records being kept. Robert Chidlow confirmed detail of required training compliance had been received in respect of the Section 31 and this would be monitored through the Quality & Safety Committees-in-Common going forward. There would be strengthened reporting within both Trusts to the Committees-in-Common and, in turn, to the Boards in Common. Shaun Stacey felt this would need to be monitored closely through internal routes to ensure responsibilities are in place. The training element was more complex as it relied upon staff disciplines to ensure attendance at mandatory training.

The HUTH Trust Board supported the recommendations and approved the CNST Year 5 Safety Action submission to be signed by the Group Chief Executive.

2.1.2 **NLaG CNST Submission – BIC(24)003**

Nicola Foster referred to the presentation shared and highlighted the compliance met within the standards at NLaG as detailed below.

SA1 (PMRT)	Compliant	SA6 (SBLV3)	Compliant
SA2 (MSDS)	Complaint	SA7 (Listening to Women)	Compliant
SA3 (ATAIN/TC)	Compliant	SA8 (Training)	Compliant
SA4 (Medical Staffing)	Compliant	SA9 (Safety Champions)	Compliant
SA5 (Midwifery Staffing)	Compliant	SA10 (HSIB/ENS/Legal)	Compliant

As ten out of the ten standards had been met NLaG are fully compliant. Nicola Foster went through the presentation and highlighted evidence provided for each standard. Actions plans had been compiled to support any deficiencies and would be monitored through the Quality & Safety Committees-in-Common. Internal assurance through relevant groups and committees would continue including oversight and scrutiny.

Gill Ponder was pleased to see NLaG had met all ten standards, however, felt that the standard at 71% compliant had been border line and queried what was in place to ensure this continued to be achieved. Nicola Foster advised NLaG had been the only Trust within the LMNS to achieve the standard. The Trust would continue to work closely with required providers to ensure continued and improved

compliance. The team were also assured this would be higher going forward. It was noted the benchmark for this had been met.

The NLaG Trust Board supported the recommendations and approved the CNST Year 5 Safety Action submission to be signed by the Group Chief Executive.

3. ANY OTHER URGENT BUSINESS

3.1 There were no items of any other business raised.

4. QUESTIONS FROM THE PUBLIC AND GOVERNORS

4.1 There were no questions raised.

5. MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON

Stuart Hall noted measures would need to be in place to ensure further declarations were met. There would be an expectation that relevant Committees-in-Common would seek assurance on relevant matters as they occurred.

6. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 8 February 2024 at 9.00 am.

Stuart Hall closed the meeting at 13.45 hours.

Cumulative Record of Board Director's Attendance 2024

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	1	0	Ivan McConnell	1	0
Jonathan Lofthouse	1	1	Simon Nearney	1	1
Lee Bond	1	1	Ashok Pathak	1	1
Tony Curry	1	1	Simon Parkes	1	1
Stuart Hall	1	1	Gill Ponder	1	1
Linda Jackson	1	1	Mike Robson	1	1
Jane Hawkard	1	1	Shaun Stacey	1	1
Jo Ledger	1	1	Kate Truscott	1	0
Sue Liburd	1	1	Kate Wood	1	0
Una Macleod	1	1			

BIC(24)008

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BOARDS-IN-COMMON ACTION TRACKER

2024

ACTION TRACKER - CURRENT ACTIONS - 8 FEBRUARY 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	TBC			
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	February 2024	Update to be provided at the Trust Boards in Common February meeting.		
9.2	05.12.23	Escalation Report from the Finance & Performance Committee - MADE Events		It was agreed a dicussion would take place outside the meeting regarding next years MADE events.	Shaun Stacey / Jonathan Lofthouse	February 2024	Update to be provided at the Trust Boards in Common February meeting.		
9.3	05.12.23	Escalation Report from the Workforce Committee - Retention Update		A Retention Update was requested for the next Board meeting.	Simon Nearney	February 2024	Update to be provided at the Trust Boards in Common February 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	February 2024	Update to be provided at the Trust Boards in Common February 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	February 2024	Update to be provided at the Trust Boards in Common February 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

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Item No: BIC(24)009

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 8 February 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 8 February 2024

1. Introduction

1.1 I am delighted to be providing my first update to the Trust Boards in Common. I would like to give my sincere thanks to the staff who have worked hard to get us to the point that we are meeting in common, marking the next milestone in our working as a Group organisation.

1.2 I am very pleased to confirm to the Trust Boards the start dates of the following Group Executive and Director posts:

- Andy Haywood, Group Chief Digital Officer, starting 26 February 2024
- David Sharif, Group Director of Assurance, starting 4 March 2024
- Anita Jackson, Group Director of Transformation, starting 4 March 2024

1.3 Interviews were held on Thursday 1 February 2024 for Interim Group Chief Nurse and I will update the Boards on this verbally.

1.4 There has been very good progress with appointments to all 6 of the Site Triumvirate posts in the last two months. Dr Caroline Hibbert, an internal HUTH candidate, has started in role as Site Medical Director for the North of the Group, and will be joined by Neil Rogers as Site Managing Director (North) and by Tracy Campbell as Site Nurse Director (North) in April 2024. Both Neil and Tracy are external appointments.

1.5 Interviews were held on 17 January 2024 for the Site Triumvirate Team for the South, and I am very pleased to confirm that Ashy Shanker and Jenny Hinchcliffe are taking up the roles of Site Managing Director (South) and Site Nurse Director (South) and are internal appointments, and we are pursuing an external candidate for the Site Medical Director (South) post, which I will be able to confirm once the pre-appointment checks are more advanced.

1.6 Significant progress has been made with the Care Group triumvirate appointments. A good amount of constructive feedback was received through the consultation process, which was considered in detail by the Group Cabinet. Interviews commenced with staff in existing Health Group and Clinical Directorate senior management roles as well as deputy roles directly affected by the new Care Group structure. These interviews were completed this week and appointments to specific roles will be announced to successful candidates from today onwards by Shaun Stacy, Group Chief Delivery Officer.

1.7 I would like to express my sincere thanks to the Non-Executive Directors, Cabinet post holders and Group Directors for their significant time commitment and energy to these appointment processes. We have put in place a robust process for every appointment and I would like to acknowledge that this would not have been possible without a lot of colleagues going the extra mile to complete these processes at pace and with integrity.

1.8 We held our first Group-wide senior leaders' event on 12 January 2024 at the University of Hull. Our 100 most senior managers received insight from a national and local perspective. I am very grateful for Sir Jim Mackey, Chief Executive of Newcastle Hospitals NHS Foundation Trust, Professor Stephen Eames, Chief Executive of our Integrated Care Board, Rob Walsh, Chief Executive of North East Lincolnshire Council

and Sarah Megan, Manager for the Hull and East Riding Centre for the Deaf, to give us the benefit of their time and expertise. Our next event is being held on 16 April 2024.

2. Patient Safety, Quality Governance and Patient Experience

2.1 As Board members are aware, an extraordinary Trust Board meeting was held on 23 January 2024 to review and sign off the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme year 5 returns. I am pleased that, following a robust review process, both returns were approved for submission.

2.2 Our focus is on patient experience and making the improvements that both Trusts have committed to. My opening presentation at our Senior Leaders' Conference was a re-set of tone, to give clarity of expectation that our Group organisation has the potential to aim for excellence in everything we do for patients, and our patients cannot afford for us to waste this opportunity.

2.3 A key aspect of quality improvement is completing what we have committed to. Our CQC action plans continue to be scrutinised by our Quality Committees, and will be brought in to the Quality Committees in Common process. We meet with the regulators and the Integrated Care Board on a regular basis to demonstrate progress with our action plans, and I welcome this external scrutiny.

3. Elective Care and Urgent and Emergency Care

3.1 The Performance, Estates and Finance Committees in Common reviewed the performance position of each of our Group organisations at their first in Common meeting in January 2024.

3.2 The headline position for Hull University Teaching Hospitals (HUTH) NHS Trust is that the Trust reported 11 patients breaching 78-weeks from referral to treatment in December 2023. The Trust remains on-track to have no patients waiting more than 65-weeks by the end of the financial year. The organisation continues to meet the faster diagnosis standard, but is not meeting the two-week wait or 62-day referral-to-treatment standard, and remains a Tier 1 Trust with NHS England in this regard. Our Hull and East Riding Urgent and Emergency Care system performance for December 2023 was 59% (combination of HUTH ED plus the Urgent Care Centres).

3.3 The headline position for Northern Lincolnshire and Goole (NLAG) NHS Foundation Trust is that there are 99 patients who are waiting over 65 weeks for treatment. The organisation remains on track for this figure to be reduced to zero by year-end. The organisation continues 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 December 2023 was 61.5% and we are still aiming to improve this for the remaining months of the year.

4. Strategy and partnership developments

4.1 On today's Trust Boards in Common agenda, we have the Group's formal submission to the Humber Acute Services public consultation. We have been an active team in supporting the public engagement events lead by the ICB during the consultation period. We have also been instrumental in arranging further sessions for those members of the public who are often overlooked during consultation, which I am pleased to report to the Trust Boards. Our submission ensures we have given a formal organisational response to the consultation as one of the key stakeholders.

4.2 On our Net Zero strategy, I am very pleased that HUTH has been notified of its successful bid for Public Dividend Capital funding from phase 2 of the NHS National Energy Efficiency Fund (NEEF) for its LED lighting project. Nationally, 179 bids totalling over £84m were submitted. We have been awarded £174,414 and the Memorandum of Understanding with the Department of Health and Social Care (DHSC) and the Department for Energy Security and Net Zero (DESNZ) is in the process of being prepared. A big thank you to our capital and facilities teams for putting together such a high quality proposal.

4.3 In partnership news, I am really pleased to note that Dr Peter Reading has been substantively appointed as Chief Executive of Yorkshire Ambulance Service. I am sure I speak for all Group colleagues to offer our sincere congratulations to Peter on this news. I recently met with Peter and members of his senior leadership team as part of Yorkshire Ambulance Service work on improving ambulance handover times and committed our full support to this important work.

4.4 I am also very pleased to note that Elaine Bayliss has been appointed as Group Chair to both United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust. I look forward to working with Elaine and her Group senior leadership team as these two Trusts also move to working in a Group structure.

4.5 I have continued to work closely with ICB colleagues on system-wide issues; most pressingly is the delivery of the Community Diagnostics Programme regionally, which is being reported up nationally, and also the system's financial position. As Senior Responsible Officer for elective recovery in our system, I have given new strategic direction to how we work more collaboratively and at pace at system level in recent meetings.

5. Financial Performance

5.1 The Performance, Estates and Finance Committees in Common reviewed the financial position of each of our Group organisations at their first in Common meeting in January 2024.

5.2 The headline position for Hull University Teaching Hospitals NHS Trust is that the Trust reported in Month 9 an in-month income and expenditure surplus of £1.0m, which is £0.1m adverse to plan. The forecast outturn position is £8.7m, which is £1.5m adverse to plan. Capital expenditure was £26.2m, against a year-to-date plan of £33.3m.

5.3 The headline position for Northern Lincolnshire and Goole NHS Foundation Trust is a Month 9 an in-month income and expenditure deficit of £0.6m, which is £2.1m adverse to plan. The forecast outturn position is £23.8m, which, with anticipated technical savings and Elective Recovery Fund that will reduce this position more in line with plan. Capital expenditure was £16.0m below plan and is forecast to be £9.5 behind plan at year-end.

5.4 The focus of my Cabinet is to deliver the financial plan for this year for both organisations and putting scrutiny into the capital schemes and capital planning for this year and next year. We will also put together a robust finance plan for 2024/25, working from a system point of view, as well as the impact of our Group organisation and the opportunities this presents.

5.5 From a capital point of view, our teams completing and handing over the final elements of the capital schemes in urgent and emergency care on our south bank sites. I was very pleased to join our team for the media launch of the new Same Day Emergency Care area at Diana, Princess of Wales Hospital on 22 January 2024. The team is quite rightly proud of the facility and the improved service offer we can give to our patients.

5.6 On 5 February 2024, our colleagues in City Health Care Partnership moved in to the refurbished Duchess of Kent Day Surgery Unit at Hull Royal Infirmary, moving across the GP walk-in service previously provided at Story Street in the city centre, and providing the opportunity have a co-located Urgent Treatment Centre on our site. This is a significant development for urgent care for our population and is an opportunity to work even more closely with a key partner organisation.

6. Workforce Update

6.1 Across the Group, we celebrated our apprenticeship programmes on 1 February 2024. I am very proud of the number of apprenticeship routes we offer across the Group. I know that both of our Group organisations have had many successes of apprentices taking up substantive employment with us over the last decade, and I believe we have the capacity and drive to do more in this space. I offer my sincere thanks to the number of staff across the Group who have provided the training, supervision, structured learning opportunities as well as mentorship to our hundreds of apprentices over the last several years, and I thank our apprentices for wanting to start their careers, or start their next career, by taking up an apprenticeship with us.

7. Equality, Diversity and Inclusion (EDI)

7.1 We marked the start of LGBTQ+ History month with a film screening of ‘Pride’ at Hull Royal Infirmary on Thursday 1 February 2024. I am really pleased to support our LGBTQ+ staff network and look forward to seeing their celebration events for this important month to our staff and patient community.

7.2 I invited Sarah Megan, Manager of the Hull and East Riding Deaf Centre, to be the closing speaker at our first Group senior leadership conference on Friday 12 January 2024. I had seen Sarah’s presentation at the Medical Society evening event a few months before and it had a profound impact on me, and what she was telling us as health professionals about local deaf people’s experiences of our services.

Sarah gave another excellent and engaging presentation to our Group senior leaders; the feedback we have received from this session tells me that Sarah’s insight and ability to convey the frustrations and needs of our deaf patients has really sparked the right conversations within our teams, and that our senior leaders are looking to lead by example to make sure their teams know how to manage even the basics of communication for our deaf patients.

8. Good News Stories and Communications Updates

8.1 New Emergency Facilities at Diana, Princess of Wales Hospital, Grimsby
In January we welcomed our first patients to our new £4.4 million Same Day Emergency Care (SDEC) and Integrated Acute Assessment (IAA) units in Grimsby.

This is the latest phase in our £65.2 million investment in improving urgent and emergency care across northern Lincolnshire. The new facility provides us with modern, well-equipped facilities that are purpose-built to meet the needs of our communities for years to come.

8.2 Walk-in centre moves to Hull Royal Infirmary

Hull's Story Street walk-in service is set to move to its new home at Hull Royal Infirmary, paving the way for improved integration of urgent care services in the city.

City Health Care Partnership CIC will continue to provide the service at the new location, and the centre will continue to offer treatment for minor illness and injury in a newly refurbished clinical space.

Co-locating the walk-in centre at the hospital means that it will benefit from better access to diagnostic services, such as X-ray. Additional minor injuries and diagnostic pathways will be established later this year to create a fully designated Urgent Treatment Centre (UTC).

The new site is located close to the main hospital entrance and clear signage is in place to direct people to the centre. The service will be open from 8am-8pm, 7 days a week.

8.3 Celebrating Apprenticeships

As part of National Apprenticeship Week which runs from 5 to 11 February, we are celebrating the success of our apprenticeships programme across our Group. More than 800 people have successfully completed an apprenticeship which has helped them into their chosen career over the last seven years.

With hundreds of different schemes running from school entry level to Master's degree, there are lots of exciting opportunities on hand for local people trying to get onto the job ladder, as well as those staff already working for the NHS who want to develop their careers.

8.4 Plans for Community Diagnostic Centre for Hull

At the end of January detailed plans for Hull's new Community Diagnostic Centre (CDC) at Albion Square were shared with the public. The £18m facility will provide a wide range of city centre healthcare and an initial CGI of the how the centre could look shows a two-storey building with an entrance on the corner of Albion Street and Bond Street.

The CDC will feature a range of services including MRI, X-ray, CT scanning and ultrasound, and is expected to provide more than 100 jobs.

This comes with the aim of identifying health problems early and improving outcomes for patients with conditions including cancer, stroke, heart disease and respiratory conditions, as well as reducing waiting times and pressures on acute hospital sites.

8.5 Renowned Haematologist Joins Our Queen's Centre Team

We were delighted to welcome Prof Adele Fielding to our Queen's Centre for Oncology and Haematology at Castle Hill Hospital, Cottingham. Prof Fielding, renowned professor of haematology will be seeing patients at the Queen's Centre as part of her role as Clinical Director of the University of York's newly opened Centre for Blood Research.

Although her main work will be at the Centre and the Hull York Medical School (HYMS) where she serves as Head of Experimental Biomedicine, Prof Fielding will be seeing cancer patients at the Queen's Centre once a week.

8.6 New Technology to Aid Maternity Care

Pregnant people will be able to access their maternity records and update their birthing preferences at the touch of a button when a new electronic system is introduced this month. BadgerNet will help pregnant women and birthing people accessing maternity services at Hull Women and Children's Hospital.

The new system is a full electronic patient record where every clinical interaction with health professionals will be recorded throughout the full course of their maternity journey. It will launch with an online portal and app called 'Badger Notes' through which anyone who's pregnant will be able to view their record and add or adjust their preferences, such as where they want to give birth and details of their birthing partner.

Jonathan Lofthouse
Group Chief Executive
1 February 2024

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)010

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Linda Jackson, Vice Chair – NLaG
Contact Officer/Author	Wendy Booth, Interim Governance Advisor
Title of the Report	Matters for Escalation from the NLaG Council of Governors January 2024 Business Meeting
Executive Summary	The report provides details of the matters discussed and agreed at the Council of Governors business meeting held on 11 January 2024 specifically, the refocused role of the Council of Governors and Governor Assurance Group – reflecting the move to group – and the approval of the Governor Observer Protocol
Background Information and/or Supporting Document(s) (if applicable)	Option 7: Aligned Governance & Decision-Making
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:

Matters for Escalation from the NLaG Council of Governors January 2024 Business Meeting:

Future Role of the Council of Governors and Governor Assurance Group and Approval of the Governor Observer Protocol

1. In accordance with the NHS Act 2006 and amended by the Health & Social Care Act 2012, the duties and responsibilities of the council of governors include (but are not limited to):

    - holding the non-executive directors individually and collectively to account for the performance of the board of directors;

    - representing the interests of the NHS foundation trust and the public.

2. The role of governors in 'holding to account' is one of assurance of the performance of the board of directors, with the forum for examining that performance and holding the non-executive directors to account properly being the full Council of Governors' meetings. Over recent years, the 'holding to account' role has been undertaken through other mechanisms such as governor attendance (with speaking rights) at board committees and through the Governor Assurance Group – mechanisms which involve only a small number of governors.

3. In order to support the move to a group model and reinforce the NLaG Council of Governors as a key part of the governance framework, the Council of Governors agreed the following changes to the current arrangements:

    - The full council of governor meetings will be the primary forum for holding the non-executive directors to account for the performance of the board of directors. Meetings will also be attended by the group chief executive and the other group executive directors.
    - Governor representatives will continue to attend board committees but in an 'observer only' capacity. Amendments have been made to the Governor Observer Protocol to reflect this change and the revised protocol was approved by the Council of Governors. This change avoids individual governors becoming involved in operational detail and decision-making and ensures a clear distinction between the statutory role of governors and that of non-executive directors.
    - Highlight / escalation reports from the board committees-in-common will in future be submitted to Council of Governors business meetings and not to the Governor Assurance Group. Again, this change reinforces the role of the council of governors as a whole for 'holding to account' and seeking assurance from the non-executive directors on the performance of the board of directors.
    - The discharge of the council of governors' statutory duty for holding the non-executive directors to account will, in turn, be evidenced within the council of governors' business meeting minutes.
    - Other mechanisms for ensuring governors continue to be able to fulfil their statutory role will include:

        - regular, and structured updates at council of governors' business meetings on 'hot topics';

- planned / structured briefings throughout the year with additional briefings being arranged as requested / the need arises;

- governors will also continue to receive board agendas and minutes and have open access to the Group Chair, Group Chief Executive and NLaG Vice Chair. This will ensure governors continue to be briefed on key trust strategic issues and risks.

- With effect from 1 April 2024, the Governor Assurance Group will be re-named and refocused on member engagement & communication; supporting the council of governors with its duty to represent the interests of its members and the public. Revised Terms of Reference were ratified by the Council of Governors.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)011

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 8th February 2024
Director Lead	Shaun Stacey, Group Chief Delivery Officer
Contact Officer/Author	Richard Peasgood, Staff Officer
Title of the Report	Group Operating Model / Care Group Structure
Executive Summary	This paper details the direct line management of the Group Chief Delivery Officer to Team North, Team South, Emergency Planning and Business Continuity Team and the Group Chief Delivery Officer's internal team. The paper shows the 14 + 2 Care Groups, whether these sit in Team North or Team South and the specialties contained within each group.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Group Executive Cabinet
Financial implication(s) (if applicable)	The final financial implications are being drawn up with the move to 14 + 2 Care Groups, all with a tri/quad leadership.
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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Operational Group Structure

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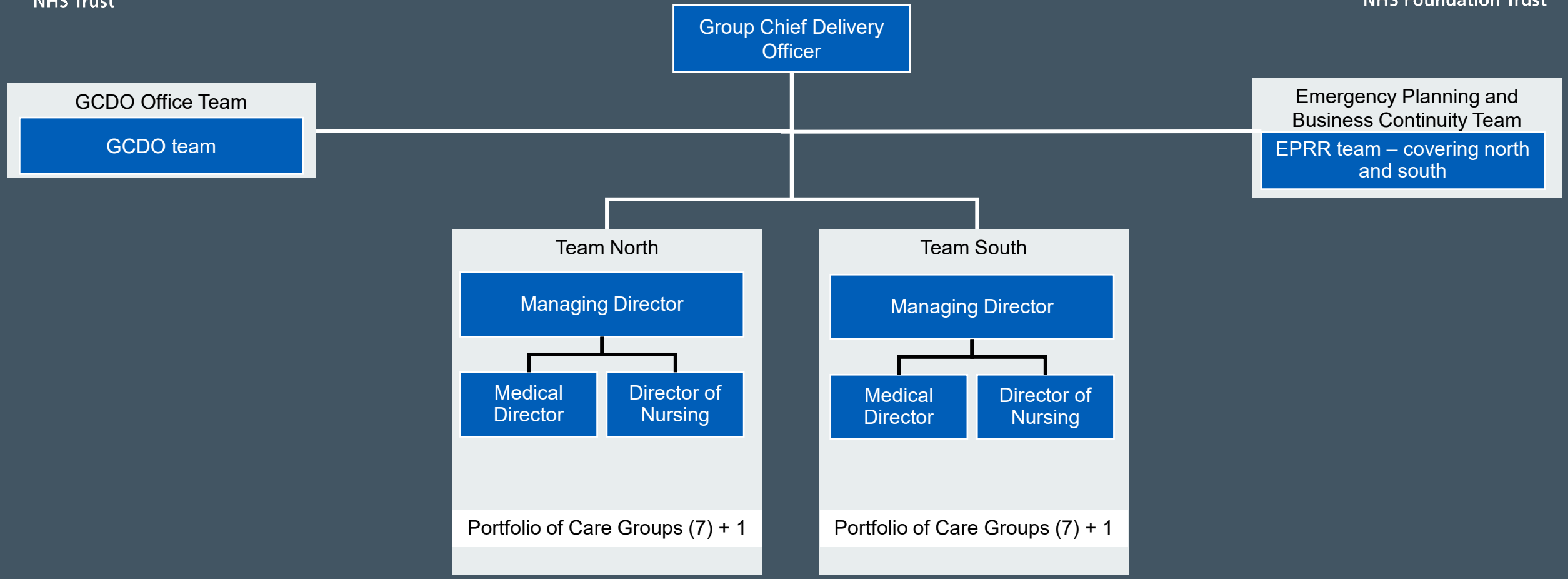

Site Management leadership Structure for each site: Managing Director, Nurse Director, Medical Director
Corporate Infrastructure Support: Senior resource in Finance, HR, Digital/Performance, Quality Governance

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Site Management (North)

Managing Director Team North	Budget: £435M	WTE: 6,532	Total Beds: 710

Cancer Network Care Group		Digestive Diseases		Head and Neck		Major Trauma Network Care Group		Theatres, Anaesthetics and Critical Care (*)		Cardiovascular Care Group		Specialist Cancer and Support Services (*)		Patient Admin	
Cancer leadership team Cancer trackers Tumour MDT leads Cancer Lead Nurse Cancer Clinical Nurse Specialists incl. MacMillan information libraries and MacMillan support workers		Upper GI Colorectal Surgery Acute Surgery Endoscopy Bowel Screening Gastroenterology		ENT Audiology Ophthalmology incl. Retinal Screening and all Ophthalmology Theatres Oral and Maxillofacial Surgery Orthodontics Restorative Dentistry Community Dentistry Orthoptist		MTU MTC C1 Neurorehabilitation centre Goole Neurorehabilitation Rehabilitation centre Community Rehabilitation Medicine		Anaesthetics Acute & Chronic Pain Service All Day Surgery units Goole Theatres All In Patient Theatres All Obstetric Theatres Pre-assessment Sterile Services North All Intensive Care All High Dependency Care All recovery and extended recovery Critical Care Outreach teams		Vascular Surgery AAA Screening Cardiac Surgery Cardiology Cardiac Cath Labs		Haematology Immunology Oncology Radiotherapy Nuclear Medicine Physics Radiation Protection Physics Radiotherapy Physics Clinical Engineering (North & South) Imaging incl. Breast Screening Pharmacy Department of Infection including Microbiology medical staff (#)		SATs Clinical Admin hubs Validation team Outpatients incl. Outpatients nursing	
Total Budget	£1.3M	Total Budget	£60M	Total Budget	£49M	Total Budget	£5M	Total Budget	£113M	Total Budget	£41M	Total Budget	£129M	Total Budget	£37M
WTE	34	WTE	853	WTE	508	WTE	98	WTE	1,556	WTE	511	WTE	1,771	WTE	1,201
WTE Vacancies	2	WTE Vacancies	55	WTE Vacancies	60	WTE Vacancies	16	WTE Vacancies	93	WTE Vacancies	46	WTE Vacancies	130	WTE Vacancies	27
Beds	_	Beds	271	Beds	28	Beds	26	Beds	65	Beds	171	Beds	149		

Care Group Management leadership Structure: Chief of Service, Care Group Operations Director, Care Group Nurse Director, Care Group Midwifery Director (**), Care Group AHP Director(*)
Corporate Infrastructure Support: Senior resource in Finance, HR, Estates and Facilities, Information, Quality Governance
Each Clinical Service within a care group will have a (site based where required) Clinical Lead, senior nursing and operational management

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Site Management (South)

Managing Director Team South

Budget: £448M | **WTE: 6,510** | **Total Beds: 1,372**

Family Services (**) (***)

Paediatric Medicine
Paediatric Surgery
Community Paediatrics
Neonatal Services
Maternity Services
Gynaecology
Child Health Information Service

Total Budget	£85M
WTE	1,272
WTE Vacancies	68
Beds	313

Pathology Network Group

SHYPS
Path Links
Laboratory Services
HUTH Mortuary
HUTH Pathologists (Medical Staff)

Note microbiologists

Total Budget	£44M
WTE	462
WTE Vacancies	54

Acute and Emergency Medicine

Acute Medicine
SDEC Medical & Surgical Emergency Medicine
Urgent Treatment Centre (south) incl. Short Stay acute medical wards North and South

Total Budget	£85M
WTE	1,297
WTE Vacancies	170
Beds	233

Neuroscience Specialist Care Group

Neurology
Neurophysiology
Stroke
Neurosurgery

Total Budget	£33M
WTE	486
WTE Vacancies	43
Beds	183

Specialist Medicine

Respiratory Medicine
Lung Health Check
Renal Medicine
Diabetes & Endocrine
Thoracic Surgery
Rheumatology

Total Budget	£50M
WTE	529
WTE Vacancies	32
Beds	164

Community, Frailty and Therapy (*)

Community Services
Prosthetics/Orthotics
Speech & Language Therapy
Dietetics
Occupational Therapy
Physiotherapy
Clinical Psychology
Podiatric Services
Palliative Care (specialist/Hospital)
Community End of Life Care
Frailty Assessment/Intervention
Frailty and Ageing
Virtual Ward
Home First (North Lincs)
Medical Day Unit/Ward
Lymphoedema
Outpatients Antibiotic and Treatment services (OPAT)
Community Equipment Library (NLAG)
Goole Community Hospital

Total Budget	£78M
WTE	1,576
WTE Vacancies	116
Beds	212

Specialist Surgery

Urology
Plastics
Dermatology
Elective/Trauma Orthopaedics
Breast Surgery

Total Budget	£65M
WTE	734
WTE Vacancies	32
Beds	217

Site Management and Discharge Teams – North / South

Site Matrons
Bed Managers
Flow Coordinators
Bed Bureau
Goole site
All Discharge Lounges

Total Budget	£8M
WTE	154
WTE Vacancies	13
Beds	50

Care Group Management leadership Structure: Chief of Service, Care Group Operations Director, Care Group Nurse Director, Care Group Midwifery Director (**), Care Group AHP Director (*), Care Group Paediatric Nurse Director (***)
Corporate Infrastructure Support: Senior resource in Finance, HR, Estates and Facilities, Information, Quality Governance
Each Clinical Service within a care group will have a (site based where required) Clinical Lead, senior nursing and operational management

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)012

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	**8 February 2024**
Director Lead	**Ivan McConnell, Group Chief Strategy & Partnerships Officer**
Contact Officer/Author	**Susan Meakin, Group Data Protection Officer**
Title of the Report	**Group Model Data Sharing Agreement**
Executive Summary	This is the first version of a Group Model Data Sharing Agreement. This document will need to be reviewed on a regular basis as the group matures. The agreement outlines the legal basis for the three key data sharing activities which will be undertaken by the Group as a Healthcare System. • Staffing • Direct Care • Management of the Healthcare System As the Group Model matures and an alignment of policies and systems takes place this must be reflected within the document with the inclusion that both partners remain legal entities and data controllers or joint controllers. The Board will need to agree who will be the signatories acting for both partners for the Agreement. Once the agreement has been approved and signed this will then be referenced in the Privacy notices for both staff and patients and both NLaG and HUTH.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	This will be presented to the IG Steering Group on the 5th 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:

Data Sharing Agreement (DSA)

In relation to the

Group Model Working

Between

Hull University Teaching Hospitals
NHS Trust

And

Northern Lincolnshire and Goole
NHS Foundation Trust

Version1
Author Susan Meakin, Group DPO
February 2024
Review February 2025

1. Parties to this agreement

Organisation name	ICO Registration
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLaG)	**Z6405159**
Hull University Teaching Hospital NHS Trust (HUTH)	**Z7140608**

If the partners to this agreement change, the agreement must be reviewed and updated by all participating parties. Partners leaving the agreement must review the data provided to it under this agreement to ensure compliance with legal obligations, such as information is only retained for as long as is necessary and it is disposed of in a secure manner.

2. Purpose of the agreement

This agreement creates a framework for the secure, lawful and confidential sharing of personal and non-personal data and intelligence, between the parties to the agreement listed in section 1, for the purpose of;

Group Model working to support a collaborative approach with a focus on improving clinical outcomes, reducing inequalities of access and addressing the known workforce and building infrastructure challenges, for the benefit of the populations both organisations serve.

3. Legal basis for sharing

For the purpose of this agreement 'data protection legislation' means the UK General Data Protection Regulation and the Data Protection Act 2018.

Where applicable the Caldicott Principles as well as the Data Protection Principles will be complied with.

3.1 This agreement will cover data sharing for the below three areas.

- Ensuring access to patient level data is available at the point of care to facilitate the safe provision of services across the Group model 'Care Groups'.

- Ensuring access to data which is required to plan and improve services within the healthcare system.

- Ensuring access to data to support the management of both the services and staff within those services.

3.2 The legal basis for the sharing of this data is identified within the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018 (DPA).

3.2.1 Provision of care and the management of the Healthcare Systems

Article 6(1) (e)

processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller;

Article 9(2)(h)

permits you to process special category data if:

processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.

3.2.2 Ensuring access to data to support the management of both the services and staff within those services

Article 6 1 (f)

processing is necessary for the purpose of the legitimate interests pursued by the controller or by a third party, except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject as a child.

Article 9 2 (b)

processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject.

Other lawfulness of processing under Article 6 of the UKGDPR may be relied upon this could be where we still rely upon consent of the data subject, or it is necessary for compliance with a legal obligation.

4. Data items to be shared

The partners agree that as part of group working staff will have access to only the minimum necessary data relevant to the specified purpose and will only be shared where it is necessary, relevant and proportionate for the purpose of direct care or management of healthcare systems and services in accordance with the data subjects' expectations as documented within both Trusts Privacy notices and specified in this Agreement.

Any onward sharing of data beyond this agreement with other parties must be restricted to numerical/aggregated/de-identified, unless a legal basis is identified.

5. How the data is to be shared

For the provision of care access to each of the providers clinical systems will be provided to each. The main systems are listed below, however this is not exhaustive.

- WebV (NLAG)
- Lorenzo (HUTH)

Access to systems will be done so in a controlled manner on a need to know basis based on role based access with strict approval processes in place. Access to clinical systems will only be granted following appropriate training.

Where access to systems is required for the management of the healthcare system under the group model for example, ESR for the management of staff or Payroll systems these will also be done so in a controlled manner.

Where access is required to paper files across sites a secure method of transport will be used to move said files between each location.

Please refer to relevant policies/procedures for the movement of physical files/records management policies.

Other routes of sharing will be done so in a secure manner via NHSMail, agreed dedicated shared electronic folders/files, Teams areas or secure OneDrive accounts.

6. Data Quality

The information shared must meet agreed standards of accuracy and quality. Any discrepancies with the data should be reported to all parties immediately on discovery

7. Retention and destruction

Data will be held by each partner in accordance with local policies and procedures and in accordance with NHS England's Records Management Code of Practice: A guide to the management of health and care records.

https://transform.england.nhs.uk/media/documents/NHSE_Records_Management_CoP_2023_V5.pdf

8. Data Security incidents and personal data breaches

Each partner organisation will employ appropriate operational and technological processes and procedures to keep the Personal Data safe from unauthorised use or access, loss, destruction, theft or disclosure. The organisational, operational and technological processes and procedures adopted are required to comply with the requirements of ISO/IEC 27001:2005 and/or Data Security & Protection/Information Governance Toolkit Compliance to a satisfactory minimum score as appropriate to the services being provided

to the Data Controller.

Security incidents/ personal data breaches (whether suspected or confirmed) shall be handled and investigated in accordance with the procedures of originating Partner or agreed Group procedures.

In the event of a data incident, the identifying partner will notify the other partner in section 1 and the incident will be investigated following their established procedures and where required reported to the ICO within 72 hours under the current Data Protection Legislation by the Group Information Governance Team.

Each partner organisation will keep each of the other partners fully indemnified against any and all costs, expenses and claims arising out of any breach of this agreement by the offending partner and in particular, but without limitation, the unauthorised or unlawful access, loss, theft, use, destruction or disclosure by the offending partner or its subcontractors, employees, agents or any other person within the control of the offending partner of any personal data obtained in connection with this agreement.

For the avoidance of doubt each party shall be responsible and liable for its own monetary penalties or fines levied by the Information Commissioner's Office (ICO) and/or any other Regulator levied on the respective party.

9. The Controls

The group will implement the following controls to ensure thataccess to patient care records is appropriately protected:

- Authentication: The group will need to ensure that the use ofappropriate processes and mechanisms for identity verification of staff, assignment to roles and groups, and strong authentication are in place.

- Authorisation: The group will need to determine the degree of access to data that will be allowed by a member of staff within a participating body. Partner organisations will need to continue to keep local access controls and privileges current and up to date.

- Audit: The group will need to be able to audit and investigateaccess to a patient's care record.

- Non-repudiation: Robust systems in place for authorisation and authentication, and audit trails generated each time a care record is accessed, individuals will not be able to repudiate accessing care records.

- Legitimate relationships: Whilst healthcare professionals can access all records this does not mean that they should. "Legitimate Relationship" confirms that the viewer has a justifiable reason to view the patient record as they are involved in their care. Legitimate relationship as defined in Caldicott Information Governance Review 2013 is "The legal relationship that exists between an individual and the health and social care professionals and staffing providing or support their care". This term is well adopted and understood assuring confidentiality within health and care organisation.

Legitimate relationships are created by patient or care events and it is only whilst the legitimate relationship exists that the care record should be accessed by the healthcare professional or by a staff member with a legitimate purpose.

- Professional standards and ethics: all registered and regulated health and care professionals are bound by a code of ethics which set out acceptable behaviours. Should said individuals choose to abuse their privileges they will be subject to investigation by the professional body with a risk of being sanctioned if they are reported for professional misconduct.

- Sanctions: If a patient record is inappropriately accessed, the staff member will be sanctioned.

- Staff training on confidentiality: All staff within the Group Model will receiveconfidentiality training. This training will be refreshed at regular agreed intervals. This is important to raise awareness and ensure that staff understand how to handle confidential patient information appropriately, to reduce the risk of breaching patient records by inappropriate access or handling.

10. Rights of the Data Subject

Data protection legislation gives individuals certain rights over their personal data. These include the right to be informed; access personal data held about them; withdraw consent; request that inaccurate data is rectified and incomplete data is completed; be forgotten (erasure of data); restrict of processing; data portability; and to object to decisions made on the basis of automated processing and/or profiling.

The Group will ensure that supporting policies and procedures are in place to support the exercise of these individual rights.

If appropriate Partners will notify other partners of any requests received.

11. Review of Agreement

An annual review of the agreement will be undertaken to ensure it remains fit for purpose. Should the agreement need to be amended then a further review will be undertaken at the time this is known.

12. Signatures

By signing this agreement all signatories accept responsibility for its execution and agree to ensure all staff are trained so that requests for data and the process of sharing data itself is sufficient to meet the purposes of this agreement.

Signatories must all ensure that they comply with all relevant legislation in the processing of personal data

Organisation name	Northern Lincolnshire and Goole NHS Foundation Trust
Organisation address	Diana Princess of Wales Hospital Scartho Road, Grimsby DN33 2BA
Specific Point of Contact for the DSA	Susan Meakin
Position / Job title	Data Protection Officer
Contact number	07523909815
Email address	susan.meakin6@nhs.net
ICO registration number	Z6405159
NHS Data Security & Protection Toolkit Assurance	☐ Standards Met ☒ Approaching Standard Met (Plan agreed) ☐ Baseline Published ☐ Not Published ☐ Not applicable – NHS patient data & systems not accessed as part of this agreement
Signatory for the DSA	
Name	
Position / Job title	
Signature	

Organisation name	Hull University Teaching Hospital NHS Trust
Organisation address	Hull Royal Infirmary Anlaby Road Hull HU3 2JZ
Specific Point of Contact for the DSA	Susan Meakin
Position / Job title	Data Protection Officer
Contact number	07523909815
Email address	susan.meakin6@nhs.net
ICO registration number	Z6405159

NHS Data Security & Protection Toolkit Assurance	☐ Standards Met ☒ Approaching Standards Met (Plan agreed) ☐ Baseline Published ☐ Not Published ☐ Not applicable – NHS patient data & systems not accessed as part of this agreement
Signatory for the DSA	
Name	
Position / Job title	
Signature	

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)013

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships Officer
Contact Officer/Author	Ivan McConnell, Group Chief Strategy & Partnerships Officer
Title of the Report	Formal Submission to Public Consultation – Humber Acute Services: Your Health, Your Hospitals
Executive Summary	The report provides the formal submission to the public consultation – Humber Acute Services Your Health, Your Hospitals from Northern Lincolnshire & Goole Hospitals NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	Group Chief Executive and Group Chair
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Assurance ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

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and Goole
NHS Foundation Trust

Diana, Princess of Wales Hospital
Scartho Road
Grimsby
North East Lincolnshire
DN33 2BA

JLo/SL/IMc/CR

4 January 2024

Humber Acute Services
Your Health, Your Hospitals
Public Consultation team

By email only hnyicb.consultation@nhs.net

Dear Colleagues,

Re: Humber Acute Services – Your Health, Your Hospitals – public consultation

Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provide a wide range of secondary care services from five hospital sites: Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH) in Cottingham, Scunthorpe General Hospital (SGH), Diana, Princess of Wales Hospital (DPoW) in Grimsby and Goole and District Hospital (GDH). In addition, HUTH provides a range of specialist (tertiary) services for the wider region and NLaG provides community services in the North Lincolnshire area.

As a hospital group (the Group), we represent one of the 12 largest hospital group organisations in the country. We are extremely ambitious for our population and want to provide the best quality healthcare for local residents across both sides of the River Humber.

We face a number of significant challenges that impact on our ability to provide high quality, sustainable hospital services for the population of the Humber:

- The way our services are organised leads to inefficiency, double-running and makes it difficult to meet national clinical standards.
- Our services do not deliver the NHS Constitutional Standards or performance standards, particularly in relation to waiting times and patient access.
- Our staff are spread too thinly across our existing services, and we are not able to recruit and retain the workforce we need.
- We face significant financial challenges, and we are not delivering efficient services due to their site configuration and service models.

Over the past three years, the five hospitals in the Group have worked collaboratively with the Integrated Care Board (ICB) and other partners to develop potential solutions to these challenges. Clinical teams, nursing and AHP leads and a wide range of other professionals from across the Group have been actively involved in developing and evaluating the potential options for change. The proposal that the ICB is consulting on has been shaped by extensive involvement from NLaG and HUTH teams. In developing the Pre-Consultation Business Case (PCBC), more than 50 workshops took place involving 1,000+ clinical colleagues from across the Group.

The Group fully supports the ICB's proposal to change the way some more complex medical, urgent and emergency care and paediatric services are delivered at our hospitals in Scunthorpe and Grimsby.

Adopting a new model of care for urgent and emergency care services across the south bank of the Humber will provide a number of key benefits for our patients, which the PCBC sets out, and help to ensure services can be sustainable for the future. In particular, consolidating specialist teams will help to tackle the

.../

south bank's long-standing recruitment and retention challenges and enable NLaG to meet key clinical standards, such as delivering seven-day consultant-led services across northern Lincolnshire.
We recognise that further detailed engagement with clinical and operational teams across the Group is required as planning for implementation continues. Our teams across the Group are primed for this and will continue to fully commit to this planning. This continued engagement will help to ensure any proposed changes are implemented in the most effective, efficient, timely and safe manner.

We trust that the ICB will continue to work with colleagues across the Group to develop detailed plans for implementation, building on the extensive work undertaken by our teams over the past 14 weeks to review and update all the underpinning activity modelling, bed assumptions, workforce modelling and financial analysis. This work has also identified key dependencies with pre-hospital and out of hospital care, as well as services provided by partners in the primary, community, social care and voluntary, community and social enterprise (VCSE) sectors.

The implementation of the programme will be reliant upon changes within community and primary care. Work has been undertaken during implementation planning to scope the range of work required to be in place prior to the proposed acute care changes. It is essential that these enabling changes are in place prior to implementation of any acute pathway changes.

We are fully supportive of the proposed plans that have been subject to consultation and are prepared to mobilise our teams to implement any changes required in line with ICB approvals.

Yours faithfully,

Sean Lyons
Group Chairman

Jonathan Lofthouse
Group Chief Executive

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)014

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Sue Liburd & Una Macleod, Non-Executive Directors and Chairs of the Quality & Safety Committees-in-Common
Contact Officer/Author	Rebecca Thompson, Head of Corporate Affairs
Title of the Report	Quality and Safety Committees in Common highlight and escalation reports from: Q&S CIC – 25 January 2024 HUTH – 18 December 2023
Executive Summary	As part of the Group Model transition there are 2 reports attached which highlight the work of the Quality Committees at HUTH (December 2023 meeting) as well as jointly in the new Committees in Common arrangements (January 2024 meeting). Each report highlights matters considered by the committees, matters for escalation to the Boards, any additional assurance required, confirm and challenge of the BAF and any action required of the Boards.
Background Information and/or Supporting Document(s) (if applicable)	The attached reports provide Committees in Common highlights and escalations to the Boards in Common.
Prior Approval Process	The attached reports have been approved by the Committees in Common Chairs and Chairs of the HUTH Committee in December 2023.
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:

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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:	8 February 2024
Report from:	Quality and Safety Committees in Common
Report from meeting held on:	25 January 2024
Quoracy requirements met:	Quoracy was not technically met due to nominated deputies for some Executives not formally in place. A number of senior Directors attended and officially nominated deputies will be in place for the February meeting.

1.0 Purpose of the report

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

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- Board Assurance Framework
- Integrated Performance Report
- CQC Action Plans
- Nursing Assurance Report
- Maternity Reports
- Patient Safety Incident Investigations
- Register of External Agency Visits
- Safeguarding Report NLAG only
- Patient Experience Report
- Clinical Effectiveness Report
- Complaints/Litigation/Incidents and PALs Report

*[*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:

a. **HUTH BAF risk 3.2 (Patient Harm)** – The CIC agreed with Executives' recommendation reducing the risk rating from 25 to 20, based on improvements in performance in the Emergency Department, particularly in respect of

ambulance handover following constructive joint rapid improvement work with Yorkshire Ambulance Service (YAS) and a marked reduction in patient safety incidents particularly in respect of harm. This will be kept under review. It was acknowledged that sustained improvements are required to maintain this rating, and much work is required to improve to target risk.

b. **Standard Hospital Mortality Index (SHMI) -** NLAG SHMI is being monitored although is still within excepted limits. Whilst the HUTH SHMI data published in January 2024 (for the period to August 2023) was within expected limits, it has presented three consecutive months of increase to a SHMI of 1.1010. There are 3 main areas identified as particular drivers to be concerns with of Acute myocardial infarction (Acute MI); Fractured Neck of Femur (FNoF) and Stroke. More detail on these (explanations and actions) - especially Acute MI was requested for next meeting, and verbal update may be possible at Board.

c. **Staffing issue in NLAG Maternity services** due to the vacancy holds on 8A and above grades, impacting on senior leadership provision. This was referred to Workforce Education and Culture Committees in Common.
Post meeting note:
WECC noted that the vacancy holds were to absorb any displacements following the Care Group interviews and any capacity issues would be picked up on a case by case basis. The vacancy hold to be lifted imminently.

d. **Friends and Family Test** - HUTH is in the bottom quartile in respect of both Inpatient scores and A&E scores. Proactive action is in progress in relation to a wider number of quality improvement projects, but these metrics should be monitored. More emphasis on disseminating and capturing compliments to be developed (again referred to WECC).

e. **External Agency visits -** Due to the progress to date in responding to the Royal College TAVI actions, the NHSE and ICB have ceased their monthly review meetings and will monitor progress via the monthly HUTH Quality Improvement Group.

4.0 Matters on which the committees received assurance

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

a. Quality Risks via the Board Assurance Framework

b. Limited assurance was received for the HUTH SHMI/Reasonable assurance was received for the NLAG SHMI. Further scrutiny is required.

c. CQC Action plans for HUTH/NLAG. Limited assurance until all actions are closed. However, good progress was being made closing actions and embedding new ways of working. The Committee noted each organisation had received independent positive assurance ratings from their separate internal auditors on governance and monitoring of CQC actions.

d. The TAVI actions have demonstrated progress and good assurance was received in respect of the arrangements for monitoring External Agency visits.

e. Maternity Report HUTH – Limited assurance was received but it was noted that the CQC Action plan was on track working to an April 2024 delivery timetable and there had been a positive LMNS visit, with triage performance in the ADU being maintained above target.
Maternity Report NLAG – Good assurance received although issues around the recruitment holds need swift resolution.

f. Patient Experience – Limited Assurance. Work is ongoing to align HUTH and NLAG processes particularly around establishing alignment in respect of different complaint KPIs given HUTH target is 40 days and NLAG is 60 days.

5.0 Matters on which the committee has requested additional assurance:

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

a. Standardised Hosptial Mortality Index – Further scrutiny is required by the Committees in Common. Particularly regarding Stroke, Acute MI and FNoF.
b. CQC Action Plans will continue to be scrutinised at every meeting.
c. Maternity Services deep dive to include CQC actions and CNST submissions.
d. Friends and Family Test, HUTH are in the bottom quartile. At the next quarterly update it is anticipated that the quality improvement actions in place will have demonstrated improvement in the low HUTH scores for A&E and Inpatients.

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 has proposed the following change(s) to the risk rating or entry:

HUTH BAF Risk 3.2 (Patient Harm) - The Q&S CIC recommend to the Boards in Common that the risk be reduced to 20 from 25 due to the ongoing improvements in performance in the Emergency Department, particularly in respect of ambulance handover following constructive joint rapid improvement work with Yorkshire Ambulance Service (YAS) and a marked reduction in patient safety incidents particularly in respect of harm. It was acknowledged that sustained improvements are required to maintain this rating, and much work is required to improve to target risk.

NLAG - The committees in Common 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:

- Approve the HUTH BAF Risk 3.2 reduction from 25 to 20;
- Review the Maternity senior leadership staffing concern at NLAG; and
- Note the other items of escalation and agree the actions required.

Una Macleod/Sue Liburd

26 January 2024

Key:
HUTH – Hull University Teaching Hospitals NHS Trust
NLAG – Northern Lincolnshire and Goole Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	8th February 2024
Report from:	Quality Committee HUTH
Report from meeting held on:	18th December 2023
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality Committee HUTH at their meeting held on 18 December 2023 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:

- Mental Health Deep Dive
- Nutrition Work Stream Update
- Surgery HG Governance Update
- Risk Strategy
- Mortality - Learning from Deaths framework (inc Medical Examiner)
- CQUIN Q2 Update
- External Agencies
- CQC Maternity
- Thirwell Inquiry
- Patient Safety Quarterly Update
- Infection Prevention Control Requests for Improvements

*[*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:

a. Infection Prevention Control Requests for Improvements

4.0 Matters on which the committees received assurance

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

a. Mental Health Deep Dive – Limited assurance
b. Nutrition Work Stream Update – Limited assurance
c. Surgery HG Governance Update – Limited assurance

5.0 Matters on which the committee has requested additional assurance:

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

a. Mental Health to receive a further update in 6 months.

b. The committee would like to see the changes to patient safety following the transition to PSIRF and how learning is embedding.

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

6.1 There were no changes suggested to the BAF risks associated with the quality committee.

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- Note the contents of the escalation report
- Note the committees support for Infection Prevention Control Requests for Improvements
- Decide if any further information or assurance is required

Una MacLeod

28th December 2023

Highlight Report to Trust Board

Report for Trust Board Meeting on:	February 2024
Report From:	Quality & Safety Committees held on 19 December 2023

Highlight Report:

The Maternity Safety Oversight report illustrated that the service was expecting to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) standards in line with the requirements. The exit plan to leave the Maternity Safety Support Programme (MSSP) was with external sign off processes.

The Annual report for Organ Donation was provided illustrating that there was engagement at the expected level and an intention to collaborate with HUTH to have an Organ Donation Committee in Common approach in the future. Dr Dharmarajah was thanked for his leadership as clinical lead, as is stepping down from the role shortly.

Division deep dives:

- Community and therapies provided insight of the success and progress, but also highlighted speech and language staffing resource impacting on stroke pathway support. A joint business case with medicine was being developed as part of business planning. Measurement of community nurse staffing using accredited tools has recently become available and will be used to assess the workforce and activity demands supported by the Chief Nurse team.
- Medicine provided oversight of their progress towards improving the recruitment to nursing and Consultant posts, although a residual issue remains on nurse vacancies at a projection of 65-70 vacant down from 100. ED consultant vacancies remain also. Oncology pathways are being reviewed with HUTH colleagues regarding Oncologist vacancies. Plans to address these issues were described, including the collaboration with HUTH were this will help bolster resources. Other workstreams to reduce length of stay further using Virtual ward and alternative pathways continue.

The Integrated Performance Report was discussed, highlighting a project on Patient Weight recording on ePMA was being refreshed with support from the Quality improvement team. Mental Capacity workstream is expected to improve with a specialist nurse post now filled to provide support to clinical teams with how the assessments and best interest decisions are documented. Development of targets for some KPI's was discussed and the intent to update for the new financial year.

The quarterly Learning from Deaths report provided details of SHMI and HSMR remain in the expected range. In the endeavour to improve further, lines of enquiry into higher risk conditions and how clinical care is recorded on electronic systems is being pursued with coding and information teams. SJR findings have reported mainly good ratings of care.

The Nursing Assurance reports provided details on the staffing levels with a Registered Nurse and Midwife vacancy rate of just over 10%. Recruitment of newly qualified and international continue to improve the position. Operational challenges with patients moving departments overnight was high, with recognition of the challenges of achieving discharges earlier in the day to improve were ongoing challenges. Complaints management performance variance was discussed and understood to be improving again.

Serious Incidents (SI) and Patient Safety Incident Investigations (PSII) updates were provided with no new serious incidents reported.

The Care Quality Commission (CQC) action plan progress was reviewed with improved assurance ratings each month. Thirteen assurance reports were being prepared for approval and then to be submitted to the CQC. Formal feedback from the CQC inspection of the Midwifery Led Unit at Goole is expected in coming weeks after positive informal feedback at the end of the onsite visit. The revised assessment framework is expected to be introduced in February or March 2024.

Patient Safety Incident Response Framework implementation plans in December 2023 have commenced for national requirements and phasing in the proportional investigation approach, supported by the policy and plan approval completed in November 2023.

The Trust response to the information request for the Thirlwell Enquiry was provided. All NHS organisations had been asked to submit a response to the Information request and this had been completed in line with the required timescale. The detailed response and reference to the range of Trust policies and procedures provided assurance.

Confirm or Challenge of the Board Assurance Framework:

Strategic Objective SO1-1.1 was reviewed in the October 2023 meeting. The Executives requested further time to review the actions and risks to represent the revised position as the Trust moves into a Group structure. The Committee approved the extension.

Action Required by the Trust Board:

The Board is asked to note:

- Maternity CNST action plan is on track for full compliance
- Support for speech and language therapists' business case
- Recommendation for an organ donation committee in common

Sue Liburd
Non-Executive Director

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)015

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Tuesday 8 February 2024
Director Lead	Group Chief Nurse / Group Chief Medical Officer
Contact Officer/Author	Nicola Foster, Associate Chief Nurse – Midwifery, Gynaecology and Breast Services (NLAG) Rukeya Miah, Head of Midwifery (HUTH)
Title of the Report	Maternity & Neonatal Safety Assurance Reports NLAG & HUTH
Executive Summary	**Hull University Teaching Hospitals NHS Trust** 1. **CQC improvement plan and Section 31 Notice** The Trust has completed 11 actions fully completed, with a further 8 delivered pending evidence of sustained improvement. Of the actions 25 actions remaining to deliver, 21 are on track, with overall delivery on track for April 2024. The Trust continues to report monthly to the CQC in respect of the Section 31 Notice including action plan delivery, training attainment and maternity dashboard performance. 2. **Clinical Negligence Scheme for Trusts (CNST) V5** HUTH has reported compliance for 5/10 standards in line with the deadline of 1 February 2024. This assurance report on the agenda of each Board meeting will routinely capture the information not routinely presented previously to satisfy the CNST criteria (as defined for Year 5 pending Year 6 publication). 3. **Workforce** The Trust's most recent Birthrate plus assessment (November 2023) indicates a budget gap of c.20WTE (10%) compared to the previous assessment in 2021. The 6 month Staffing report has been completed utilising the template provided by the MIS to demonstrate compliance with CNST requirements. 4. **Patient Experience and Service User Feedback** The Maternity Service continues to receive relatively low numbers of new complaints and PALS concerns, and along with NLAG scored 100% of the Friends and Family Birth Test. 5. **Maternity Safety Champions** Feedback from the Maternity and Neonatal Safety Champions is documented in the report and separately in the Champion specific report.

	Northern Lincolnshire and Goole NHS Foundation Trust **1. Workforce** Midwifery vacancy rate remains a challenge in November. 7 international midwives have joined the maternity service and a further 4 have joined the service in January. Newly qualified midwives recently recruited and positively impacting on midwifery vacancies. **2. Clinical Negligence Scheme for Trusts (CNST) V5** Full compliance has been reported for year 5 in line with the deadline of 1 February 2024. **3. Quality Improvement** Current ongoing Quality Improvement (QI) projects within maternity services include: Induction of Labour; Neonatal Thermoregulation; Antenatal clinic/Antenatal Day Unit. Phase 2 of the Maternity Triage Service has gone live as planned on 16 October 2023. **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 commenced and maternity services have commenced co-production of maternity services with the MNVP. **5. Maternity Safety Support Programme** The Trust has confirmation that the Maternity Safety Support Programme will be exited in February 2024, 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** The Trust has hosted a CQC inspection of Maternity Services (Goole) 21 November 2023 and is pending receipt of the final report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	The reports have previously been presented at the Quality and Safety Committees in Common in January 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:

HUTH Maternity Services

Board Report

January 2024

Lorraine Cooper Director of Midwifery

Introduction

NHS organisations are accountable for ensuring the fundamental standards of quality are delivered, including managing quality risks, and reducing inequalities and variation and continuously improving the quality of services in a way that makes a real difference to the people using them.

Maternity services have been under significant scrutiny over the last few years due to recent independent investigations and public inquiries including Ockenden (2022), East Kent (2022) and more recently the forthcoming Thirwell Inquiry.

The purpose of the maternity report is to provide Trust Board assurance that senior leaders and services are able to rapidly identify risks and issues, evaluate and mitigate these risks and provide assurance that statutory functions are being met.

The report will include reporting requirements for the national maternity incentive scheme.

Acknowledgements:

- Bereavement Team
- Neonatal Team
- Governance and Risk Team
- Midwifery Matrons
- Midwifery managers
- Obstetric and Medical leadership team

CONTENTS

(Maternity Incentive Scheme Safety Action 1)

Perinatal Mortality Review Q3 Data

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

NHS Resolution is operating a fifth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions,

Trusts demonstrating they have achieved all ten of the safety actions, will recover their contribution, and will receive a share of any unallocated funds. The scheme relaunched in May 2023 and will included eligible cases between the **30th May and 7th December 2023**. In order to be eligible for payment under the scheme, Trusts must demonstrate that they have been compliant with action one and submit their completed declaration form to NHS Resolution by 12 noon on **1st February 2024**.

Trust submissions will be subject to a range of external verification points including cross checking with the following:

- MBRRACE-UK data (safety action 1 point a, b, c).
- NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive)
- Against the National Neonatal Research Database (NNRD)
- MNSI for the number of qualifying incidents reportable (safety action 10, standard a).

Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Requirements for Safety Action 1; are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard. **Appendix 1 and 2**

a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30th May 2023**, MRBRRACE-UK surveillance information should be completed within one calendar month of the death.
b) For 95% of all deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30th May 2023**
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30th May 2023**. 95% of reviews should be started within 2 months of the death, and a minimum of 60% of multidisciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
d) Quarterly reports should be submitted to the Trust Executive Board from **30th May 2023**

The PMRT is designed with the following principles:

- A comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth

- Reviews conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- Review by a multidisciplinary group at a meeting where time is set aside for doing the work;
- Parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored;

- The review should result in a written report, which nned sharing sharing with families in a sensitive and timely manner.
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

Summary

The below summaries Q3 October to December 2023, the reporting period of the CNST year 5 incentive scheme commenced at the end May 2023

a) There were 6 eligible baby deaths in the Trust, in 100% of the cases the MBRRACE-UK perinatal surveillance was commenced within 7 days and completed within one calendar month

b) The parents' perspective was sought in all 6 cases occurring in Q3, achieving 100% compliance with the standard.

c) 100% of the cases in Q3 when babies were born and died in the Trust, have been commenced within the standard of 2 months. 1 case has been reviewed and the report is in the writing stage, the remaining 5 are still under review. 5 of the cases in which the babies deaths occurred within Q2 (October – December 2023) the reviews have been completed and reported upon which maintains a 100% compliance. All remaining cases under PMRT review the babies were born at another Trust and the death occurred in HUTH, or are under HSIB investigation and are not subject to the standard.

d) Quarterly report submitted as per standard and discussed with the Trust safety champion

Quarterly reports are submitted as per standard and discussed with the Trust safety champion

(Maternity Incentive Scheme Safety Action 2).

Avoiding Term Admissions into NICU Q3 Data

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. This report will update progress from Hull University Teaching Hospital NHS Trust in regards Safety action 3: “Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme”. Furthermore this report will focus on an action plan to address local themes from Avoiding Term Admissions into Neonatal unit reviews, this will be agreed with the Maternity and Neonatal Safety Champions and Board level champion.

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

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

In Quarter 3 the auditors for this report have focused on the primary reason for admission with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed, in order to develop the action plan.

In addition year 5 of CNST, Trusts are required to report on the number of babies admitted to the NNU that would have met current Transitional Care (TC) admission criteria, but were admitted to the NNU due to capacity or staffing issues. In addition the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on. Finally reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

HUTH - Current position

As demonstrated by table 1 there has been a decrease in the number of Term Admissions to NNU since 2016. Table 1 highlights the number of admissions to the NNU during the commencement of the ATAIN programme.

Table 1

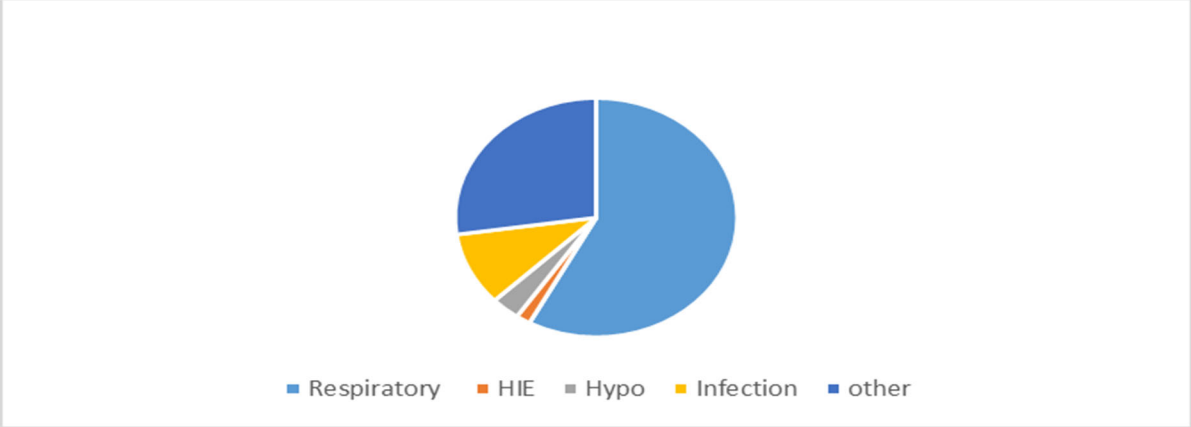
Year	Total Term Admissions to NNU	% of total NNU admissions	% of Term admissions to NNU
2016	191	39.6%	4.1%
2017	186	37.7%	3.9%
2018	154	35.2%	3.3%
2019	175	35.5%	3.1%
2020	159	33.3%	3.2%
2021	187	39.9%	2.6%
2022	186	41%	2.3%
2023	198	41%	2.8%

All unexpected term admissions to NNU is reported via the DATIX system and investigated via weekly Maternity ATAIN multi-disciplinary meetings. The CNST approved template ATAIN proforma is completed for data collection purposes. Themes, trends and learning is shared amongst all clinical staff from both Maternity and Neonatal services. In addition, an online training package is available on the Trust HEY 24/7 educational platform which is required learning for all midwives which covers these learning points. Table 2 demonstrates term admissions into NICU in Q1, Q2 and Q3 (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..3%
Quarter 4 2023					

Unexpected Term Admissions to NICU cases, reviewed through Maternity ATAIN review equated to 23 cases in quarter 3. Themes identified are presented below. The average gestation at admission to NICU was 39+0 -39+6 weeks. The primary reason for admission to NNU was for respiratory support requiring Continuous positive airway pressure (CPAP). 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



Preventable admission – Perinatal management

It has been identified that changes in the perinatal management may have prevented admission to NICU. Most common mode of delivery for admission to NNU was Emergency Caesarean Sections. As babies born by this mode can struggle with adaptation and in view of National recommendation a baby should be placed skin to skin at least until after the first feed and for as long as the mother wishes. This is currently not standard practice with this mode of delivery within a theatre situation therefore this has been added as a quality improvement within the action plan.

Birth Weight/Length of Stay

The most common birth weight range at admission to NICU was 3.0 – 4.0kg and the average length of stay on NICU was most commonly between 1 -3 days.

Suitability for transitional care

The number of babies admitted to the NNU that would have met current Transitional Care admission criteria but were admitted to the NNU is 0 compared to 7 in quarter 2 and the

number of babies that were admitted to, remained on NNU because of their need for nasogastric tube feeding is 0 as the transitional care support at Hull University teaching Hospital supports nasogastric feeding.

The themes as identified above were reviewed and the following action plan agreed through multidisciplinary discussion. Compliance with the below action plan will be monitored regularly through the weekly Maternity Case Review meeting. A copy of this report will be shared through the Obstetric Governance meeting and, the Family, and Women's Health Group Governance meeting. It will also be shared with the Executive Maternity Safety Champion and the Neonatal Safety Champion. An update of progress on this action plan will be reported via the Health Group Governance process.

Action	Lead	Status
Respiratory management platform to be trialled for respiratory support (CPAP) at the bed side on labour ward	Neonatal consultant	In progress
The service to explore theatre gowns which allow babies to be safely placed skin to skin.	Labour ward coordinators Infant feeding co coordinators	In progress

(Maternity Incentive Scheme Safety Action 6)

Growth Assessment Protocol Q3 Data (GAP)
The purpose of the information is to provide assurance to the Trust Board that the organisation, to the standard required by the Clinical Negligence Scheme for Trusts (CNST), is compliant with Safety Action 6: Element 2: Outcome Indicators 2d & 2e & with Saving Babies Lives Care Bundle Version 3 (SBLCB3) Element 2 Outcome Indicators 2d & 2e, with additional data provided for Point 2.22.

Saving Babies' Lives Care Bundle Version 3 (SBLCBv3) is a care bundle for reducing perinatal mortality across England published in July 2023. This third version of the care bundle includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

Element 2 covers Fetal Growth: Risk assessment, surveillance, and management. Data required:

a) Percentage of babies born <3rd birthweight centile >37+6 weeks' gestation (Outcome indicator 2d & 2d in CNST)
b) Percentage of live births and still births >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected

Percentage of live births and still births <3rd birthweight centile born >37+6 gestation Q3:

- Number of babies born at HUTH <3rd centile (denominator) = 60
- Number of babies born at HUTH < 3rd centile & >37+6 (numerator) = **27**
- **Percentage = 45%**

Percentage of live births and still births >3rd birthweight centile born <39+week's gestation, where growth restriction was suspected (SBLV3 Intervention Ref 2.19) Q3:

- Number of babies born at HUTH >3rd centile (denominator) = **1078**
- Number of babies born at HUTH > 3rd centile (<10th centile) & <39+0 (numerator) = **44**
- **Percentage = 4.08 %**

Additional reporting elements required SBLV3 Element 2 - 2.22 Point b)

Ongoing case-note audit generated from the Trust DATIX reporting, Trust BI report and reported through the Perinatal Institute Growth Assessment Protocol (GAP) Score system of <3rd birthweight centile babies >38 weeks not detected in the antenatal period.

For Quarter 3 (October, November, and December 2023), there were 3 cases identified:

2 cases were identified as midwifery-led care through the pregnancies, so only had had fundal height measurements undertaken within guideline, so no growth USS undertaken that may have picked up low birthweights.

1 case fell outside the accepted difference between birthweight and estimated fetal weight (i.e. true missed case of SGA) and this case details was sent to the sonography department.

There were 20 cases in this quarter with missing birth centiles entered into the Lorenzo maternity IT system (1.68% of births in this quarter)

From the GAP score report produced during this quarter, a GAP newsletter was distributed to all maternity staff in mid-January 2024. This covered:

- Perinatal Institute GAP data involving detection rates of babies born under 10th centile
- highlighted the new Saving Babies Lives Version 3
- encouraged to think risk at every contact
- explained the new mandatory face to face GAP training for 2024
- A brief explanation of the GROW 2.0 system linked to the new BadgerNet IT maternity system.

Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies

- Quarter 3 data (October, November, and December 2023)
- Number of babies born at HUTH <10th birthweight centile & >39+6 = **36**
- **Percentage = 3.02%**

The report provides assurance of oversight of

1. CNST Safety Action 6, Element 2 Point 2d & SBLV3 Element 2 Point 2d: Percentage of live births and still births <3rd birthweight centile born >37+6 gestation has been documented

2. CNST Safety Action 6, Element 2 Point 2e & SBLV3 Element 2 Point 2e: Percentage of live births and still births >3rd birthweight centile born <39+0 gestation, where growth restriction was suspected has been documented

3. Data has been provided to evidence SBLV3 Element 2 Point 2.22

(Maternity Incentive Scheme Safety Action 6)

Saving Babies Livers Version 3 Update
The purpose of providing this information to Board regularly is with the aim to provide assurance that the organisation, to the standard required by the Clinical Negligence Scheme for Trusts (CNST), becomes compliant with Safety Action 6.

Saving Babies' Lives care bundle version 3 (SBLCBv3) is a care bundle for reducing perinatal mortality across England published in May 2023. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice.

The 6 elements of the care bundle are:

1. Reduced Smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancy at risk of growth restriction
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring
5. Reduced preterm birth
6. Management of Diabetes

The new element 6 covers the management of pre-existing diabetes in pregnancy for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes. It recommends multidisciplinary team pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance.

A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives.

As part of the Three year delivery plan for maternity and neonatal services, NHS trusts are responsible for implementing SBLCBv3 by March 2024 and integrated care boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

SBLCBv3 also sets out a number of important wider principles to consider during implementation. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the 6 elements.

HUTH have being using the new national implementation tool to track compliance with the care bundle and HUTH have quarterly meetings with LMNS and ICB to track progress (table 1 demonstrates progress).

Table 1

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	50%	Partially implemented	40%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	70%	Partially implemented	50%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	20%	Partially implemented	20%	CNST Not Met
Element 5	Preterm birth	Partially implemented	44%	Partially implemented	48%	CNST Not Met
Element 6	Diabetes	Partially implemented	33%	Partially implemented	17%	CNST Not Met
All Elements	TOTAL	Partially implemented	50%	Partially implemented	43%	CNST Not Met

As the table documents, HUTH has not met the 70% overall and 50% thresholds for each standard in Year 5 of the scheme at the date of the report.

ACTION for SBLV3

- A Saving Babies Lives working group has been establish led by the Head of Midwifery
- All audits have been registered but need undertaking and reported through speciality governance.
- Task and Finish has been established specifically for diabetes
- Increase in PA time for dedicated obstetric lead for fetal monitoring, to 1PA (4hrs)

(Maternity Incentive Scheme Safety Action 7)

Listening to women – Maternity and Neonatal Voices Partnership (MNVP) update

The Three-year delivery plan for maternity and neonatal services recognises that listening and responding to all women and families is an essential part of safe and high-quality care. Listening to women and families with compassion improves the safety and experience of those using maternity and neonatal services and helps address health inequalities.

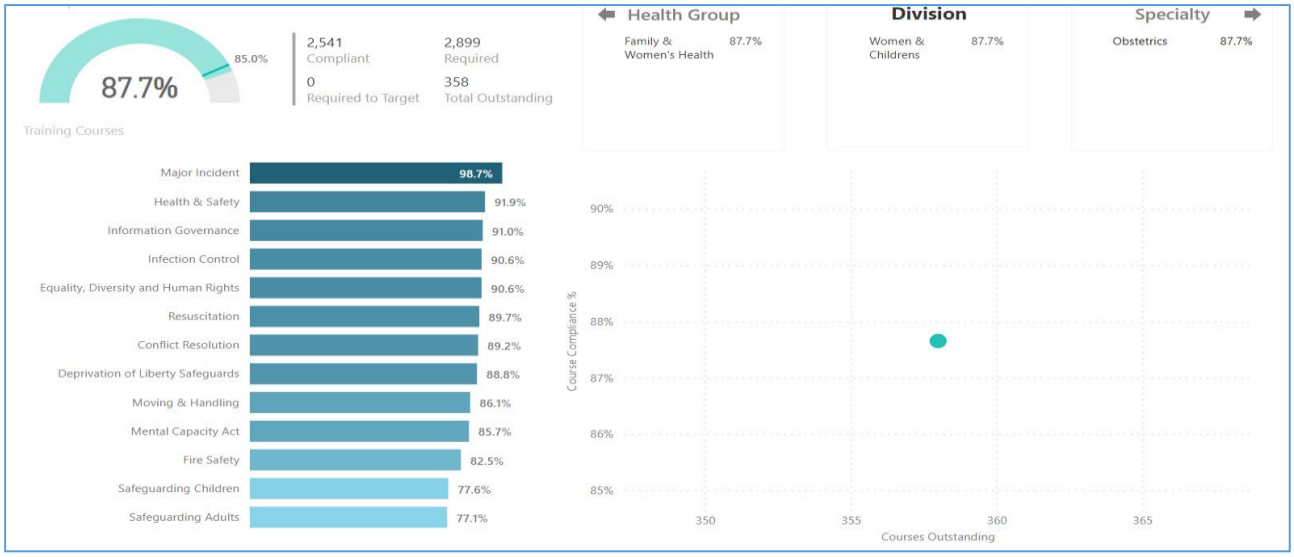
Maternity and Neonatal voices partnerships (MNVPs) ensure that service user voices are at the heart of decision-making in maternity and neonatal services. The ambition for MNVPs is set out in the Three-year delivery plan for maternity and neonatal services. HUTH has a well establish MNVP forum and has recently undertaken the 15 steps in maternity in March 2023 and a further refresh in September 2023. An action plan has been developed and coproduced with members from the MNVP and monitored via the specialist governance meetings.

Maternity services have invited the MNVP group to the maternity quality and safety meetings (as below), to represent women and families voices:

1. Specialty Governance meetings
2. Safety Champions meeting
3. SBLV3 working group
4. Maternity Incident Review Group
5. Monthly Assurance Visits
6. Recruitment processes for senior midwifery roles

(Maternity Incentive Scheme Safety Action 8)

Trust Mandatory Training Compliance - January 2024



Maternity Specific Mandatory Training

The table below shows the compliance rate for each required competency by area within maternity services. The data is taken from HEY247 and is live data. The most recent data set was taken on 23rd January 2024. A Trust target of 85% compliance is in place for each competency with the exception of Information Governance which has a target of 95% in line with national requirements.

Training progress since December 2023

- There has been an improvement in compliance rates for **14** out of the 22 competencies as detailed in the table below.
- There are **10** areas now above the 85% target. Key areas of improvement have been Perinatal Gap e-learning, Fetal Monitoring and Pool evacuation.

To bring the Trust in line with partner organisations a decision has been taken to move all medical staff to undertake Safeguarding at a level 3 for adults and children and young people. This has impacted on the level 3 compliance rates for January, however work is currently on-going to ensure that doctors are booked onto the training as soon as possible to ensure minimum impact.

There is also on-going impact on training relating to staffing levels and the training programme to get staff trained on the Badgernet system prior to launch in February.

Competency	19.10.23	20.11.23	21.12.23	23.1.24
Information Governance	87.8%	84.9%	88.8%	88.1%
Resuscitation	84.1%	82.4%	84.0%	85.3%
Health, Safety and Welfare	96.3%	90.9%	90.5%	90.9%
Moving and Handling	82.0%	79.2%	83.4%	83.3%
Fire Safety (clinical)	81.1%	79.8%	81.4%	81.9%
Mental Capacity Act	80.8%	80.3%	80.5%	82.2%
Deprivation of Liberty	85.7%	85.2%	85.7%	86.7%
Infection Control	87.5%	87.7%	88.8%	88.4%
Equality, Diversity and Human Rights	92.7%	89.7%	90.0%	88.4%
Safeguarding Children Level 2	88.5%	89.5%	89.5%	93.3%
Safeguarding Children Level 3	82.1%	78.0%	77.0%	74.8%
Safeguarding Adults Level 2	84.4%	86.9%	87.0%	92.2%

Safeguarding Adults Level 3	79.6%	75.5%	77.9%	70.7%
Conflict Resolution	89.0%	87.7%	87.4%	87.8%
Perinatal Gap E-learning	69.2%	63.8%	67.2%	70.1%
Fetal Monitoring	70.4%	75.4%	75.9%	78.4%
Fundal Height Measurement	69.2%	61.2%	69.1%	85.3%
Newborn Life Support	69.1%	52.2%	63.0%	64.1%
PROMPT	76.2%	78.1%	77.1%	73.9%
Mandatory Training Day 2	69.1%	50.4%	58.6%	58.3% (December data)
Pool Evacuation	N/A	51.6%	57.1%	68.3%
K2	82.4%	76.8%	82.4%	85.1%

Following the completion of the Badgernet training at the end of January 2024, the service will have a renewed focus on mandatory training. Changes have been made in the delivery of the training by splitting down the training days and pre-booking staff onto training 2 months prior to the expiry of compliance. The continued key areas of focus over the next four weeks are:

- Information Governance
- Perinatal Gap E-learning
- Fetal Monitoring
- Fundal Height Measurement
- New born Life Support
- K2
- Safeguarding Children Level 3

On-going actions to be/being undertaken to support improvement

- January CQC compliance report to be shared with all midwifery line managers
- Managers to discuss compliance rates with the Head of Midwifery on a weekly basis to provide progress reports
- Monthly Performance meetings in place with Head of Midwifery, HR Business Partner, Matrons and managers to discuss and set targets around KPI's including training.
- HR Business Partner to meet with Head of Midwifery, Lead Midwife, and Clinical Director for Obstetrics and relevant training leads to discuss areas of concern and put actions in place to improve and sustain compliance in the short/medium and long term.
- Managers to send reminder e-mails to individual staff members who are out of compliance with a timescale for completion to be set.
- Managers to meet with individuals who have a low compliance rates with a timescale for completion set and follow up discussion if not achieved by required date.
- Reminder e-mail to go out to all staff regarding the option to do training in their own time and to be paid/take time off in lieu confirming what process they need to follow should they wish to claim for undertaking training in their own time.

(Maternity Incentive Scheme Safety Action 9)

Maternity and 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.

For 2024 HUTH will be embedding monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the venue each time. This will provide 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.

All trust Board Safety Champions were involved in the recent external LMNS support visit in November 2023. The visit to Hull Royal Infirmary, Women & Children's building, in November 2023 was coordinated by the LMNS with the support of the NHSE regional team and other local and regional stakeholders. We would like to thank Trust colleagues present on the day for their warm welcome and for hosting the proceedings.

Areas of good practice – for wider sharing at LMNS learning and celebration event

- TRiM (Trauma Risk Management) process recognising requirement to support staff after significant incidents is well regarded and valued by teams and managers
- Launch of the 'incivility reporting tool' has been well received and used – review group includes HR and the Chief Nurse. Data is available to review to flag themes/trends
- Development has taken place of a live dashboard for monitoring ADU attendance of planned and unplanned activities against the BSOTs model. KPIs are set and there is a fortnightly review of data and identified breaches to further improve workflow
- 'Ask a Midwife' and 'Thankful Thursdays' show good evidence of engagement
- The monthly 'Carousel' event is a popular event, that evaluates well, for service users and could be duplicated elsewhere
- Postnatal ward – the 'fifteen steps' review this year generated a poster providing focus on mental health aimed at dads, partners and non-birthing parents
- Use of the Trust wide AMAT (Audit Management and Tracking) system should help to group audit programme together, consolidate results and actions and standardize audit reports. This has the potential to improve evidencing of clinical practice and improvements such as for the Saving Babies Lives Tool and learning could be shared if there are positive outcomes as it is embedded
- Maternity Governance links into Trust-wide Patient Safety and Clinical Effectiveness Committee and the separate Quality Committee – staff acknowledged that restructuring and alignment with NLaG will bring opportunities for shared pathways and learning
- Engagement with the national MUSA (Midwifery Unit Self-Assessment) project and use of the tool to continuously improve MLU provision was described; it was suggested the HUTH team could further promote the outputs and outcomes from this project across the LMNS.

Observations noted by the visiting team to inform their oversight of the services viewed

- Quadrumvirate well informed and engaged
- The Medical and Clinical Directors had very good oversight of concerns and issues

- Commencement of capacity/demand assessments across ward areas will better inform ongoing projects around management of demand
- Fetal medicine and screening – effective/proactive planning was described against their expected activity increases
- The Newly Qualified Midwives spoken to felt well supported
- The team noted the appointment to the Midwifery Recruitment and Retention Lead post; a review of the preceptorship programme was suggested to take place; potentially the Recruitment and Retention post can support this when in role
- Neonatal team culture was described as very family centred
- We observed a good level of transparency with service users around CQC results; there was positive feedback from a service user in Rowan Ward noted on the day
- Noted a board promoting human milk for premature babies in the transitional care area and another advising on safe sleep in the birth centre which the team thought was appropriate and helpful
- Neonatal unit refurbishment near completion and the visiting team noted there are no staff vacancies and it felt very family centred and welcoming
- Governance processes include daily review of incidents logged on Datix maternity incident review meetings 3 times a week and quarterly thematic reviews of incidents. Any incidences graded moderate and above are escalated to the Trust weekly patient safety summit. However, it was also noted that the Maternity Incident Review Oversight Group (MIROG) does not meet regularly and action notes are scant.
- We saw that the specialist midwives we spoke to all understood the importance of their role and had a good understanding of the different challenges facing the Hull demographic.

Areas for consideration/improvement

- ADU discussion with service user – the individual reported feeling informed and aware of choices but did not want to write a birth plan for fear of the psychological impact of it not being able to adhere to. Work is needed to inform/strengthen midwifery training and understand how service users can be assured that birth plans will be supported wherever possible.
- Regarding the safety champion role and the ongoing work to embed and enable visibility; NLaG safety champions have badges on their lanyards, the team suggest that this could also be easily and quickly actioned at HUTH.
- Some staff reported feeling confident to approach line managers but advised that they seldom saw other senior leaders and felt not able to approach them. This contradicted the perspective of the leadership team who thought they were very visible. We recommend that the leadership team should ask staff what they would like to see more of – walk rounds, presence at meetings, written information etc.
- The birth pool area was full of clutter and looked to be not in use on labour ward; the area was described as ‘not welcoming’. Staff reported a lack of confidence to facilitate water births. Recent local work on ‘birth in water’ locally in conjunction with Oxford Brookes University has been carried out and there are opportunities to use this as a lever to promote/enable more births in the pool on the labour ward. We recommend that discussions be held with the labour ward leads to understand activity and demand, ensure the pool is usable and a consistent offer is being made to those who could benefit.

- The visiting teams reported a disconnect between staff on labour ward and the MLU – we recommend consideration of rotational posts as per East Kent report re: divisions of midwifery.
- A Maternity Incident Review Oversight Group (MIROG) has been established and terms of reference have been written. Further work is now required to ensure regular meetings are held with sufficient time to present cases, review incident reports and their outputs to ensure that learning responses contain strong actions appropriate to report findings prior to sign off; this will support many of the ongoing governance requirements.
- As part of the ongoing change to PSIRP governance processes, the team should now ensure mechanisms are in place to track, monitor and evidence improvements and actions generated from incident responses.
- There is still an outstanding requirement to articulate/document plans to involve MNVP leads and members in governance processes with timescales for achievement; we recommend that MNVP leads are immediately invited to relevant meetings where they can coproduce an agreement about the timings and levels of involvement.
- Some staff reported providing information in response to incident investigations and complaints but not being sighted on final results or the outcome of those complaints; we recommend that all those involved in the investigation or complaints also receive a copy of the outcome as it is distributed.
- Better internal communications around MSW upskilling/job roles are required to truly support and embed this development; the LMNS and other providers have good examples of this and can support this requirement if HUTH can identify a lead.
- It was felt by several stakeholders that communication and culture between wards continues to be poor generally. There is a two-year support programme from the HUTH ODT (Operational Development Team) on civility and culture underway and the ICB will also be supporting some work in 2024. The review team encourage ongoing engagement with these from staff at all levels.
- Evidence of a disengaged workforce was noted. Staff report very low morale in staff survey and conversations and described feeling overloaded and overworked. More input is needed so that individuals feel involved in the improvement work, again at all levels.
- Better utilisation of the existing PMA function and potential deployment and embedding of the A-EQUIP model (including Restorative Clinical Supervision) could help provide welfare and wellbeing support to staff. Again, the new Recruitment and Retention lead could also be involved in supporting this improvement.
- The review team felt that choice options/discussions could be improved including increased promotion of the MLU and home birth; we do acknowledge the staffing difficulties restrict these options currently but would be happy to offer additional support as staffing issues decrease. It was suggested that alternative options around a more diverse workforce could be utilized LMNS wide.
- Maple Ward – we felt there was a missed opportunity to display information on induction and birth choices in areas of the ward that service users most visit; leads should identify relevant information and display this as soon as possible.
- The review team also noted that the loss of Maternal Mental Health Services and the HUTH local birth afterthoughts service was described as ‘being felt’ by staff. The former is currently being escalated at an ICB level and we would encourage local stakeholders to be involved in discussions about this and the resumption of birth afterthoughts services in 2024 to ensure that all avenues are explored and service users are able to input into improvement.

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				

	2023		
	Oct	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	Aspirin not prescribed to a woman which may have affected the outcome for the baby pathway being reviewed	A woman did not receive steroids or antibiotics which may have affected the outcome for the baby Development of guideline surrounding Extreme Preterm SROM antibiotic therapy and repeating steroids pathway	A woman presented at community midwife with reduced fetal movements and was not referred Any woman that mentions that they Have reduced fetal movements even if they state that they are now felt, consistent advise to be given and referred to antenatal triage
1a Number of cases referred to MNSI/ENSR	0	0	1
1c Number of family's informed of referral to MNSI/ENSR	0	0	1
2. Findings of review of all cases eligible for referral to HSIB	Nil reported	Nil reported	See page 20 for incident detail
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	**1 Catastrophic** **4 moderate** Escalated to WPSS 1 PSII 2 AAR 2 downgraded following investigation	**3 Catastrophic** **2 Moderate** Escalated to WPSS 1 PSII 2 AAR 2 downgraded following investigation	**2 Catastrophic** **3 Moderate** Escalated to WPSS 1 MNSI referral 3 downgraded following investigation
4.Staff feedback from frontline champion and walk-abouts	Staff have reported high acuity and issues with the Induction pathway – task and finish group set up to address	Staff have reported that the operational matron is with the Induction pathway – task and finish group set up to address	Staff have reported improved triage performance and better environment following estates works and access to refreshment.
Birth rate + red flag reported	**13 red flags reported** 9 missed or delayed care 1 delay in providing pain relief 1 delay between admission for induction of labour and commencement 1 delayed or cancelled time critical activity 1 Labour ward Co-ordinator not supernumerary caring for woman in established labour	**7 red flags reported** 2 delayed or cancelled time critical activity 1 labour ward co- ordinator not supernumerary caring for woman in established labour 1 missed medication 1 delay between admission for IOL and commencing process 1 delay between presentation and triage 1 missed or delayed care	**6 red flags reported** 2 delay between presentation and triage 2 delay between admission for IOL and commencing process 1 delayed or cancelled time critical event 1 missed or delayed care
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	n/a	The Trust received a letter from NHSE regarding compliance with CNST year 4 , the trust were invited to review the submission following the CQC report	Following the submission from CNST year 4 review NHSE invited the Trust to review year 3 submission
6.Coroner Reg 28 made directly to Trust	0	0	0
07.Progress in achievement of CNST 10			5/10 compliance

(Maternity Incentive Scheme Safety Action 9)

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 October – December 2023 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

1. PSII/2023/19595 Incident details
Booked with second pregnancy previous spontaneous birth but baby was small. The woman was a smoker CO 13 at booking. The woman was on the methodone programme with a plan for 40 weeks and 7 days for induction of labour. Antenatal care in line with local guidance deviation from national guidance due to smoker and required Growth assessment protocol had a growth scan at 32 weeks due to drop in Fundal height. At 40 weeks gestation the woman presented at routine community appointment with reduced fetal movements, however during the appointment the woman then reported that she could feel movements and a plan was made not to attend Antenatal Triage as baby was very active. The woman was given safety netting advice and the midwife completed a Midwife completed Stretch & Sweep, and fetal heart auscultated post pre and post procedure. The cervix was slightly dilated, with a plan made for the woman to attend the Induction of labour clinic in 1 weeks' time. A urine sample was sent to off as per guidance for 1 plus of proteinuria .The woman was asked to attend Antenatal Triage as the woman had a raised Protein Creatinine ratio (PCR) and the woman reported reduced fetal movements. The midwife completed a full antenatal check and Intra uterine death confirmed on scan. The woman fed back that when she was in the community clinic the sound of baby's heartbeat was the same rhythm and sound that she heard in hospital. We cannot verify if this was fetal heart heard.

Immediate learning/actions
Bereavement care was given to the woman and staff involved were referred for Trauma Risk Management (TRiM) support. Any woman that mentions that they have reduced fetal movements even if they state that they are now felt, consistent advise to be given and referred to antenatal triage.

2. Awaiting reference number from Maternity and Neonatal safety Investigations (MNSI)

It was the woman's second baby previous normal vaginal birth. The woman went into spontaneous labour at 40 weeks and 5 days and was planned for a low risk birth on the Fatima Allan birthing centre. Care was transferred to labour ward at the point the woman requested an epidural. A CTG was commenced and reviewed and was documented as none reassuring. Decision for trial in theatre was made. Baby was born by forceps delivery in poor condition. Apgar's 1, 6, and 9, cord gasses low and met criteria for cooling. The Baby's MRI was later reported as normal. This woman's care meets the criteria for external investigation by MNSI.

Immediate learning/actions

- CTG 18:30hrs reviewed as 'suspicious' if categorised 'Abnormal' may have changed management of care.
- Woman's care used for teaching by fetal monitoring leads.
- Clinicians involved in woman's care have undertaken reflections.

Serious incident investigation - completed

There was one internal Serious Incidents for Maternity closed November 2023 (2023-110414). Immediate learning response **Appendix 2**

ACTIVE INVESTIGATIONS

At the time this report there are currently five active investigations, three are being supported by the Patient Safety Team and one is an 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	Number of days open for investigation	Date Due at MIROG	Date Due to LFPSE	Family Involvement
Comprehensive	PSII/2023/15178	**174**	TBC	TBC	No questions from Family
Comprehensive	PSII/2023/16089	**143**	TBC	TBC	The family are being supported by the bereavement team and have contributed to the Perinatal mortality review meeting
Comprehensive	PSII/2023/19595	**98**	TBC	TBC	The family are being supported by the bereavement team and have contributed to the Perinatal mortality review meeting

External Investigations

There is one external investigation DATIX W296616 declared on STEIS in December 2023.

Patient Experience update to Board

Complaints and PALS

- Overall, the Maternity Service provides an improving patient experience and in comparison to the wider Trust, receives minimal PALS and Complaints.
- The Maternity Service received the following between April and December 2023:
    - 58 PALS cases (in comparison to 2,340 Trust-wide – 2.4% of PALS within Maternity). Only 5 of which were received for ADU – all are closed and resolved.
    - 17 formal complaints (400 received Trust-wide – 4.2% of complaints in Maternity). Only 5 of which was received for ADU – 5 complaints remain open.
    - 50 compliments (324 received Trust-wide – 15.4%). All are shared with the relevant areas. However, it is acknowledged that there is more work to do to capture compliments in Maternity, which currently excludes the numerous thank you cards received by staff.

- Themes are treatment, delays, assistance with care, comfort and attitude.
- The delay issues encountered earlier in the year have subsided following the work in ADU in respect of triage, with 95% of patients seen in targeted waiting time in January 2024.

Friends and Family Test for Maternity

Hull has sustained a positive FFT Birth Score for Maternity for May to November 2023 from nationally available data.

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Organisation
98%	100%	96%	96%	100%	94%	97%	100%	Hull University Teaching Hospitals
94%	96%	96%	100%	100%	100%	98%	100%	Northern Lincolnshire and Goole
100%	95%	100%	100%	100%	100%	98%	98%	York and Scarborough Hospitals

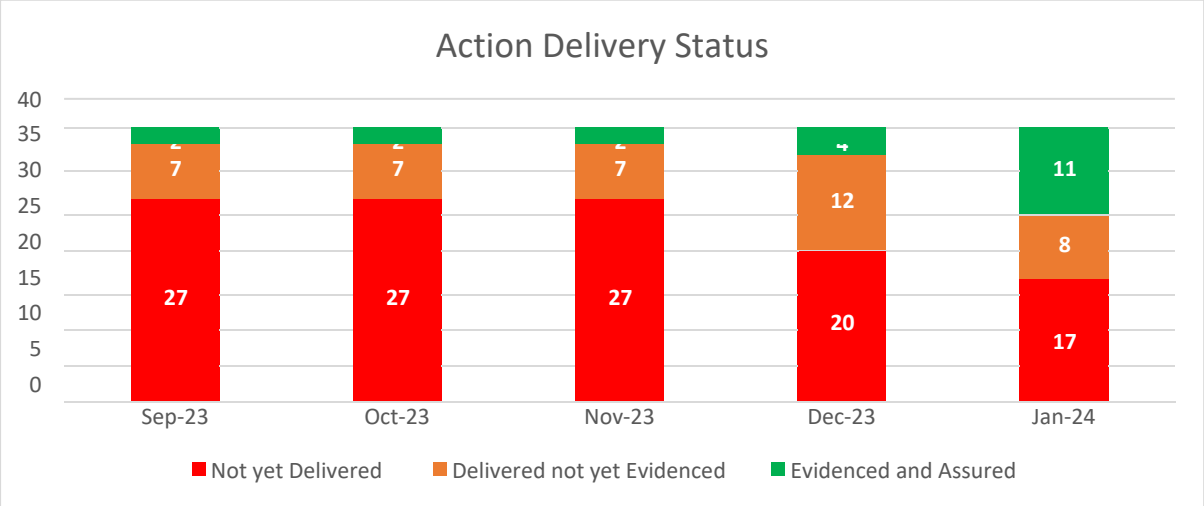
CQC Maternity Transformation Assurance Committee (MTAC) Update on Actions

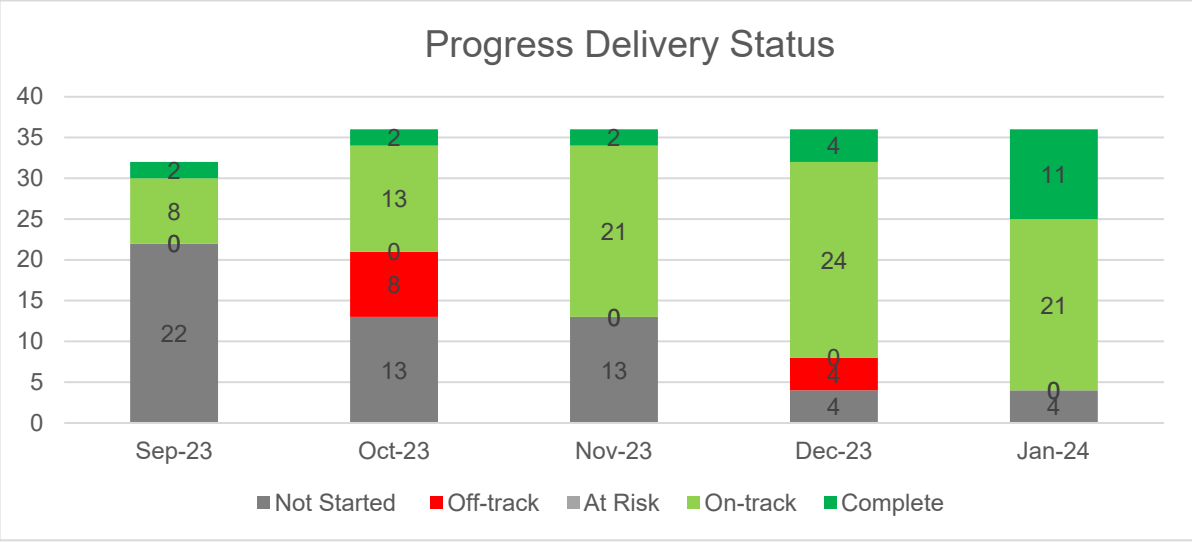
The Executive Directors resolve to establish the Maternity Transformation Assurance Committee (MTAC), which is responsible to Trust Executive, The Quality Committee, and the Trust Board

This is an assurance committee, and is responsible for the oversight, monitoring, and overall governance and assurance 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 is developed]*.

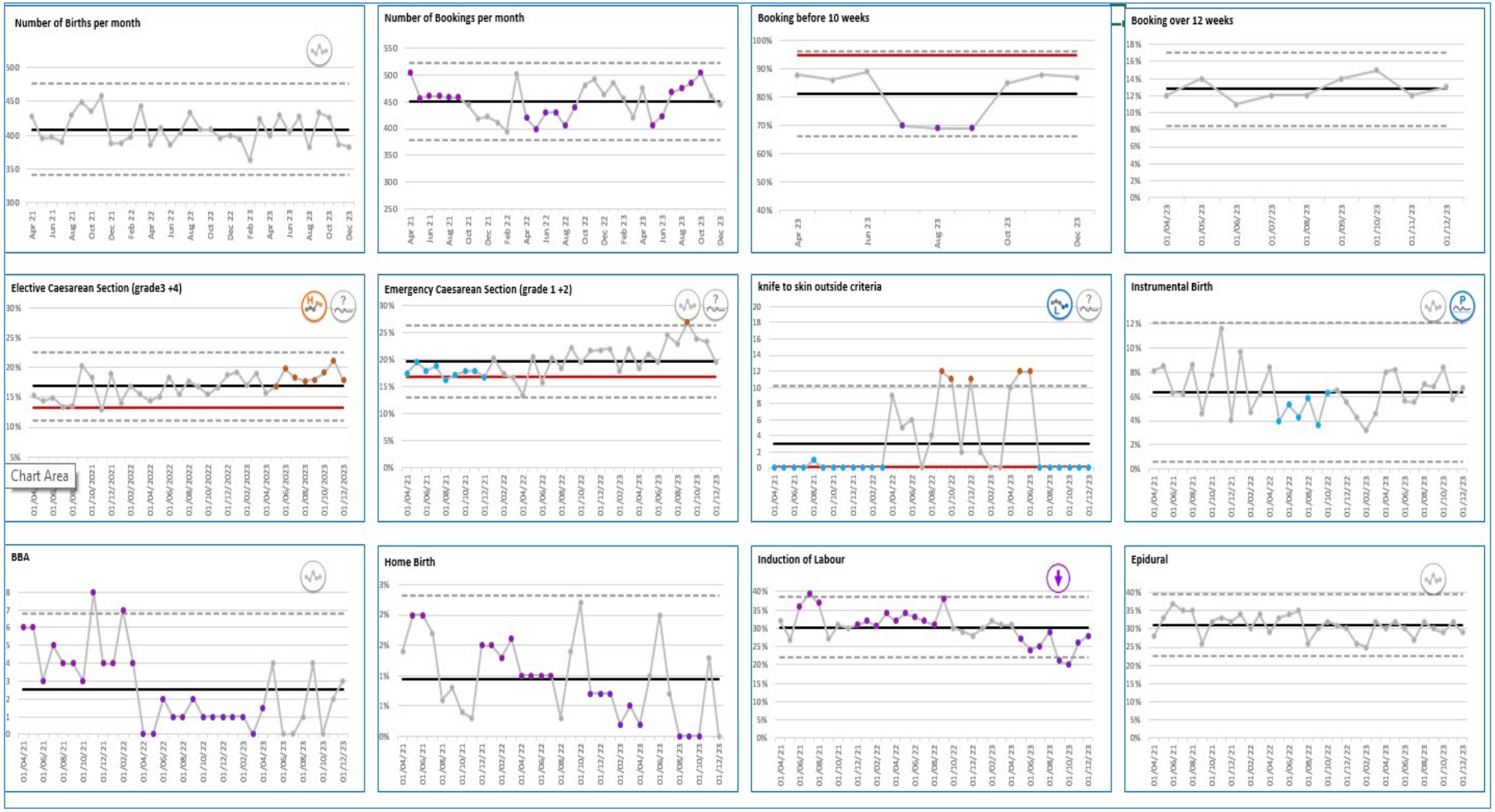
This is to ensure continuous improvements in the quality of care (safety, effectiveness and experience) provided to women and families. This includes ensuring continued, sustained and evidenced improvements throughout maternity services, and for taking corrective action, where required.

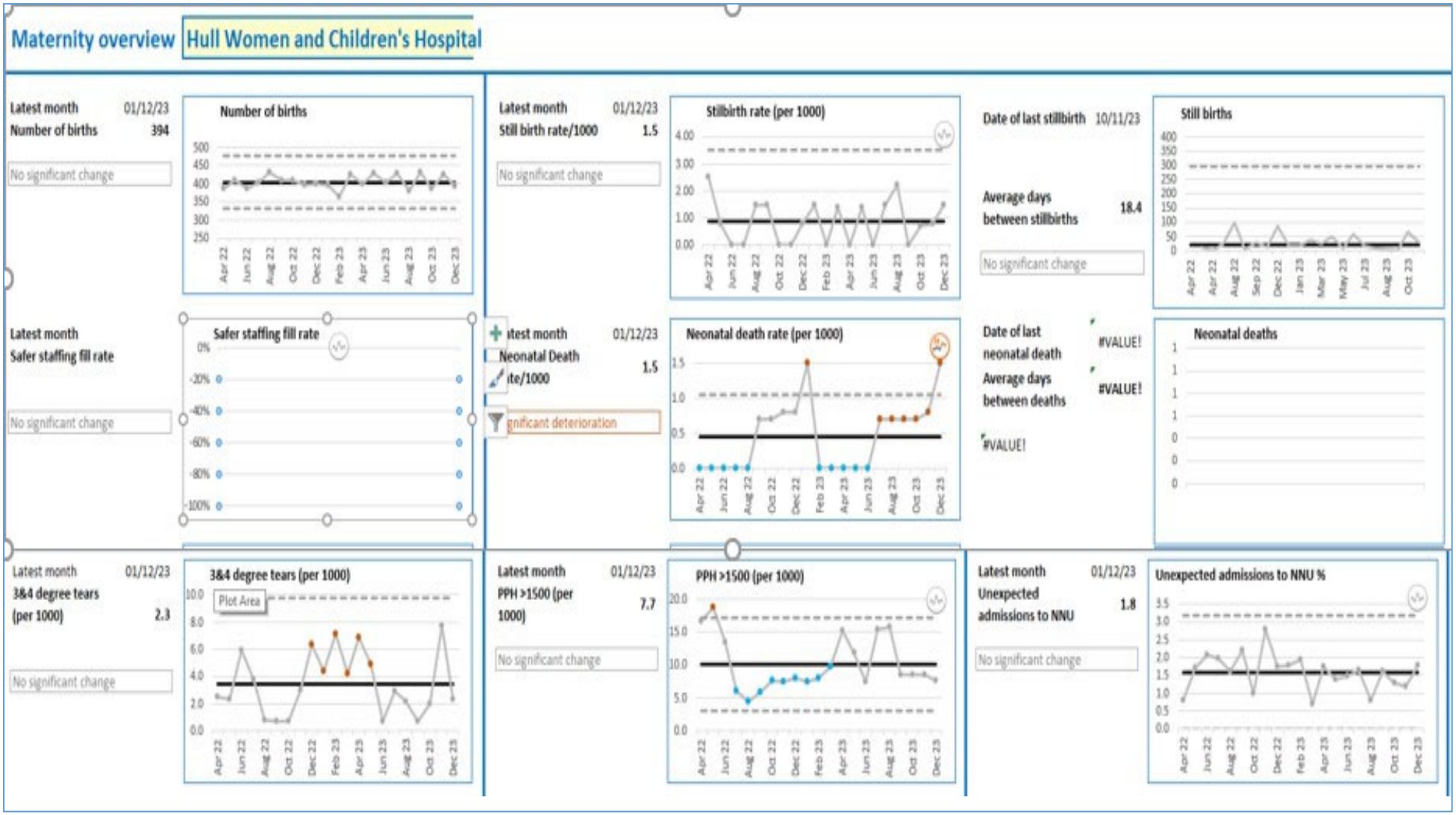
The Maternity Transformation Programme Group (MTPG) will report and account to this committee. MTAC meetings are fortnightly and below is an update of CQC action delivery status.





Maternity Services Dashboard – December 2023




Maternity overview
Hull Women and Children's Hospital
Latest month 01/12/23
Number of births 394
No significant change
Number of births
Latest month
Safer staffing fill rate
No significant change
Safer staffing fill rate
Latest month 01/12/23
Still birth rate/1000 1.5
No significant change
Stillbirth rate (per 1000)
Date of last stillbirth 10/11/23
Average days between stillbirths 18.4
No significant change
Still births
test month 01/12/23
Neonatal Death ite/1000 1.5
gnificant deterioration
Neonatal death rate (per 1000)
Date of last neonatal death #VALUE!
Average days between deaths #VALUE!
#VALUE!
Neonatal deaths
Latest month 01/12/23
3&4 degree tears (per 1000) 2.3
No significant change
3&4 degree tears (per 1000)
Plot Area
Latest month 01/12/23
PPH >1500 (per 1000) 7.7
No significant change
PPH >1500 (per 1000)
Latest month 01/12/23
Unexpected admissions to NNU 1.8
No significant change
Unexpected admissions to NNU %

Dashboard Narrative

Neonatal deaths

Please note the increase in neonatal death rate is being measured on per 1000 obstetric bed days and not per neonatal bed days. All Neonatal deaths, which meet the PMRT criteria, investigated through this process. In the month of December 2023 Hull University Teaching Hospitals have reported 1 neonatal death. This has been reviewed through the PMRT process- Case ID: 89684 27 week gestation, neonatal death which was graded as B (neonates) which demonstrates that the care management was appropriate. No Coroner's inquest

Postpartum haemorrhage

The graph demonstrates a significant fall in PPH over 1499mls. In June 2022, the service launched the 'PPH proforma' which is used in all areas which has contributed to this trajectory. In addition for continuous quality improvement the service have a registered audit in place for all PPHs >500-1499 mls in order to gain an insight into the care provided in the smaller postpartum haemorrhages.

3rd and 4th degree tears

The graph demonstrates that they appears to be a rise in the month of November in incidents however this is not a significant amount to cause concern. All 3rd and 4th degree tears are now reported as moderate incidents on the Trusts incident reporting system and reviewed as part of the Maternity Incident Review Meeting (MIRM). MIRM is a three times per week incident review meeting held with the Multi-Disciplinary Team. MIRM was initiated following the CQC inspection in March 2023. All moderate incidents and above are presented at the Trust Weekly Patient safety summit for discussion and decision for the appropriate learning tools

Knife to skin outside criteria

The business report where this information is collating from is incorrect there appears to be an error on the information, submitted in Lorenzo (trust digital system). The service has a registered audit, which demonstrates compliance against NICE guidelines for these criteria.

Instrumental rate

The service has a decreasing overall trend with instrumental births however; both the Emergency caesarean section and Elective caesarean section rates are increasing. In May 2021 the service had a high profile coroner's case were sadly a baby died from a Keilands forceps birth, even though no action was taken against the Trust this may have contributed to woman's perception of the safe modes of birth in our community. In addition, in March 2022 maternal choice added into the NICE guidelines, which may have been a contributing factor with the mode of birth.

APPENDIX 1 - PMRT Newsletter

What happens in HUTH?

Monthly PMRT meeting with a multidisciplinary team

Dates for 2024 to be published soon

22 weeks, stillbirths, neonatal deaths and postnatal deaths on NICU are reviewed utilising the PMRT on-line tool *(excluding MTOP's)*

Parents provide feedback for the review.

Verbal or written responses to their questions are provided

PMRT meetings now have external representation at all meetings

Mrs. Fan is the Obstetric Consultant Lead for PMRT

Thank you to Mrs. Sivakumar for leading PMRT for the previous 5 years

Grading of care is agreed by the team at the meetings and the review is completed.

A report is written and published as soon as possible

PMRT Statistics

22 PMRT cases up to date in 2023

14 SB's & 8 NND's

13 cases are completed and 9 remain under review

One cases has been investigated externally by HSIB and the report is pending

Two cases have been referred for PSII investigations

Learning points from October PMRT reviews

Reminder to use AmniSure when SROM suspected to aid confirmation

Every effort should be made to have an appropriate interpreter service

Ensure a CO reading is undertaken at all booking appointments and document reason if unable to undertake

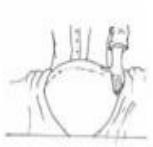
Offer smoking cessation referral to family members when indicated

Ensure all available postnatal investigations are offered to women following a bereavement

Ensure women are offered and receive adequate pain relief in labour regardless of stage of labour

APPENDIX 2 – shared Learning (GAP Presentation)

Growth Assessment Protocol
(GAP) Newsletter
Shared Learning



Important News

News for you in our work around referral & detection of small for gestational age (SGA) babies (under 10th centile):

Our quarter 2 data (July- September 2022) showed our referral rates for USS based on fundal heights dropped to 39.2% (it is normally around the 45% rate) and in October 2022, it dropped to 29.8%

It is really important to refer for an USS based on fundal height not following the curve expected for that baby, and think/reassess risk factors at every antenatal contact. Growth USS can be booked directly on Lorenzo or by contacting the USS department

News

Please read our Trust GAP guideline aligned with the requirements o Saving Babies Lives Version 2 (Risk Assessment & Surveillance of the SGA fetus – Guideline 704)

This has changed the:

GAP USS pathway/gestations for certain clinical/obstetric issues
Definition of Fetal Growth Restriction
GAP pathway and smoking
GAP referral form used at booking

Remember to continually screen throughout pregnancy for the identification of risk factors for a small for gestational age fetus

Datix

DATIX Reporting

Please continue to keep reporting all missed antenatally detected low birthweight centile babies via the DATIX categories for these.

Please DATIX these using the mother's details, rather than the babies details.

From this information given to the Perinatal Institute, we now have our eighth report with common themes for learning

Datix

8th Report

Data from 31 cases from late July 2022 – mid November 2022

Concentrates on missed babies born SGA but not recognised antenatally on USS or fundal height or both

The biggest risk factor continues to be:
Maternal smoking (any) – 35.5% (Perinatal Institute considers any smoking, regardless of CO readings)

Increased risk factor from the previous report:
BMI>35 – 16.1% (increased from 12.9%)
When providing antenatal care for women with these risk factors, be especially aware that SGA may occur

The report

Outcomes of the 31 cases

48.4% underwent induction of labour (huge decrease from 73.3% in the last report), mostly for other reasons other than fetal growth concerns as other clinical factors played a role

41.9% were born by LSCS (increased from 36.7% in last report) and 3.2% by instrumental birth (decreased from 10% in last report)

3.2% (N=1) of babies were admitted to NICU (not for prematurity) which is very good news

TOP TREND & LEARNING POINT:

Growth problems not being recognised (35.3%) – a large increase from 13.3% in the last report

There have been some missed opportunities for USS referral when fundal heights have increased or decreased, some incorrect geography stated as ethnic origins for the growth charts and some missed GAP referrals completely eg for BMI>35

Learning Points

Think risk when booking ladies & throughout pregnancy
Book for USS when need based on fundal height measurements
Check your geography when stating ethnic origins for ladies

GAP TRAINING

You will be able to get your annual fundal height assessment done on your MDT2 training day

Your GAP online training (2 modules) are via HEY 24/7 which links to the e-LfH site – you may already have a log in previously for this

If you do not have a log on for e-LfH, please go to their log in page via your HEY 24/7 which takes you to the e-LFH log in page where you can email them, raise a support ticket or they have a live chat function to use

When you have completed your online training, it will be updated after the end of the month in which you complete

APPENDIX 3 – Learning From Incidents (One page learning response)

INCIDENT LEARNING RESPONSE

What happened? Pre term birth - SI- 2023/110414

The woman booked for maternity care at York and Scarborough Teaching Hospitals NHS Foundation Trust. It was the woman's second pregnancy the woman was referred to Consultant care due to pre-eclampsia in the previous pregnancy. The woman was admitted to York Maternity hospital on the 24 January 2023 at 21 weeks and 6 days gestation as her ' waters' had spontaneously ruptured .
On the 30 January 2023 a plan of care was made with the woman and the York Obstetric Consultant made a plan to transfer to Hull University Teaching Hospital. On arrival to Hull Teaching Hospitals, the Neonatal team were informed of the woman's admission and a plan made for active survival management. It was documented in the care notes that woman is on bed rest. The Hull Teaching Hospitals Obstetric Registrar reviewed the woman's plan of care shortly following arrival, and the woman stated that she had increased pressure in the vagina.

The woman felt strong urges to push, the Neonatal team where present the woman continued to push, at 23:17 the Obstetric Registrar performed an artificial rupture of the membranes. The woman continued to push but the baby was not born. The woman's contractions subsided and the woman was left to rest. At 01:10, the woman moved from the bed to the commode for urination and felt a strong urge to push the baby was born with a Midwife present. The Neonatal team arrived when the baby was 48 seconds of age and transferred the baby to the Neonatal intensive Care Unit (NICU) the baby sadly died the following morning. York and Scarborough Teaching Hospitals NHS Foundation Trust reviewed the care in March 2023 for maternity care and the Perinatal Mortality Review Tool (PMRT) was commenced. The review tool was completed by Hull Teaching Hospitals in May 2023 and graded that care received at Hull Teaching Hospitals may have affected the outcome for the baby

What we learnt

The panel concluded that they is no evidence either Locally or Nationally to support Performing an artificial rupture of membranes in pre term birth to aid progress. Therefore the panel are unable to state if the ARM may have changed the outcome for this baby

The panel concluded that the mother's risk factors where not appropriately reviewed by an Obstetric Consultant or involvement in the management plans for her birth prior to the establishment of labour or elective delivery. In accordance with the Roles and responsibilities of a consultant Twice-daily consultant led and present multidisciplinary ward rounds SOP – 665 and The roles and responsibilities of the Obstetrics and Gynaecology Consultant providing acute care- SP736

The panel concluded that the Midwife acted within National guidelines by advising the woman to get up out of the bed for a shower. The panel concluded that they is no evidence either Locally or Nationally that restricting a woman's movements reduces preterm birth

The woman should have received one to one midwifery care following the ARM

Our Promise To women

We will - re audit of Consultant attendance at the criteria as set in the Role and Responsibility of the Consultant Providing Acute Care in Obstetrics and Gynaecology into the Service in Accordance with the RCOG Workforce The woman's journey to be shared for learning at the perinatal mortality Meeting

A review of the pre term birth guideline around augmentation of birth to provide clarity on artificial rupture of membranes in pre term labour

A review of the pre term birth guideline around providing one to one care when a woman is in the antenatal and intrapartum period of pre term birth.

Northern Lincolnshire and Goole NHS Foundation Trust

Maternity & Neonatal Oversight Report

January 2024

(Nov 2023 data)

1 Workforce/Staffing

	Registered	Unregistered
DPOW	13.2 WTE	3.6 WTE
SGH	9.8 WTE	2.8 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 1:20.84 in November (DPOW 1:21.39 and SGH 1:20.14) which is better than the acceptable ratio of 1:28. 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 Nov 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.7%**	**▲ 2.4%**	**76.1%**	**▲ 0.1%**	**11.3**	**▲ 1.61**
Registered Nurses and Midwives	88.5%	▼ 0.0%	69.8%	▼ -1.2%	7.0	▲ 0.83
Care Staff	97.3%	▲ 6.6%	87.2%	▲ 2.3%	4.4	▲ 0.78
Central Delivery Suite	**83.4%**	**▼ -10.7%**	**53.4%**	**▼ -11.3%**	**26.3**	**▼ -5.80**
Registered Nurses and Midwives	84.1%	▼ -13.0%	51.5%	▼ -11.5%	21.3	▼ -5.30
Care Staff	80.3%	▼ -1.5%	61.0%	▼ -10.6%	4.9	▼ -0.50
Jasmine & Honeysuckle	**91.4%**	**▲ 3.7%**	**75.3%**	**▼ -1.2%**	**16.4**	**▲ 1.06**
Registered Nurses and Midwives	87.1%	▲ 4.6%	68.4%	▼ -2.6%	10.5	▲ 0.80
Care Staff	100.4%	▲ 2.0%	89.5%	▲ 1.6%	5.9	▲ 0.26
Ward 26 SGH	**78.0%**	**▼ -4.2%**	**44.5%**	**▼ -15.1%**	**6.1**	**▼ -0.28**
Registered Nurses and Midwives	74.9%	▼ -3.1%	35.4%	▼ -14.5%	4.2	▼ -0.14
Care Staff	86.3%	▼ -7.0%	69.3%	▼ -16.5%	1.8	▼ -0.13
Total	**86.8%**	**▼ -1.7%**	**63.9%**	**▼ -6.1%**	**11.8**	**▲ 0.28**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	61.5%	▼ -1.6%
Central Delivery Suite	81.2%	▼ -1.8%
Jasmine & Honeysuckle	64.1%	▲ 0.8%
Ward 26 SGH	70.2%	▲ 0.8%
Total	**68.2%**	**▼ -1.0%**

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

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

Fill Rate Dashboard **Nov 2023**
By day or night - display may exceed pri

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	1,035.0	1,070.3	103.4%	1,035.0	1,045.2	101.0%	690.0	578.5	83.8%	690.0	632.5	91.7%
NICU DPoW	1,725.0	1,141.8	66.2%	1,725.0	1,224.5	71.0%	690.0	471.5	68.3%	690.0	396.5	57.5%
Total	**2,760.0**	**2,212.0**	**80.1%**	**2,760.0**	**2,269.7**	**82.2%**	**1,380.0**	**1,050.0**	**76.1%**	**1,380.0**	**1,029.0**	**74.6%**

The fill rate for Registered Nurses (RN) at Scunthorpe NICU remains above the target of 95% for both days and nights.

At Grimsby 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 a deterioration in month sue to sickness absence. 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 active and an improvement is anticipated over the next 3 months.

The 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 **Nov 2023**

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

Staff	Registered Nurses and Midwives				Care Staff				Nursing Associates				**Total**			
Ward name	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	**Actual Hours**	**Patients**	**Planned CHPPD**	**CHPPD**
NICU SGH	2,115.4	249	8.3	8.5	1,211.0	249	5.5	4.9		249			**3,326.4**	**249**	**13.9**	**13.4**
NICU DPoW	2,366.3	215	16.0	11.0	868.0	215	6.4	4.0		215			**3,234.3**	**215**	**22.5**	**15.0**
Total	**4,481.7**	**464**	**11.9**	**9.7**	**2,079.0**	**464**	**5.9**	**4.5**		**464**			**6,560.7**	**464**	**17.8**	**14.1**

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.

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

2 Patient Experience/Service User Feedback

The following section details the feedback received via Formal Complaints, Patient Advice and Liaison Service (PALS) concerns, Compliments and the Friends and Family Test (FFT). This information is taken from November 2023 information and includes performance data and themes.

Formal Complaints and PALS Data

* **KPI** -Key Performance Indicator

Table A

Obstetrics	**Jun-23**	**Jul-23**	**Aug-23**	**Sept-23**	**Oct-23**	**Nov-23**
Number complaints open/ongoing	5	6	5	5	6	2
Number of open complaints out of timescale	0	1	1	1	1	0
Number complaints closed this month	0	1	2	3	0	4
Number of new complaints	2	3	1	3	0	1
	Jun-23	**Jul-23**	**Aug-23**	**Sept-23**	**Oct-23**	**Nov-23**
Number of PALS open	2	3	3	2	2	2
Number of PALS out of timescale	1	2	2	2	2	0
Number of PALS closed this month	9	5	4	6	4	4
Number of new PALS	7	6	4	5	4	4
	Jun-23	**Jul-23**	**Aug-23**	**Sept-23**	**Oct-23**	**Nov-23**
% of complaints closed within timescale (KPI 85%)	0%	100%	50%	33%	0%	75%
Average length of time to respond to complaints closed (working days)	0	29	32	55	0	50
% of PALS closed within timescale (KPI 60%)	33%	80%	25%	66%	25%	25%
Average length of time to respond to PALS closed (working days)	12	4	17	7	12	10

Children & Young People including Neonates	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**
Number complaints open/ongoing	5	3	5	5	1	3
Number of open complaints out of timescale	0	0	0	2	0	0
Number complaints closed this month	1	2	2	1	2	0
Number of new complaints	2	1	2	1	0	3
	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Number of PALS open	5	7	7	3	2	1
Number of PALS out of timescale	2	4	4	0	2	1
Number of PALS closed this month	11	7	12	9	11	10
Number of new PALS	11	9	12	5	8	9
	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Oct-23
% of complaints closed within timescale (KPI 85%)	100%	100%	50%	0%	0%	N/A
Average length of time to respond to complaints closed (working days)	54	44	32	64	74	0
% of PALS closed within timescale (KPI 60%)	18%	71%	17%	33%	18%	60%
Average length of time to respond to PALS closed (working days)	14	5	12	17	13	6

November saw 4 formal complaints closed in Obstetrics, with 75% (3) closed in timescale, with 2 ongoing complaints open – 0 of which being out of timescale. 1 new complaint was logged, with the Theme being lack of Support for Mental Health. The central team continue their work with the Divisional Medical Director and Associate Chief Nurse for Family Services to address complaints in a timely and appropriate manner.

There were 4 new PALS concerns, 2 Clinical Treatment, 1 Nursing Care and 1 Communication. 25% of closed PALS concerns achieved the 5-day timescale for closure, this is a continued deteriorated position alongside the previous month (25%) and falls below KPI for this report. 2 concerns remain open, both of which are within timescale.

Children and Young People received 3 new formal complaints. 0 complaints were closed this month, but none were out of timescale, so a percentage is not applicable for this month's reporting.

Nine new PALS concerns were logged, main theme related to delays/cancelations in appointments (4), clinical treatment (3) and Communication (2). These are all related to paediatric areas and not neonatal areas. 60% of the 10 PALS closed were in timescale (against a KPI of 60%), with an average of 6 days to close a concern being noted.

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. However, with the Patient Experience Lead being relatively new in post and a fluctuating performance for Complaints and PALS a meeting has been arranged with both Associate Chief Nurses (ACN) to discuss causes and explore where further support can be offered. This will allow the Lead to establish a robust plan of action with the ACNs to work towards improved performance, provide assurance and increase oversight.

Three compliments were formally logged on Ulysses in November: 2 Paediatric/Neonate (SGH) and 1 Obstetrics (SGH). They relate to compassion, support and the excellent care given.

Maternity collected 71 pieces of Friends and Family Test feedback (FFT), with 48 at Diana, Princess of Wales (DPOW) and 21 at Scunthorpe General Hospital (SGH), 68 were rated positive and 3 rated negative. Children and Young people collected 14 FFT feedback; 8 at SGH and 6 at DPOW with all rating positive. Our new FFT system is now live in Maternity from December (Phase 1). Numbers for Maternity should start to see an increase in the coming months – Ward FFT will continue with the current interim collection plan.

2.1 Maternity Survey 2023

The 2023 National Maternity Survey shows a consistent position for Northern Lincolnshire and Goole NHS Foundation Trust, in comparison to the 2022 survey, with positive or maintained improvements to our internal and external benchmarking scores.

The Trust showed improvement in 4 out of 4 of its patient focussed agreed actions from the 2022 survey and the following actions will carry over for continued improvement:

- Offered choice of where to have baby
- Partner/companion involved during labour and birth
- Found partner was able to stay with them as long as they wanted (in hospital after birth)

The Trust in comparison to the other 61 trusts rated on average better in the following areas:

- ✓ Asked about mental health by midwives (antenatal)
- ✓ Provided with relevant information about feeding their baby
- ✓ Able to ask questions afterwards about labour and birth
- ✓ Found hospital ward very or fairly clean
- ✓ Saw the midwife as much as they wanted (postnatal)
- ✓ Told who to contact for advice about mental health after having baby

- ✓ Received support or advice about feeding their baby during evenings, nights or weekends

The 2023 Maternity National Survey results are positive and show some improvements, whilst maintaining a positive experience for mother, baby and partner from the 2022 survey.

The GP Service results will be an agenda item at Northern Lincolnshire Women and Children's Board for discussion.

All data will be triangulated against other patient feedback sources. To ensure oversight the 3 areas highlighted in the survey are the proposed focus for 2023 - 2024. These actions will be transitioned into the overarching national survey improvement plan.

Divisional ownership of the actions will be monitored quarterly via Divisional Patient Experience Reviews, Patient Experience Group meetings and monthly via Divisional Quality Improvement and Monitoring Group, any escalations will be through Quality Governance Group.

3 Assurance

15 Steps Challenge data, Maternity and Neonatal Services November 2023
Two 15 Steps Challenge visits took place within Maternity and Neonatal Intensive Care Units (NICU) during November 2023. Ward 26, Scunthorpe General Hospital, achieved a rating of requires improvement, with further assurance required within standard 1 (observation of environment) and standard 2 (documentation).

NICU, SGH achieved a rating of Good, personal appraisal and development reviews (PADR) and Ward Assurance Tool (WAT) compliance was poor which impacted on the overall rating achieved.

Acute 15 Steps Challenge Visits			
Date of visit	Ward/ Department	Previous Rating	2023 Rating
21/11/2023	Ward 26, SGH	29/09/2022	21/11/2023
23/11/2023	NICU, SGH	20/09/2022	23/11/2023

*Rating Guidance

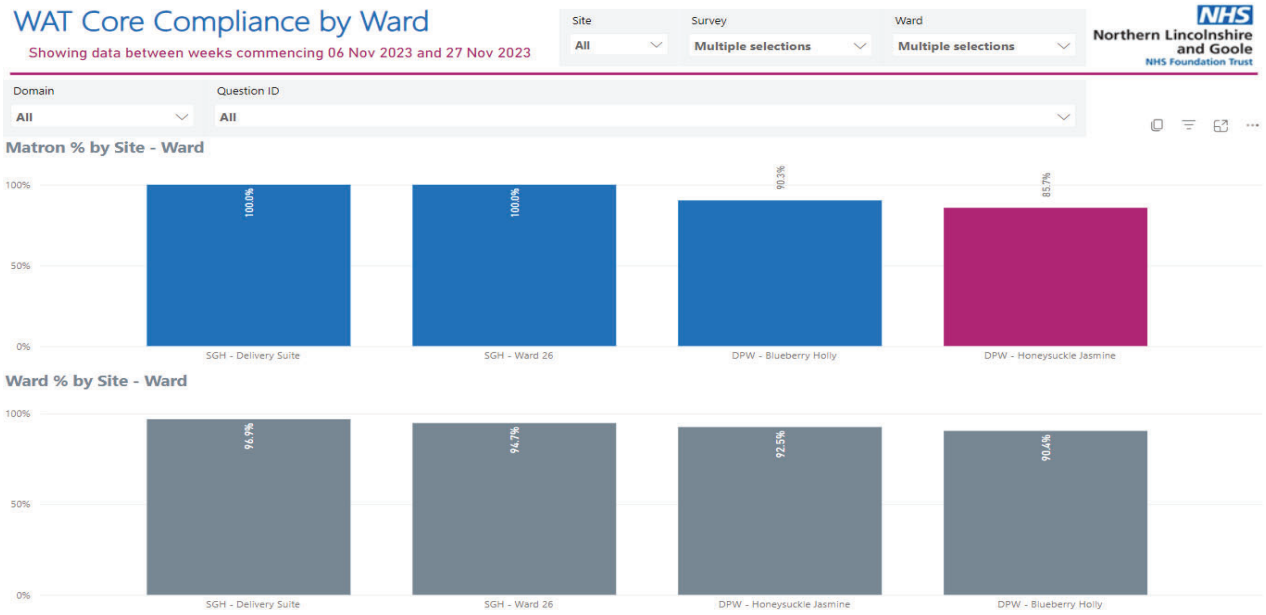
Outstanding	Good	Requires Improvement	Intensive Support

Supportive visits continue to take place across Women's and Children's Services to review individual 15 Steps improvement plans and gain further assurance with ongoing actions.

Ward Assurance Tool (WAT) data, Maternity and Services, November 2023
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).
Improved compliance noted across Matron Surveys completed in November.

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

Honeysuckle and Jasmine, fell below 90% compliance with quality standards on Matron surveys. Note minimal surveys completed in November by Matron and Manager for Ward 26 and Delivery Suite, SGH therefore compliance percentage for quality standards may be unreliable.

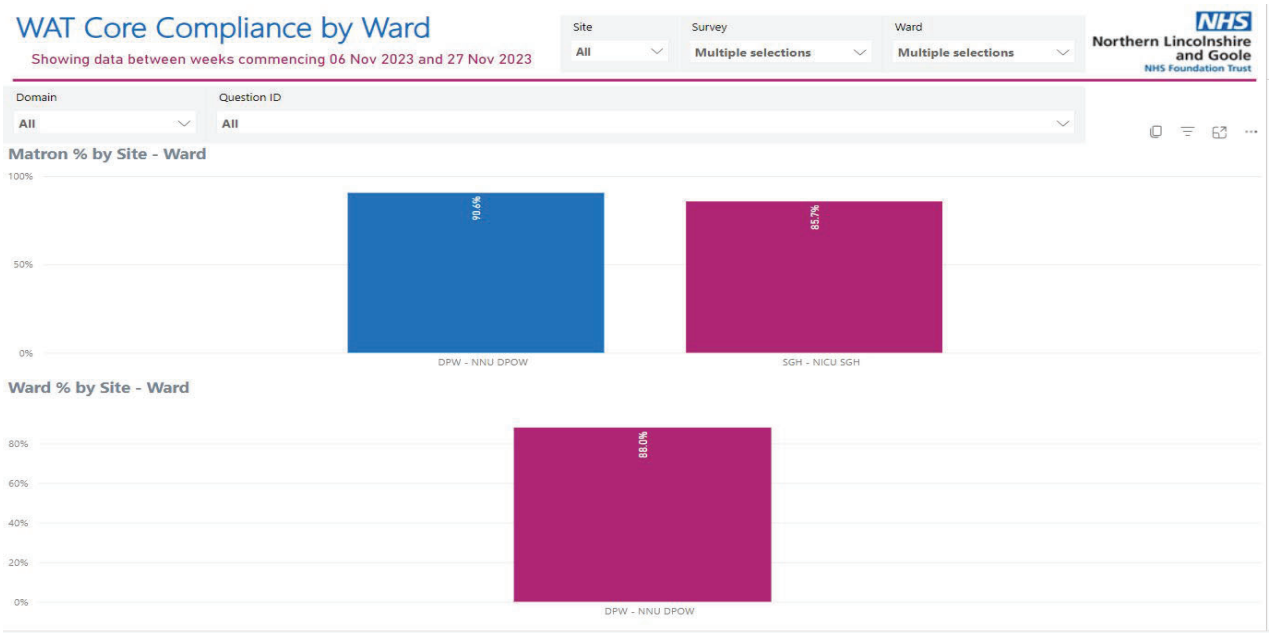


Ward Assurance Tool (WAT) data, Neonatal and Services, November 2023
The table below demonstrates individual number of assurance surveys completed across Neonatal Intensive Care units (NICU) out of an expected 4 by Manager and 4 by Matron per area, at DPOW and SGH. Note 0 Manager surveys and 1 Matron survey completed at SGH Neonatal Unit.

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

Unable to report Neonatal Unit SGH for Managers.

Neonatal Unit, SGH fell below 90% compliance with quality standards on Matron surveys and Neonatal Unit DPOW fell below 90% compliance with quality standards on Manager surveys.



The overall compliance with completing the Ward Assurance Tool across Maternity and Neonatal Services at SGH remains low, impacting the level of assurance with expected standards able to to be reported through Power Bi.

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.

The walkaround for November was undertaken at DPOW.

Escalated Issues:-

- No issues 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

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 improve safety, 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 16th October.

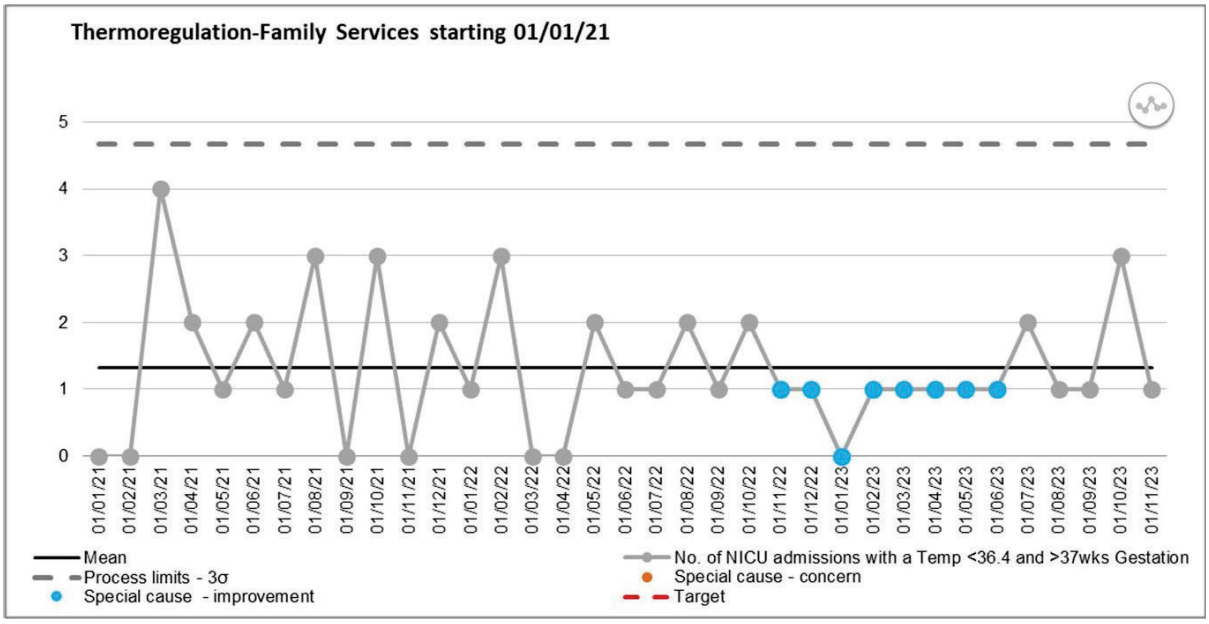
Reducing Thermoregulation

New-born babies following birth are at risk of thermoregulation (loss of body temperature) which can lead to other health related issues requiring admission to NICU. This Quality Improvement projects aim is to have no more than 10% of NICU admissions as a result of babies with a temperature outside of the optimal limits (<36.4) for babies >37 week gestation by 31st March 2023 (based on a baseline mean of >1 Jan 2021 – Jan 2023 equating to 97 babies).

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

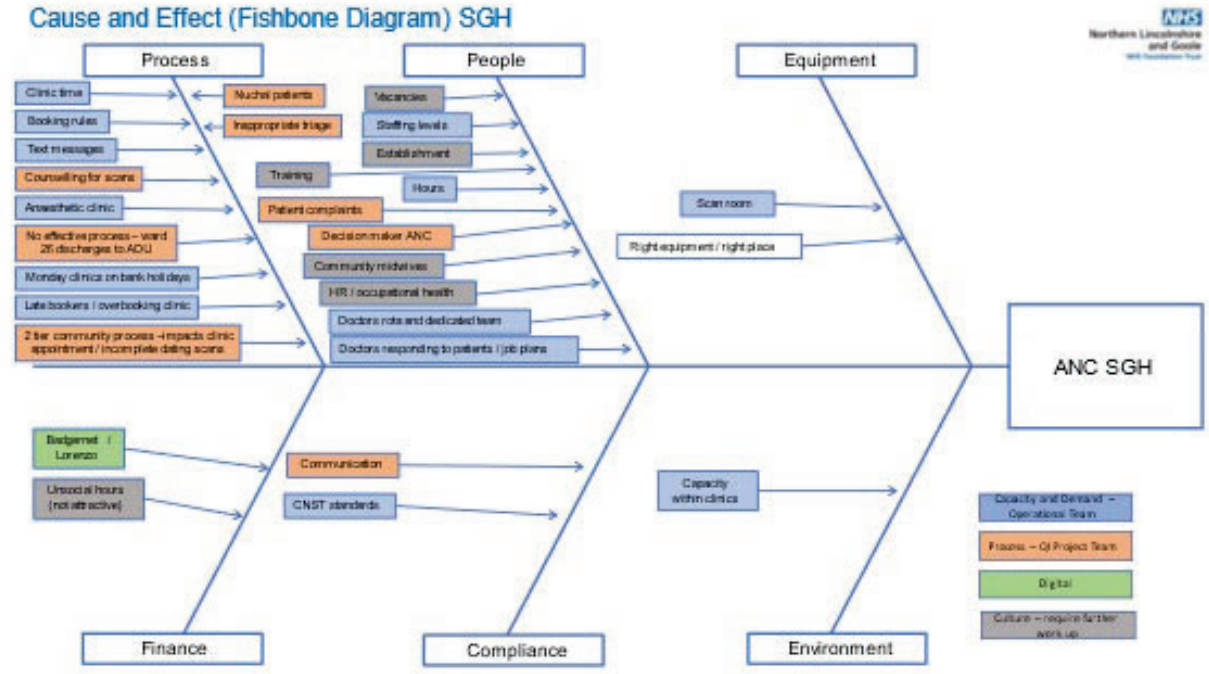
The below SPC chart shows an increase to 3 babies attending NICU for Thermoregulation during October before returning to 1 during November, however this is within normal variation and there is no special cause - concern. This is the first time since February 2022 that 3 babies within the criteria have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

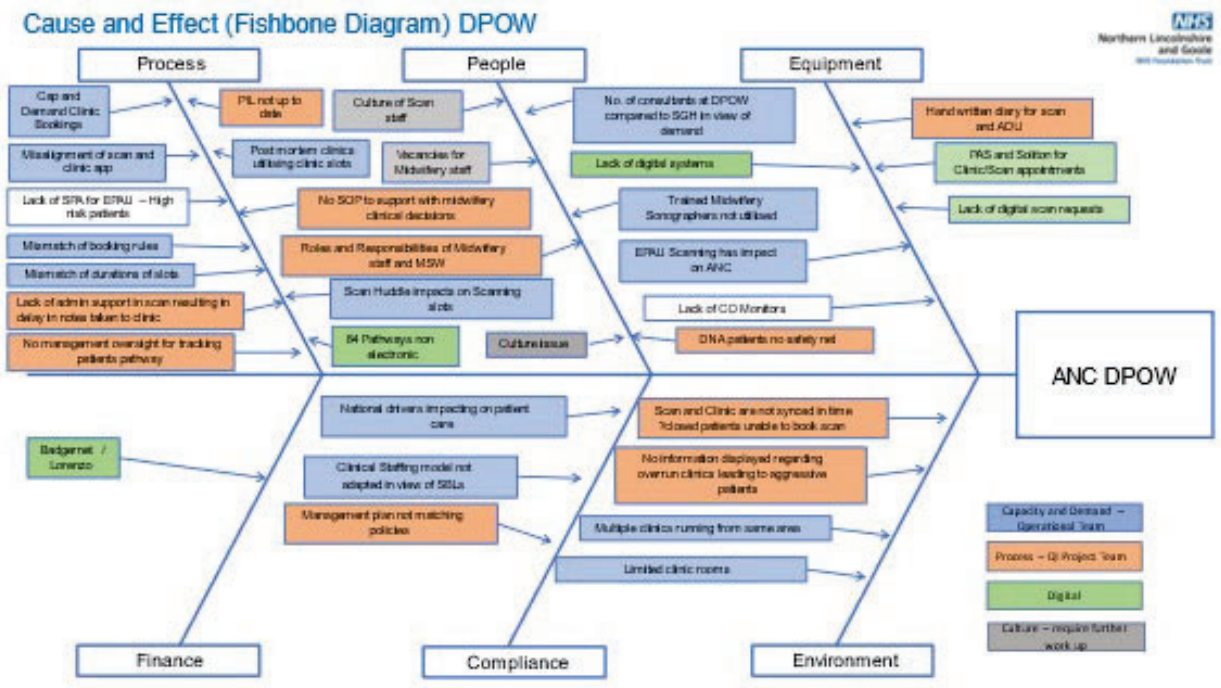
On review of these babies in October there were issues with the heating system on the ward due to scheduled maintenance, this was escalated and ultimately resolved, but did result in the ward been difficult to heat for a period. In addition, October saw new Junior Doctors rotate into the department whom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



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. Engagement session at both SGH and DPOW have been conducted to capture the root causes of the problems from our frontline teams, by way of a cause and effect diagram. Both SGH and DPOW diagrams can be seen below, with the work to address these issues been divided up between Capacity and Demand, Process improvement and Digital. These themes will form workstream to be progressed.





6 Serious Incident (SI) Reporting

Open Maternity Serious Incident Investigations as at 9 January 2024

There are currently 6 Maternity Serious Incidents open in the Trust. One of these incidents are being investigated by the Maternity and Neonatal Safety Investigations programme (MNSI), formerly HSIB.

Please note that the cases described in this report may be represented in the Serious Incident report to the Quality and Safety Committee, but 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 and has previously been provided, update with deadline extensions agreed where relevant.

STEIS Ref	Site	Description	Stage	Immediate Action	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.	25.01.2024
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 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	16.02.2024

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
				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 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.	15.02.2024

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
2023 12695	SGH	Lower Segment Caesarean Section (LSCS) admitted to ITU	Investigation	Investigation report being written	12.01.2024
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.	19.01.2024
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 – none

Other Maternity & Neonatal Safety Investigations (MNSI) Investigations

Ulysses Reference	Description	Comments
311118	Unexpected admission to NICU.	Did not refer to MSNI. A multi-disciplinary rapid review of the care delivered has taken place. The group agreed that the care in labour and delivery was at the expected standard and appropriately given meeting and delivered as per trust policies. The neonatal element of resuscitation and care was reviewed and also agreed to be of the expected standard and appropriately meeting and delivered as trust policies. There were no themes or trends identified to be acted upon. Verbal Duty of Candour has been provided to the family and they have received all the relevant support information.

Risks and themes

- There is a risk that Consultant Obstetricians are not getting compensatory rest and as a result of this there is a significant risk of not delivering Ockenden immediate and essential actions, along with the risk of health and wellbeing of a Consultant workforce.
- The risk is the potential inability to safely staff the maternity unit to provide care and treatment to a defined establishment due to sickness and vacancies. If the staffing levels are reduced, this will impact on the ability to provide safe care to women and their babies, resulting in increased incidents and potential poor outcomes.

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 in February 2024, 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 February 24
- Maternity and Neonatal Safety Conference – Spring 24
- Professional Midwifery Advocates (PMA)

8 External Visits

- CQC inspection of Maternity Services (Goole) 21 November 2023

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 related to communication and kindness, with much of the positive comments relating to this.

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, induction of labour, 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.

Clinical Negligence Scheme for Trusts (CNST)
Plan for submission of compliance for all ten safety actions. Assurance and monitoring provided by:

- Family Service quad oversite and escalation as required
- Quality & Safety Committee and Trust Board oversite
- Multidisciplinary CNST meetings taking place fortnightly
- Introduction of Maternity Audit and Compliance Manager
- Development of CNST/Saving Babies Lives annual audit calendar in collaboration with central audit team
- Introduction of Saving Babies Lives implementation tool – allowing consistent ICB reporting / LMNS oversight
- LMNS Check and Challenge meeting 26 January 2024
- Extraordinary Trust Board 23 January 2024

Saving Babies Lives (SBL) V3
Compliance achieved for all 6 elements of SBL (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; 57 green, 28 amber and 0 red actions.

Serious incidents (SI) and Maternity and Neonatal Safety Investigations (MNSI) formally HSIB (Healthcare Safety Investigation Branch) cases remain low with one reported SI (MNSI) in November 2023. As with complaints and PALS (Patient Advice & Liaison Service), due to the limited number there are no themes, however all learning is widely shared across all areas and reported into the Local Maternity and Neonatal System (LMNS) Perinatal Quality Safety and Assurance Group (PQSAG) and Perinatal Quality Safety Oversight Group (PQSOG) meeting.

Mandatory Training

K2 and PROMPT compliance

K2 Perinatal Training Programme (PTP) – Fetal Monitoring

Obstetric (Obs) Consultant	94%
Medical staff Obs Rota	85%
Midwives	97%

Practical Obstetric Multi-Professional Training (PROMPT)

Obstetric Consultant	94%
Medical staff Obs Rota	88%
Anaesthetic Consultant	96%
Anaesthetic staff on Obs Rota	95%
Midwives	95%
Health Care Assistants (HCA)	95%

Appendix I – Trust wide Maternity Dashboard

Trustwide Maternity Dashboard

Indicator	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Midwife to Birth Ratio	24.2 ↗	23.7 ↘	23.4 ↘	22.2 ↘	22.4 ↗	22.3 ↘	23.0 ↗	23.1 ↗	23.3 ↗	22.8 ↘		
Red Flags	20.0 ↗	3.0 ↘	1.0 ↘	4.0 ↗	6.0 ↗	15.0 ↗	25.0 ↗	2.0 ↘	7.0 ↗	14.0 ↗	3.0 ↘	14.0 ↗
(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	0.0	0.0	2.0 ↗	2.0	0.0 ↘	0.0	3.0 ↗	1.0 ↘	3.0 ↗
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	3.0 ↗	1.0 ↘	0.0 ↘	3.0 ↗	2.0 ↘	3.0 ↗	0.0 ↘	0.0	3.0 ↗	3.0	1.0 ↘	2.0 ↗
(c) Missed medication during an admission to hospital	0.0 ↘	0.0	0.0	0.0	2.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘	0.0	0.0	0.0	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	0.0	0.0	1.0 ↗	0.0 ↘	1.0 ↗
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	1.0 ↗	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	9.0 ↗	1.0 ↘	1.0	1.0	1.0	3.0 ↗	5.0 ↗	0.0 ↘	1.0 ↗	1.0	1.0	0.0 ↘
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	1.0	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	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.	6.0 ↗	1.0 ↘	0.0 ↘	0.0	0.0	6.0 ↗	16.0 ↗	2.0 ↘	2.0	5.0 ↗	0.0 ↘	8.0 ↗
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 %	91.0 ↘	93.1 ↗	92.3 ↘	97.2 ↗	97.8 ↗	98.2 ↗	94.8 ↘	94.2 ↘	92.8 ↘	94.5 ↗		
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1:1 Care in Labour %	100.0	100.0	99.5 ↘	100.0 ↗	100.0	100.0	100.0	100.0	100.0	99.5 ↘	99.0 ↘	99.4 ↗
Vacancies	40.4 ↘	42.2 ↗	41.7 ↘	34.4 ↘	16.0 ↘	10.5 ↘	14.5 ↗	14.9 ↗	15.5 ↗	15.4 ↘	27.9 ↗	29.4 ↗
Vacancies - Registered	34.4 ↗	36.0 ↗	37.3 ↗	30.5 ↘	17.6 ↘	13.9 ↘	18.0 ↗	17.6 ↘	19.1 ↗	15.9 ↘	27.5 ↗	23.0 ↘
Vacancies - Unregistered	6.0 ↘	6.1 ↗	4.4 ↘	3.9 ↘	-1.6 ↘	-3.4 ↘	-3.5 ↘	-2.7 ↗	-3.6 ↘	-0.4 ↗	0.4 ↗	6.4 ↗
Serious Incidents	2.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0	1.0	1.0	0.0 ↘	1.0 ↗	1.0	0.0 ↘
Complaints	0.0 ↘	1.0 ↗	1.0	1.0	2.0 ↗	1.0 ↘	0.0 ↘	3.0 ↗	1.0 ↘	3.0 ↗	0.0 ↘	1.0 ↗
PALS	3.0 ↘	3.0	3.0	4.0 ↗	1.0 ↘	6.0 ↗	6.0	6.0	4.0 ↘	5.0 ↗	4.0 ↘	3.0 ↘
Sickness Absence (Division) %	6.7 ↗	5.6 ↘	5.5 ↘	5.9 ↗	6.0 ↗	5.7 ↘	5.2 ↘	5.5 ↗	5.7 ↗	5.4 ↘	5.4	

Appendix II – PQSM Dashboard

Maternity Services						
CQC Maternity Ratings	**Overall**	**Safe**	**Effective**	**Caring**	**Well-led**	**Responsive**
	RI	RI	Good	Good	RI	Good
	Good	Good	Good	Good	RI	Good
	RI	RI	Good	Good	RI	Good

Maternity Safety Support Programme	Yes	Fiona McDonagh / Jasmine Leonce

	Aug-23	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**
Findings of review of all perinatal deaths using the real time data monitoring tool	During Q2 the multidisciplinary team has reviewed care and completed the PMRT tool for 1 neonatal death, 1 antepartum late fetal loss and 3 antepartum stillbirths. Actions have been taken to address concerns/issues identified and 1 serious incident investigation is underway.		During Q3 the multidisciplinary team has reviewed care and completed the PMRT tool for for 1late fetal loss, 1 neonatal death and 7 antepartum stillbirths in thefor 1late fetal loss, 1 neonatal death and 7 antepartum stillbirths in the review period. Actions have been taken to address concerns/issues identified and 1 serious incident investigation is underway.			
Findings of review of all cases eligible for referral to MNSI	1 referral to HSIB	0 referrals to HSIB	0 referrals to MNSI	0 referrals to MNSI		

Report on:						
	Reported (N=3)	**Reported (N=4)**	**Reported (N=0)**	**Reported (N=2)**		
The number of incidents logged graded as moderate or above and what actions are being taken	**Actions Taken:** 1) Direct feedback to operating consultant involved Instrument removed from theatre. 2) Safeguarding review completed Concise RCA investigation currently ongoing. 3) Duty of candour given, doctors contacted and lessons learnt, matron to feedback to midwifery team to cross check plan before discharge.	1) Readmission to maternity services via A&E- Undiagnosed hypoplastic aortic arch and VSD on USS. Action Taken: Transferred to LGI awaits operation, process reviewed for management of high BMI. 2) Cat 1 EMCS abruption, PPH 2746ml, EUA, hysterectomy. Action Taken : Currently being investigated. 3) Cat 1 EMCS for abruption PPH 2746ml returned back to theatre EUA Action Taken : Action Taken: Currently being investigated. 4) Notified that the baby was cremated within a shared cremation however this baby was registered as a neonatal death. Action Taken: NVF service has been discontinued until processes have been fully reviewed and the governance is such to ensure this would not happen again. SI investigation underway.		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.		
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training:						
Core competency – S&G Maternity (all staff groups)	82.9%	82.0%	84.20%	81.64%		
Core competency – DPOW Maternity (all staff groups)	92.1%	92.7%	92.10%	90.96%		
Role Specific Training – S&G Maternity (all staff groups)	76.8%	77.0%	79.93%	78.31%		
Role Specific Training – DPOW Maternity (all staff groups)	86.6%	86.6%	86.83%	87.17%		
Other competencies – S&G Maternity (all staff groups)	64.9%	58.9%	76.24%	77.10%		
Other competencies – DPOW Maternity (all staff groups)	74.3%	69.1%	78.51%	81.36%		
K2 Training (Trustwide Maternity Services)	N/A	N/A	97.10%	94.68%		
PROMPT (Trustwide Maternity Services)	N/A	N/A	93.41%	94.68%		

Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual cover:

Maternity Services						
Midwifery staffing (source: safer staffing dashboard, Power BI)						
Blueberry/Holly - DPOW	Planned hrs: 2,939.1 Actual hrs: 2,657.0 Fill Rate: 90.4%	Planned hrs: 3,204.3 Actual hrs: 2,323.6 Fill Rate: 72.5%	Planned hrs: 2,939.1 Actual hrs: 2,602.3 Fill Rate: 88.5%	Planned hrs: 2,884.3 Actual hrs: 2,517.4 Fill Rate: 88.5%		
Central Delivery Suite - SGH	Planned hrs:2,933.8 Actual hrs: 2,608.8 Fill Rate: 88.9%	Planned hrs:2,839.2 Actual hrs: 2,670.9 Fill Rate: 94.1%	Planned hrs:2,933.8 Actual hrs: 2,848.6 Fill Rate: 97.1%	Planned hrs:2,839.2 Actual hrs: 2,388.0 Fill Rate: 84.1%		
Jasmine and Honeysuckle - DPOW	Planned hrs: 2,933.8 Actual hrs: 2,441.9 Fill Rate: 83.2%	Planned hrs: 2,839.2 Actual hrs: 2,275.9 Fill Rate: 80.2%	Planned hrs: 2,839.3 Actual hrs: 2,419.2 Fill Rate: 82.5%	Planned hrs: 2,839.2 Actual hrs: 2,471.8 Fill Rate: 87.1%		
Ward 26 - SGH	Planned hrs: 2,567.1 Actual hrs: 1,876.9 Fill Rate: 73.1%	Planned hrs: 2,484.3 Actual hrs: 1,933.3 Fill Rate: 77.8%	Planned hrs: 2,567.1 Actual hrs: 2,003.6 Fill Rate: 78.0%	Planned hrs: 2,484.3 Actual hrs: 1,861.0 Fill Rate: 74.9%		
Obstetrician staffing - cover on the delivery suite, gaps in rotas						
Delivery Suite - SGH	100.0% 0 gaps identified	100.0% 0 gaps identified	100.0% 0 gaps identified			
Delivery Suite - DPOW	100.0% 0 gaps identified	100.0% 0 gaps identified	100.0% 0 gaps identified			
Service User Voice Feedback	MNVP Lead - vacancy 15 Steps - Antenatal clinic at SGH received 'Good' Friends of Family Q2 Results: DPOW 40 responses submitted - 100% positive feedback received, SGH 0 responses submitted	MNVP Lead now in post 15 Steps - Antenatal clinic at SGH received 'Good' Friends & Family Q2 Results: DPOW 40 responses submitted - 100% positive feedback received, SGH 0 responses submitted	15 Steps - Central Delivery Suite at SGH were visited and achieved a rating of 'good'. Friends & Family October Results: DPOW received 50 responses - 48 (96%) were positive. Negative responses related to poor communication. SGH received 22 responses - 100% were positive.	15 Steps - Ward 26 at SGH were visited and achieved a rating of 'requires improvement'. Friends & Family October Results: Not yet available for Nov 23 on Power BI.		
WAT Tool Ward Area Compliance	96.70%	96.7% (July - Sept 23)	96.4% (Aug - Oct 23)	96.2% (Sept - Nov 23)		
Staff feedback frontline champions and walk abouts	5 open actions - action plan in place and monitored (Reported to Board / Q&SC)	7 open actions - action plan in place and monitored (Reported to Board / Q&SC)	7 open actions, 4 relate to action required from Estates & Facilities Team. Action plan in place and monitored (Reported to Board / Q&SC).	10 open actions, 4 relate to action required from Estates & Facilities Team with expected completion dates of end of January 24. Action plan in place and monitored (Reported to Board / Q&SC).		
Learning from Feedback (Patient Experience)	**Q1 Maternity Themes identified:** Distress caused by birth experience Communication Staff attitude Waiting times for appointments Support provided to mother following birth Delay with patients attending afterthoughts clinic **Action Taken:** Discussion with staff members about inappropriate comments made to patients through Just and Learning Safety Huddles Afterthoughts clinic process reviewed and expression of interest to increase midwife capacity	**Q2 Maternity Themes identified:** Communication Continuity Attitude & Behaviours Discharge **Action Taken:** Staff informed of positive feedback and feedback following complaints. Individuals concerned spoken to and reflection undertaken. Complaints have been around medical staff communication rather than midwives.	**Q2 Maternity Themes identified:** Communication Continuity Attitude & Behaviours Discharge **Action Taken:** Staff informed of positive feedback and feedback following complaints. Individuals concerned spoken to and reflection undertaken. Complaints have been around medical staff communication rather than midwives.	**Q2 Maternity Themes identified:** Communication Continuity Attitude & Behaviours Discharge **Action Taken:** Staff informed of positive feedback and feedback following complaints. Individuals concerned spoken to and reflection undertaken. Complaints have been around medical staff communication rather than midwives.		
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust	0	0	0	0		
Coroner Reg 28 made directly to the Trust	0	0	0	0		
Progress in acheivement of CNST SA 10	On track	On track	On track	On track		

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	22 responses (please see sheet 2)
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)	1 response (please see sheet 2)

Family Services Operational Dashboard - Power BI
Safer Staffing - Power BI
WAT Women and Childrens - Power BI

Appendix III – Safety Champion Improvement Plan

Overdue or Incomplete
In Progress
Completed

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Dat Rais	How conce	Site DPOW/SG	Theme	Concern Raised	Action Taken	Responsible Perso	Escalatio	Plan to close	Action by Dat	Statu	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 – Quote obtained and plan now being put in place with regards to repair works and closing of areas etc throughout January/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. **The fire warden has concerns about storage units in a corridor, she is coming early Jan 24 to review the situation and possibly consider fire retardant doors.**
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		CS met with KL 6/12/23 – to organise repairs urgently CS – Repairs planned to take Place January 2024
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
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 Management Team	Repairs/replacement to desk	31/01/2024		CS met with KL 6/3/23 – to organise repairs urgently CS – Repairs to take place by end of January 2024
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 as part of the project.	30/11/2023		Increased demand following the implementation of Saving Babies Lives which exceeds capacity. This is a cross site issue.

Appendix IV – Maternity Sustainability Plan

Act I	Sustainability Action Plan	Specific actions to be implemented to ensure ongo	Progress	Measurement	RAG Ratin	SRO	Action Owne	Target Dat Timeline	Evidence
SAP1	Developed maternity risk management strategy	Periodic review as per document control policy	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	Associate Chief Nurse	Jun-23	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/se lf 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)up2 date,incident learning lessons Review SOP section 5.0 monitoring compliance and effectiveness 12/9/23 SOPS reviewed and reflect monitoring process

Act I	Sustainability Action Plan	Specific actions to be implemented to ensure ongo	Progress	Measurement	RAG Ratin	SRO	Action Owne	Target Dat Timeline	Evidence
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
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	

Action ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date/ Timeline	Evidence
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
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

Act	Sustainability Action Plan	Specific actions to be implemented to ensure ongo	Progress	Measurement	RAG Ratin	SRO	Action Owne	Target Dat Timeline	Evidence
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 groups.	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
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	

Ac	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Ratin	SRO	Action Owne	Target Dat Timeline	Evidence
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
MSAT9	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Evidence required 15/6/23 RD to contact BC (LMNS) 14/7/23 Intention for a 6 monthly review of the maternity patient safety profile and its link to the Patient Safety Incident Response Plan. Risk Profile and theming being taken forward, with a view to arrange a meeting with LMNS to progress during July/August and when inital plan agreed, to review 6 monthly with with learning and review of safety profile. PSIR policy in draft, setting out the PSIRP monitoring approach and orgnisation wide safety summit.				Richard Dickinson, Associate Director of Quality Governance	Sep-23	12/9/23 Maternity PSIRP. Attended national webinars and now developing PRSIP plan for maternity. Meeting between maternity and governance team 30/8/23. Need evidence KB. 25/9/23 Patient safety incident response plan (draft)9/1/24 PSIRF implemented across the Trust (inclusive of maternity)
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				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'

Act I	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Ratin	SRO	Action Owne	Target Dat Timeline	Evidence
MSAT11	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	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				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	
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

Act I	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Ratin	SRO	Action Owne	Target Dat Timeline	Evidence
MSAT14	Safety huddles	Audit of compliance against safety huddle guideline/SOP	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 registered	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

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)016

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Group Chief Nurse
Contact Officer/Author	Sue Liburd / Stuart Hall
Title of the Report	Maternity & Neonatal Safety: NED Safety Champions' Reports – NLaG and HUTH
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. Section Three of the report sets out the five matters for reporting / escalating to the Trust Board from recent activity.
Background Information and/or Supporting Document(s) (if applicable)	The role of a 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, Lead Obstetrician, and the Trust board to understand, communicate and champion learning, challenges, and successes. Key responsibilities include bringing a degree of independent, supportive challenge to the oversight of maternity & neonatal services and ensure the provision of board level oversight and assurance.
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:

Hull University Teaching Hospitals NHS Trust

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Non-Executive Maternity & Neonatal Safety Champions Report

Report for meeting of the Trust Boards to be held on:	08 February 2024
Report from:	Non-Executive Maternity & Neonatal Safety Champions
Report from meeting held on:	29 January 2024

1. Purpose of the report

1.1 This report sets out the activities undertaken by the Non-Executive Maternity & Neonatal Champions to provide assurance to the relevant committees and boards in the provision of high quality, safe maternity, and neonatal clinical care. It highlights those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Activities undertaken this month:

2.1 The role of a 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, Lead Obstetrician, and the Trust board to understand, communicate and champion learning, challenges, and successes. Key responsibilities include bringing a degree of independent, supportive challenge to the oversight of maternity & neonatal services and ensure the provision of board level oversight and assurance.

2.2 The Non-Executive Maternity & Neonatal Champions undertook the following assurance activities:

NLAG

- Chairing of NLaG Maternity Transformation & Improvement Board 16 January 2024.
- Attended the Extraordinary meeting of Quality and Safety Committees-in-Common (CIC) reviewing the Clinical Negligence Scheme for both NLaG and HUTH Trusts (CNST) 19 January 2024.
- Attended the Extraordinary Board meeting HUTH & NLaG CNST year 5 safety actions 23 January 2024.
- Attendance at the Quality and Safety CIC on 25 January 2024 where the Maternity Assurance reports were presented and discussed.
- Attendance the NLaG maternity safety champion walkaround at Scunthorpe General Hospital (SGH) 24 January 2024

The Maternity Report to Board from the Maternity Team continues to document the Safety Champion activity at NLAG (Section 4).

HUTH

- Attended the extraordinary meeting of Quality and Safety Committees-in-Common (CIC) reviewing the Clinical Negligence Scheme for both NLaG and HUTH Trusts (CNST) 19 January 2024.
- Chaired the Extraordinary Board meeting for CNST approval meeting 23 January 2024 which reviewed the evidence supporting both NLAG and HUTH CNST submissions.
- Meeting with HUTH Maternity Champion and Lesley Heelbeck on 17th January 2024.
- Attendance the HUTH maternity safety champion walkaround at Hull Royal Infirmary on 24th January 2024.
- Received the monthly Section 31 submission, which is consistent with the progress reported to Board.
- In the next period the HUTH Maternity Safety Champion is scheduled to attend the following meetings:
    - 5 Feb - Badgernet implementation;
    - 6 Feb HNY LMNS PQSAG;
    - 13 Feb HNY LMNS Delivery Board;
    - 8 Mar Maternity assurance visit;
    - 8 Mar Maternity and neonatal champions;
    - 20 Mar Maternity Safety Support Programme (MSSP) Maternity Improvement Advisor (MIA).

The Maternity Report to Board from the Maternity Team continues to document the Safety Champion activity at HUTH (Section titled Maternity Incentive Scheme Safety Action 9 which is aligned to the Year 5 CNST requirements).

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The Non-Executive Maternity & Neonatal Champions agreed the following matters for reporting and escalation:

NLaG

a. The Non appointment of Director of Maternity Services and not having a substantive Group Chief Nurse in post has detracted from having the full desired leadership team in place. During the restructure, there was a temporary pause on some vacancies to reflect the acting up nature of some roles in situ. This matter has been referred by Quality and Safety CIC to Workforce Education CIC.

b. NLaG are awaiting the CQC report following an inspection of Goole Midwifery services in November 2023. High level feedback was positive.

HUTH

c. There will be a financial impact resulting from the 5/10 CNST safety compliance at HUTH to the value of £0.609m.

d. The Maternity Report from HUTH presented at Quality & Safety CIC (and on the Board agenda) provided limited assurance, principally on the basis there is

more work to do on delivering the core training requirements as set out in the report. It was noted this has shown monthly improvement since November 2023 and 9/22 sub components are above the 85% threshold for January 2023. Action plans and task and finish groups are in place to remedy.

e. The HUTH team are working through the output of the latest Birthrate+ assessment dated December 2023 which has identified a required uplift of clinical staff from 187.89 WTE to 197.48 WTE (c.5%). The team is working with the Maternity Improvement Advisor in respect of the specialist and managerial roles and uplift required.

4.0 Good practice, improvements, and innovations

NLaG:

4.1 A meeting with the pastoral care midwife on the maternity walkaround at SGH, showcased and evidenced the positive impact the support is delivering in transitioning and retaining newly qualified and internationally educated nursing and midwifery staff.

4.2 Nicola Foster, Associate Chief Nurse – Midwifery, Gynaecology & Breast Services, has been invited to speak at a national conference on the success of the labour, delivery, recovery and postpartum (LDRP) family centred service at Grimsby.

HUTH:

4.3 Progress is being made against the CQC actions, which are overseen by the Maternity Transformation Assurance Committee (MTAC) which is attended by Trust Executive members and ICB representation. MTAC meets fortnightly. At this stage, reporting is on track to deliver actions by April 2024.

4.4 The progress against the delivery of the CQC actions continues to be supported by ICB and NHSE colleagues when scrutinised on the monthly HUTH Quality Improvement Group (QIG). This group has received and congratulated the work in respect of the work in the Antenatal Day Unit. One of the most significant issues within the CQC findings was the Trust's lack of risk based approach to triaging patients when they presented in an unplanned manner. Crucially, the changes that the Trust has made to triaging patients and distinguishing between planned and unplanned care has resulted in more than 95% of women presenting to the Antenatal Day Unit (ADU) in January 2024 being seen within the appropriate timeframe. This is 15 minutes for patients assessed as high risk.

5.0 Trust Board Action Required

The Trust Boards are asked to:

- Note the report.
- Note escalations.

Sue Liburd, Non-Executive Director NLaG
Stuart Hall, Non-Executive Director HUTH, Associate Non- Executive Director, NLaG
26 January 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)017

Name of the Meeting	Trust Boards-in-Common - Public
Date of the Meeting	8 February 2024
Director Lead	Simon Parkes and Jane Hawkard, Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common
Contact Officer/Author	Simon Parkes / Jane Hawkard
Title of the Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – January 2024**
Executive Summary	The attached highlight / escalation report summarises the key matters presented to, and discussed by the inaugural meeting of the Audit, Risk and Governance Committees-in-Common on 25 January 2024.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 25 January 2024
Prior Approval Process	-
Financial implication(s) (if applicable)	-
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ 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:	8 February 2024 - Public
Report from:	**Audit, Risk and Governance Committees-in-Common**
Report from meeting held on:	25 January 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 25 January 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:

- NLAG Theatre Data Quality Action Plan Update
- External Audit update
- Internal Audit reports / overdue recommendations
- Group LCFS update
- Group IG Highlight Report
- Arrangements for Raising Concerns – HUTH and NLAG
- NLAG Recovery Support Funding Requirements
- IFRS16 PFI Accounting Update
- Policy for Engagement of External Auditor for Non-Audit Work – NLAG and HUTH
- HUTH Corporate Credit Card Policy
- ARG CiC Terms of Reference – HUTH and NLAG
- ARG CiC Aligned Workplan
- Results of Audit Committee Self-Assessment Exercises – NLAG and HUTH*

*[*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:

a. HUTH Internal Audit Report – Discharge Management – the report received a '*Reasonable Assurance*' opinion with three medium and one low recommendation being made. The committees were advised that the report would be received at the Group Cabinet Risk and Assurance Committee on 5 February 2024 for further review and discussion. The committees requested

an update on this report's management actions be brought back to its April 2024 meeting.

b. Internal Audit overdue management actions - significant progress reported in the level of overdue management actions at HUTH has been made, with the data as at 11 January 2024 showing nine overdue actions and a further 18 overdue but with revised implementation dates. The Committee noted on going work to complete these actions.

c. The Data Security and Protection (DSP) Toolkit requires 95% compliance for mandatory DSP Training which at 31 December 2023 stood at 90.1% (HUTH) and 88% (NLAG).

d. A move to a coordinated approach to internal audit reviews conducted across both organisations within the Group where appropriate. The planning process for the 2024/25 internal audit plans is underway.

e. The NLAG ARG CiC approved the extension of the existing Standing Financial Instructions and Scheme of Delegation to 30 April 2024 whilst the new Group governance documents are being prepared.

f. The HUTH ARG CiC approved the inclusion of a specific reference to the committee acting as its Auditor Panel in its Membership and Terms of Reference document.

g. The committees approved the results of their latest self-assessment exercises for submission to the Trust Board for information.

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

a. Counter fraud work across the Group – including the 93% compliance rate for mandatory fraud awareness e-learning at NLAG. The Local Counter Fraud Specialist (LCFS) is currently applying to have the training made mandatory at HUTH and the Committee endorsed such a move to ensure consistency across the Group.
b. Arrangements for raising concerns across the Group.
c. Policy for Engagement of External Auditor for Non-Audit Work – reviewed and re-approved for both Trusts.
d. HUTH Corporate Credit Card Policy – reviewed and re-approved.
e. Arrangements to implement IFR16 for PFI schemes.

5.0 Matters on which the committee has requested additional assurance:

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

a. Subject Access Requests (SARS) – the committees expressed concern at the number of SARS exceeding the 30 day response deadline (set by the Information Commissioners Office (ICO)) at HUTH. In comparison it was noted that there were no such issues at NLAG. Work is underway to review this position and the committees asked for an update on this specific issue at the next 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 has proposed the following change(s) to the risk rating or entry:

N/A - BAF not discussed at this meeting.

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to note the report.

Simon Parkes
NLAG ARG CiC Chair / NED

Jane Hawkard
HUTH ARG CiC Chair / NED

25 January 2024

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)033

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Gill Ponder and Mike Robson, Non-Executive Directors / Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report
Contact Officer/Author	Gill Ponder and Mike Robson, Non-Executive Directors / Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report
Title of the Report	Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report
Executive Summary	The attached highlight / escalation report provides an overview of the of the key matters presented to, discussed and escalated at the inaugural meeting of the Performance, Estates and Finance Committees-in-Common meeting held in January 2024 as part of the Group Model transition. It also provides the same details for the previous individual meetings held in December 2023 for the NLaG Finance and Performance Committee and the HUTH Performance and Finance Committee.
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 reports have 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 below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for the meeting of the Trust Boards in Common to be held on:	8 February 2024
Report from:	Performance, Estates and Finance Committees in Common
Report from meeting held on:	24 January 2024
Quoracy requirements met:	The following meetings were all quorate: • Performance, Estates and Finance Committees in Common meeting - 24 January 2024 • Finance and Performance Committee meeting (NLaG) – 20 December 2023 • Performance and Finance Committee meeting (HUTH) – 18 December 2023

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the newly formed Performance, Estates and Finance (PEF) Committees-in-Common (CiC) at their meeting held on 24 January 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

1.2 This report also sets out the items of business considered at the December 2023 meetings of the Finance and Performance Committee (NLaG) and the Performance and Finance Committee (HUTH).

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

PEF CiC meeting - 24 January 2024

- Board Assurance Frameworks (BAF)
- Annual Plan (1st draft)
- CQC Actions Report
- Financial Reports – Month 9

Finance and Performance Committee (F&PC) meeting (NLaG) – 20 December 2023

- CQC Actions Report
- Integrated Performance Report
  PCIP – including deep dive into cancer standards
- Procurement
- BAF SO3 – 3.1 Deep Dive
- High and Low Voltage electrical management
- Finance Report Month 8
- Corporate Benchmarking Report

Performance and Finance Committee (PAFC) meeting (HUTH) – 18 December 2023

- Performance Report and Elective Recovery
- Month 8 Finance Report
- Board Assurance Framework
- Cancer Screening Programme Update
- Capital Resource Allocation Committee

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 - 24 January 2024

a. **Performance**

- **Emergency Care and Ambulance Handovers** - Concerns remain over delays in ambulance handovers and performance against the 4 hour standard for both Trusts. The opening of an Urgent Treatment Centre and Ground Floor process improvements are expected to improve performance at HUTH. The introduction of a front door frailty model and escalation of ambulance handover delays over 30 minutes are amongst the improvement initiatives underway at NLAG.

- **No Criteria to reside** (NCR) – In December 2023 at HUTH there was an increase to 211 patients per day with No Criteria to Reside (with no medical need for acute service), causing an average impact of 3.8 days increase on Length of Stay, 3,896 lost acute bed days and negatively impacting on patient flow through the ED. This continues to be above the baseline and the single largest factor affecting daily performance levels including over 12 hours waiting in ED.

- **Industrial action** – This has impacted upon theatre and outpatient appointment (OPA) sessions during December 2023 and will continue into January 2024. This has also impacted on increased time for patients waiting in the Emergency Departments and flow across the organisations.

b. **Elective Recovery**

- Both Trusts were on track to deliver zero 65 week waits by the end of March, but there were risks at HUTH, where there were 11 patients that had waited over 75 weeks and risks from ongoing validation of waiting lists across both Trusts, with many patients at HUTH not yet risk stratified after waiting over 12 weeks. A recovery plan was in progress.

c. **Cancer Performance**

- **62 days referral to treatment** - there are ongoing challenges in meeting 62 days from referral to treatment. Both Trusts are performing below the revised national standard of 70% and are currently achieving 54.4% (HUTH) and 52.5% (NLaG) with provisional December positions. The under-performance is due to significant capacity and consultant workforce shortages which have impacted on all aspects of the pathway including diagnosis, staging and treatment.

***d*. Contract Approvals**

- Provision of Outpatient Pharmacy Dispensing Services for NLaG by Lloyds Pharmacy (current supplier) for two years was considered and approved.

- Provision of Total Healthcare Waste Management Services for HUTH by Mitie Waste and Environmental Services Limited (the incumbent supplier) was considered and approved until September 2025.

- Both contracts are to bring existing contract expiry dates into line across both Trusts to enable joint procurement exercises to maximise buying power to be conducted in future.

***e*. Capital and Finance**

- 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 2024It was also essential that the 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.

<u>F&PC meeting (NLaG) – 20 December 2023</u>

***a.* Review of NLaG Financial position (Finance Report) (SO3.1/SO3.2b)**

- Overtaken by the latest position covered during the January Committees in Common meeting and outlined above.

***b*. High Voltage (HV) and Low Voltage (LV) electrical management**

- Generator site wide tests had identified gaps in the Uninterrupted Power Supplies (UPS). Replacement feasibility studies were taking place. The UPS in the IT main server room at Scunthorpe General Hospital (SGH) also needed to be replaced at a cost of £88k, due to it being on the verge of failing. Parts had been ordered and were awaiting delivery. Plans had been made to replace the back-up diesel generator, CSSD1 and a generator had been hired to mitigate the risk. Black starts were required on the generators at SGH which would require a major shutdown. Due to uncertainty about the restoration of power after a shutdown, the

feasibility was being assessed by an external contractor. In the meantime, black starts were being simulated.

- The Committee raised concerns about patient and staff safety issues and clinical risks arising from items on the action log that came to the Committee as an Appendix to this report, as risks were presented but recorded responses to logged issues were not reducing the risk significantly. These included issues with Nurse call bells in some areas. The clinical risks of logged issues would be reviewed to see if any items needed to be prioritised for funding allocation.

PAFC meeting (HUTH) – 18 December 2023

- Overtaken by update above from January Committees in Common meeting.

4.0 Matters on which the committees received assurance

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

PEF CiC meeting - 24 January 2024

a. **Cancer performance**
The Committees were assured that the Faster Diagnostic Standard (FDS) of 28 days was achieved for both Trusts. The standard of 75% has consistently been met at HUTH since July 2023 with the exception of November 2023. NLaG achieved over 72% from August 2023 onwards and achieved the 75% target in December 2023. A joint transformation plan to implement best practice timed pathways is underway for both Trusts.,

b. **63+ backlog (including 104+)**
The number of HUTH patients waiting over 63 days or more at 31 March is being achieved. This reflects the revised recovery trajectory and associated actions / performance relative to the £1.3m additional national and local investment and provided assurance to the Committee.

c. **Elective Recovery Performance (ERF)**
The Committees were assured that the Group is ahead of the revised 2019/20 Activity Baseline (102% for HUTH and 103% for NLAG) at 106%, earning £1.3m in additional ERF income YTD.

d. **Security**

The Committee were assured by the Security reports from both Trusts, but agreed that the annual deep dive into each technical specialism would be discontinued in favour of a monthly assurance reports on Estates and Facilities issues in general. It was felt that that approach would enable the Committees to get more frequent assurance on Estates and Facilities significant risks and emerging issues.

F&PC meeting (NLaG) – 20 December 2023

a. **Procurement -** The Committee were fully assured on progress with delivering the procurement improvement workstreams.

b. **Corporate Benchmarking Report -** The Corporate benchmarking report had shown that the Trust compared favourably to other Trusts in many areas but had also raised a number of areas where there appeared to be opportunities to reduce costs, which would be investigated further.

PAFC meeting (HUTH) – 18 December 2023

a. **Performance -** Limited assurance although greater confidence had been gained due to the ongoing improvement work.

b. **Cancer Screening -** Limited due to the constraints on resources, but it was noted that this was being covered by the Cancer Programme.

c. **Finance in-year position -** Limited due to the industrial action and associated costs

d. **Underlying position -** Limited as no plan in place yet.

e. **Capital Plan -** Reasonable although more clarity is required around the electronic patient record (EPR) funding position.

5.0 Matters on which the committee has requested additional assurance:

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

PEF CiC meeting - 24 January 2024

a. **Cancer performance** - The Committees requested initiatives be presented against performance details for cancer improvement trajectories to provide clarity and further assurance on progress towards achieving the required standards.

b. **Performance report** – Inclusion of links to initiatives in the report were requested by the Committees to evidence any links to performance levels and support assurance levels.

F&PC meeting (NLaG) – 20 December 2023

a. **Unplanned Care**

The Committee raised concerns over ambulance handover performance. The Committee were informed that actions were in place to try and improve this performance, such as frailty pathways at the front door, Urgent Care Services at Diana, Princess of Wales (DPOW) and Scunthorpe General Hospital (SGH) sites moving to 24/7 in a phased way and opening of the new Integrated Acute Assessment Units (IAAUs) The Committee requested performance versus trajectory reports against the ED and ambulance handover reset targets that the Trust had agreed to for the remainder of the financial year.

b. **Planned Care**

The Committee discussed the End-of-Life Theatre equipment that was being transferred between sites, which was having an adverse effect on theatre productivity and resulting in cancelled lists according to the narrative in the IPR. The Committee asked what the equipment was, the costs of moving it between sites, if moving it was shortening its life span, the cost of the lost sessions and what could be done to improve the situation. Answers to these questions would be brought back to the Committee and the medical equipment replacement process would also be checked to find out where these pieces of equipment sat in the priority list.

c. **Cancer Deep Dive**

- The Committee reiterated their concern about the number of Cancer patients waiting over 104 days and had previously requested a trajectory showing planned reductions in the number.

- To reduce the backlog of patients waiting for urology prostate biopsies, clean rooms were needed to free up theatres. Funding was available, but the work had not taken place due to capacity constraints in the Estates and Facilities team. Priorities would be reviewed to see if the work could be completed.

PAFC meeting (HUTH) – 18 December 2023

a. **ED Performance and reporting** clarification, urgent treatment centre (UTC) development and triage, Cancer performance, ED Summit, Ambulance turnaround times, patients with no criteria to reside.

b. **Finance** – strike action costs, underlying position and capital EPR funding.

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 proposed the following change(s) to the risk rating or entry:

PEF CiC meeting - 24 January 2024

NLaG BAF - Strategic Objective (SO) 3 - 3.1 - The Committees reviewed this objective and agreed to reduce the risk score from 20 to 16 to reflect the improved confidence in achieving the year end forecast financial position, subject to no further industrial action.

F&PC meeting (NLaG) – 20 December 2023

SO3 - 3.1 - The Committee reviewed this objective and agreed with the risk scores.

PAFC meeting (HUTH) – 18 December 2023

a. The committee considered the areas of the BAF (performance, in-year financial plan, the underlying deficit and expenditure against the Capital Plan). No changes were proposed.

b. BAF 7.1 (in-year financial position), would be reviewed at month 9 with a view to a reduction in the risk if the forecasted achievement of the plan had not changed.

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- **PEF CiC meeting - 24 January 2024 -** To note the contents of the report.
- **F&PC) meeting (NLaG) – 20 December 2023 -** Note the key points highlighted above.
- **PAFC meeting (HUTH) – 18 December 2023**
  - Note the contents of the escalation report.

Gill Ponder, PEF CiC Chair for the meeting on 24 January 2024

Gill Ponder, F&PC (NLaG) Chair for the meeting on 20 December 2023

Mike Robson, PAFC (HUTH) Chair for the meeting on 18 December 2023

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Boards-in-Common Front Sheet

Agenda Item No: BIC(24)019

Name of the Meeting	**Trust Boards in Common**
Date of the Meeting	8th February 2024
Director Lead	Tony Curry & Kate Truscott, Non-Executive Directors / Chairs of Workforce, Education & Culture Committees-in-Common
Contact Officer/Author	Tony Curry & Kate Truscott, Non-Executive Directors / Chairs of Workforce, Education & Culture Committees-in-Common
Title of the Report	Workforce, Education and Culture Committees in Common highlight and escalation reports from: WEC CIC – 30 January 2024 HUTH – 11 December 2023
Executive Summary	As part of the Group Model transition there are 2 reports attached which highlight the work of the Workforce, Education and Culture Committee at HUTH (December 2023 meeting) as well as jointly in the new Committees in Common arrangements (January 2024 meeting). Each report highlights matters considered by the committees, matters for escalation to the Boards, any additional assurance required, confirm and challenge of the BAF and any action required of the Boards.
Background Information and/or Supporting Document(s) (if applicable)	The attached reports provide Committees in Common highlights and escalations to the Boards in Common
Prior Approval Process	The attached reports have been approved by the Committees in Common Chairs and Chairs of the HUTH Committee in December 2023.
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
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	8th February 2024
Report from:	Workforce, Education and Culture Committees-in-Common
Report from meeting held on:	30th January 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 meeting held on 30th January 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:

- *Freedom to Speak Up Guardian Q3**
- *Workforce Performance Metrics*
- *Impact of Industrial Action*
- *CQC Progress Report (NLaG)*
- *Gender Pay Gap*
- *Equality Delivery System Standards*
- *Registered Nursing and Midwifery Staffing*
- *Staff Survey 2023 Initial Feedback*
- *Group Transformation Programme*
- *Guardian of Safe Working Q3*
- *Retention*

*[*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:

a. Specific areas within NLaG with low mandatory training compliance with particular reference to Safeguarding and Mental Capacity Act training within the Medicine Division.

b. Training space requirements across the Group including the closure and demolition of Suite 22, HUTH.

c. Deployment of Advanced Clinical Practitioners (ACPs).

d. Medical engagement with NLaG CQC Action Plan, notable lack of progress with medical staff training rates.

e. The number of staff in NLaG who did not attend booked training.

f. Lack of diversity in leadership roles within the Group.

4.0 Matters on which the committees received assurance

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

a. Freedom to Speak Up – Reasonable, due to robust aligned processes in place for

both organisations. The guardians are collaborating when this is appropriate.

b. Registered Nurse & Midwifery Staffing – Reasonable, sufficient controls in place to mitigate impact on patient safety and experience.

c. Workforce Performance Metrics – Reasonable with exceptions of mandatory training compliance and hotspots of high sickness absence.

d. Impact of Industrial Action – Limited due to further balloting for industrial action for junior doctors and rejection of the consultant pay award.

e. CQC Progress report (NLaG) – Limited due to the lack of improvement in medical training rates.

f. Group Transformation Programme – Reasonable due to recruitment campaigns being on track. This will be kept under review and become a standing agenda item.

g. Gender Pay Gap – Reasonable due to compliance with the standards at both Trusts.

h. Equality Delivery System Standards – Limited as both Trusts have been rated as developing.

i. Guardian of Safe Working (NLaG) – Reasonable due to robust processes in place and no issues raised.

j. Retention (NLaG) – Limited. This will be monitored by the Committees in Common and a further written report to be provided.

5.0 Matters on which the committee has requested additional assurance:

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

a. A deep dive regarding the Medical Workforce vacancies in NLaG was requested.

b. A deep dive into the turnover within the 1st year of employment in HUTH was requested with a focus on inequalities.

c. A deep dive into CDC recruitment was requested.

d. A deep dive into the retention of NLaG staff was requested.

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 has proposed the following change(s) to the risk rating or entry:

a. *HUTH BAF Risk 2 (Workforce) to reduce from 16 to 12 to reflect the improved nursing establishment and vacancy position.*

b. *NLaG Strategic Objective 5 risk to increase from 12 to 16 due to the ongoing senior leadership changes relating to the new Group transition.*

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

31st January 2024

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	8th February 2024
Report from:	HUTH Workforce, Education and Culture
Report from meeting held on:	11th December 2023
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.2 This report sets out the items of business considered by the HUTH Workforce, Education and Culture Committee at their meeting held on 11th December 2023 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:

- *Pastoral Support for International Nurses*
- *Freedom to Speak Up Guardian**
- *eRostering*
- *Covid and Flu Vaccination Progress*
- *Group Values*
- *Nursing and Midwifery Staffing*
- *Guardian of Safe Working**
- *Junior Doctor eRoster Roll-Out*
- *LGBTQ+ Network Objectives*
- *People Strategy Performance*

*[*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:

a. The indefinite leave to remain visa amount has increased by over £400 per person, the committee agreed to send a letter to local MPs asking for exemption from visa fees for NHS staff.

b. The overall number of Freedom to Speak Up Guardian concerns has exceeded the total for 2022/23 in Q3 of 2023/34, capacity will soon be reached for the Freedom to Speak Up Guardian.

c. The Trust will not reach the 75% target for Covid and Flu vaccinations.

4.0 Matters on which the committees received assurance

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

a. Nursing and Midwifery Staffing – Substantial due to low vacancy levels for registered and non-registered nurses and reduced turnover.

b. Freedom to Speak Up Guardian – Substantial.

c. Guardian of Safe Working – Reasonable due to the increase in exception reports, however this is due to the increase of rotas available on eRoster.

d. Junior Doctor eRoster Roll-Out – Reasonable as 11 rotas are currently not on eRoster however the number of rotas live on eRoster has hugely increased.

e. eRostering Report – Substantial, the Trust is predicted to be at level 4 against the national levels of attainment.

f. LGBTQ+ Network Objectives – Reasonable, the Zero Tolerance to LGBTQ+ Framework is yet to be launched.

g. Covid and Flu Vaccination Progress – Limited as the 75% target will not be met due to vaccination fatigue and removal of additional day's leave incentive.

h. People Strategy Performance Report – Reasonable as turnover remains high, however vacancies are low and mandatory training is above target.

5.0 Matters on which the committee has requested additional assurance:

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

a. Support to staff during the Group organisational change.

b. High turnover rate for staff in their first year of working at the Trust.

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.

8.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- Note the contents of the escalation report.
- Decide if any further information or assurance is required.

Tony Curry

2nd January 2024

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)020

Name of the Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday, 8 February 2024
Director Lead	NLAG – Simon Nearney, Group Chief People Officer HUTH – Jo Ledger, Interim Chief Nurse
Contact Officer/Author	NLAG – Liz Houchin, Freedom to Speak Up Guardian HUTH – Fran Moverley, Freedom to Speak Up Guardian
Title of the Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 3)**
Executive Summary	Each report provides the Q3 report for 2023/2024 for NLAG and HUTH respectively. Each report gives an update from the Q2 Board reports including an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by each Freedom to Speak Up Guardian. The HUTH report includes detail of the proposed future plans for Freedom To Speak Up as a Group. Each report is for assurance.
Background Information and/or Supporting Document(s) (if applicable)	Not applicable
Prior Approval Process	Both NLAG and HUTH reports have been submitted to the Workforce, Education and Culture Committee in Common on 30 January 2024.
Financial implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up (FTSU) Guardian – Quarter 3 Report October to December 2023

Liz Houchin
8th January 2024

Contents

1. Executive Summary

1.1 This paper provides an update regarding Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLaG) activity for Q3 2023-24 (which covers the period October to December 2023). Within this paper the results of the National Guardians Office (NGO) publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper satisfies the Trust Strategic Objective of 'Being a good employer' and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

3. Introduction / Background

3.1 The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement. The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

4. Assessment of FTSU Concerns Raised

4.1 In Q3 2023-24,104 concerns were received. 28% of these were closed on the same day after giving advice or signposting.

- 6 concerns were raised anonymously in Q3. A high percentage of these have come through the Staff App.
- In Q3 21 concerns involved an element of patient safety. This puts the Trust in the high quartile nationally, the peer figure being 11 (figures accessed from Model Hospital data November 2023).
- In Q3 13 concerns involved an element of bullying and harassment which puts the Trust in the mid-high quartile nationally, the peer median figure being 6.

4.2 The Q3 figure of 104 is significantly higher than Q3 in 2022-23 which was 71. The figure of 104 is the highest quarterly number recorded for the Trust since the introduction of the FTSU Guardian role. Q3 is usually the highest quarter due to the nation 'Speak Up' campaign in October.

4.3 The main themes raised were around behaviours, process and patient safety.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed.

Concerns		Q2.2023 24 (July September 2023)	Q3. 2023 24 (October December 2023)
		76	**104**
Themes	Behaviour / relationships	38	63
	Bullying & Harassment	11	13
	Culture	2	3
	Leadership	0	3
	Patient Safety	11	21
	Process/Systems	29	43
	Personal Grievance	0	0
	Worker Safety	10	19
How raised	Openly	10	21
	Confidentially	59	77
	Anonymously	7	6
Perceived detriment		1	2

NB. Please note some concerns may have more than one element.

Report Breakdown by Role

Q2. 2023 24 (July September 2023)		Q3. 2023 24 (October December 2023)	
Role	**Number**	**Role**	**Number**
Doctor/Dentist	9	Doctor/Dentist	19
Nurse/Midwives	18	Nurse/Midwives	31
HCA	13	HCA	7
Healthcare Scientists	0	Healthcare Scientists	1
Admin	11	Admin	18
AHP	9	AHP	7
Other	9	Other	19
Not Known	7	Not Known	2

4.6 FTSU Guardian Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The FTSU Guardian recently changed to MS forms which can be completed online to encourage a higher response rate. The feedback has been provided by staff that have spoken up and has been predominantly positive.

Quarter 2023 24	Feedback received	Would you speak up again? Yes
Q1	8	7
Q2	7	7
Q3	11	10
Q4		

Data analysis of the completed evaluation forms indicate colleagues aged between 25-70 accessing the FTSUG. With regard to ethnicity colleagues from Asian, Asian British and White backgrounds accessed the FTSUG in Q3.

Within the feedback received, the following are extracts of qualitative feedback received:

I don't know who else I could have spoken to that would have been my voice to take my concern seriously. I can't thank you enough. Things have improved so much.

Don't feel department have really taken it completely seriously with a full resolution.

I am so grateful to have been informed about the service. The Guardian was kind, and approachable. She was able to fit the meeting in around my work and was very easy to talk to. She listened to ALL my concerns (there was more than one raised) and gave me advise on each concern. The support was very well received and has since made a positive impact on my own wellbeing and the service I work in.

4.7 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The FTSU Guardian received a concern from a colleague concerned that agency staff did not know how to complete DOLS appropriately. The FTSUG contacted the Bank Office and shared this information (Bank Office made a note but felt that this was not an ongoing issue). The FTSUG also contacted the ward manager who said that they would check that the agency colleague knows the correct procedure for future learning.

5. Regional and National Information and Data

5.1 National update

The National Guardian's Office reported 25,382 cases were brought to Guardians in 2022-2023, an increase from the previous year. There are now over 1000 Guardians in post across the country. Nearly a third of cases nationally included an element of inappropriate behaviours and attitudes and over a quarter included an element of worker safety or wellbeing.

The NGO have presented their annual report to parliament (November 2023) and will be developing a new strategy in 2024.

All FTSU Guardians now must take an annual competency test, the FTSU Guardian has passed this for 2023.

Q3 data for 2023-24 has been submitted to the NGO by the Guardian.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included how the NGO support Guardians, FTSU and PSIRF, and discussion about what tools/support Guardians use/access to maintain their own wellbeing.

6. Proactive work of the FTSU Guardian during Q3

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Health & Wellbeing Steering Group and Culture Transformation Board
- Attendance at all Trust inductions
- Attendance at Junior Doctors Forum
- Attendance at Regional FTSU Guardian meeting
- Speak Up Month activities including recruiting 'Speak Up Champions'

Future Plans

- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian.
- Work with HUTH FTSU Guardian to develop a group FTSU Strategy

7. Conclusion

7.1 The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

The Trust Board is asked to:
a) Note the report for assurance

Compiled By: Liz Houchin
Date: 8th January 2024

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

Development areas to address in the next 6-12 months	Target date	Action owner	Progress Update
1. Board development session to get all Board members to agree a vision for Speaking Up (including role modelling values of the organisation) and to commit to it	June 2023	HRD/Vice Chair	Board development session to be planned once new Group Executive team in post in 2024
2. Discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course	June 2023	HRD/Vice Chair	Will form part of the board development session in 2024
3. Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme) – Review FTSU input after 12 months delivery	January 2024	OD/FTSU Guardian	All leaders undertaking the leadership development course complete 'listen up' training. Programme is designed to develop compassionate leaders with elements about creating a speak up environment
4. Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board- review in 6 months	June 2023	HRD/CIO	FTSU information sent to divisional management teams quarterly
5. Update and Communicate new policy to staff	March 2023	HRD	New policy launched in Feb 2023, using Fb, Hub, and Wed Weekly News

6. Develop ways of measuring the effectiveness of the communications strategy for FTSU	June 2023	FTSU Guardian/Comms	Bi-monthly meetings held with Comms Jan 2023 – walk round with Comms to sense check awareness of FTSU Guardian and most effective comms method
7 Ensure FTSU information on local induction check list	March 2023	FTSU Guardian/People Directorate	FTSU listed on Induction Checklist for New Starter (DCM716)
8 Further work needed on how we can encourage managers including targeted support through cultural transformation work to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale.	October 2023	OD/HRD	FTSU information included in the Manager's monthly email FTSU Guardian part of the Cultural Transformation Working Group FTSU Guardian presented at OMG away day – October 2023 FTSU Guardian held Manager Drop-In sessions during October

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 3 2023/2024

1. Purpose of the paper

This paper provides the Group Trusts Boards-in-Common (meeting held in public) with an overview of the Freedom to Speak Up Guardian (FTSUG) activity during quarter 3 (Q3) of the 2023/2024 reporting year. The paper further provides an update on the Trust's speaking up arrangements, including the themes of the concerns raised and the activities undertaken by the Trust's FTSUG. The paper also includes details of the ongoing joint working with the FTSUG at Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) as the Trusts create a Group leadership structure.

2. Introduction/background

Following the Francis Review, all organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. This role acts impartially and provides an option to raise concerns in a confidential manner. There are a number of processes at HUTH in place that allow staff to raise concerns. These include:

- Line manager or senior manager
- FTSUG
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)
- Counter Fraud Plus (CFP) Team

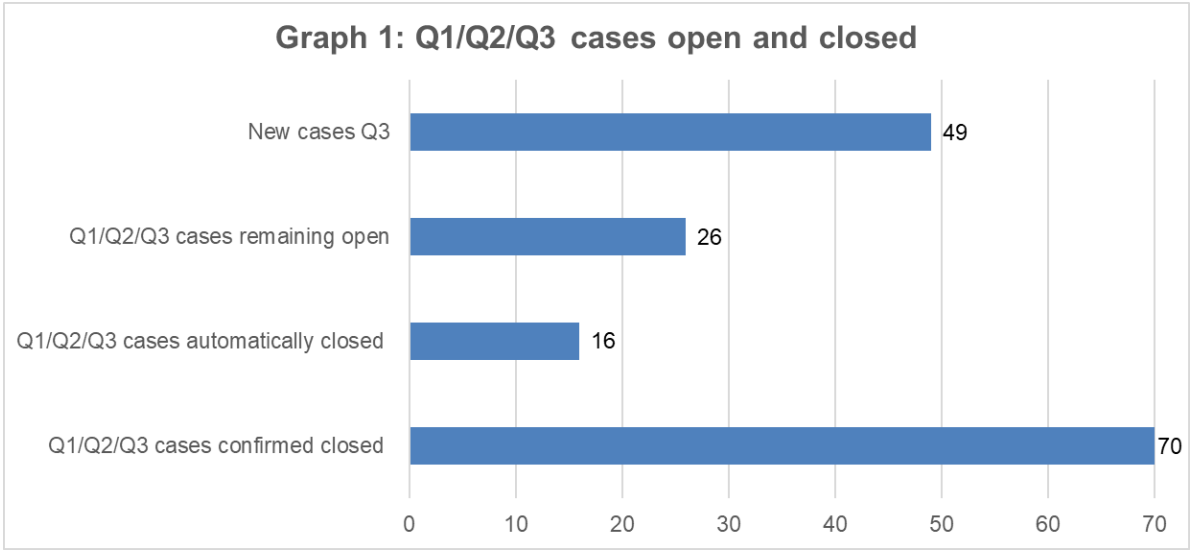
There are other routes as ways in which staff can receive support if they are experiencing difficulties at work, for example Occupational Health and other staff support services.

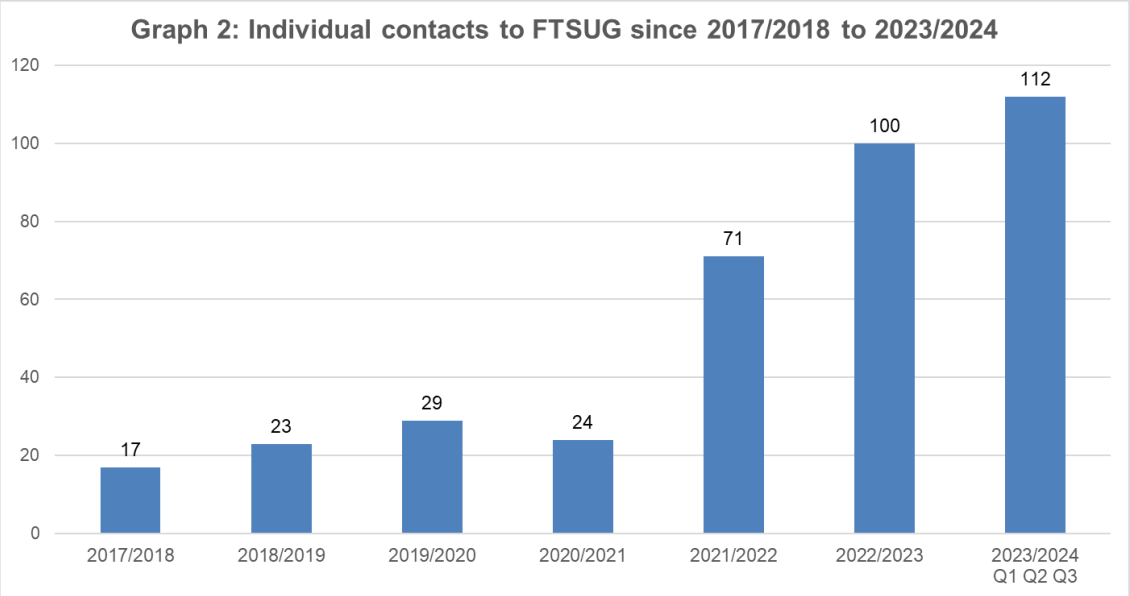
In addition, professional organisations such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) issue guidance which sets out the expectations on healthcare professionals to take appropriate action to raise concerns about patient care, dignity and safety.

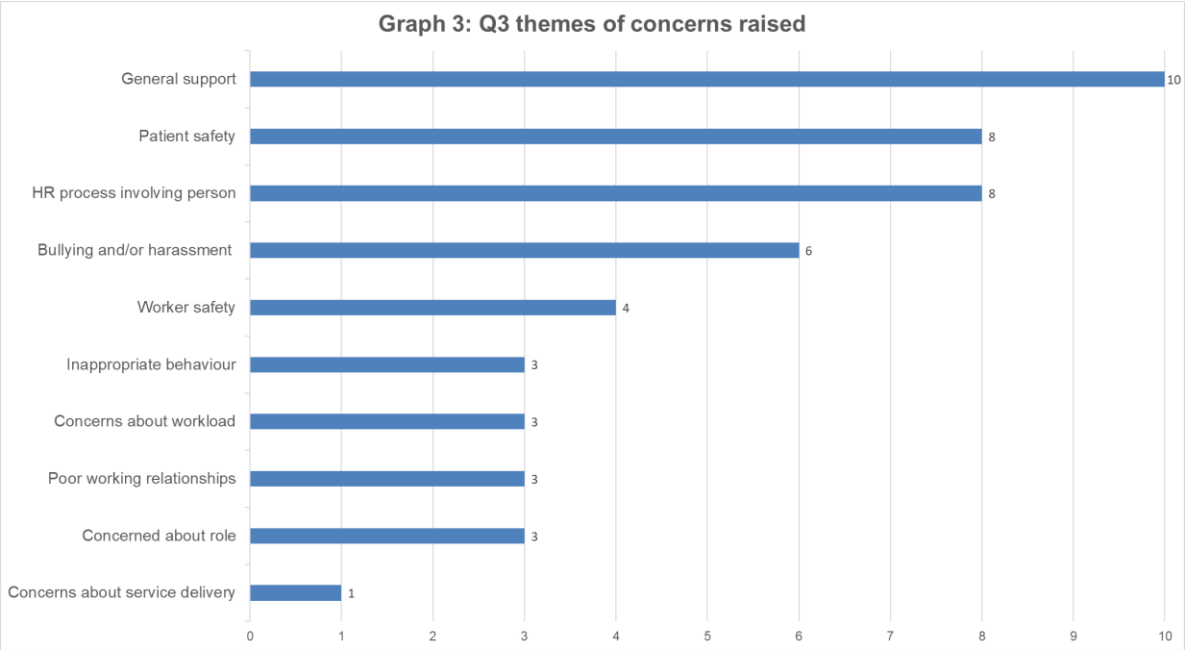
3. Trust contacts during 1st October 2023 to 31st December 2023 (Q3)

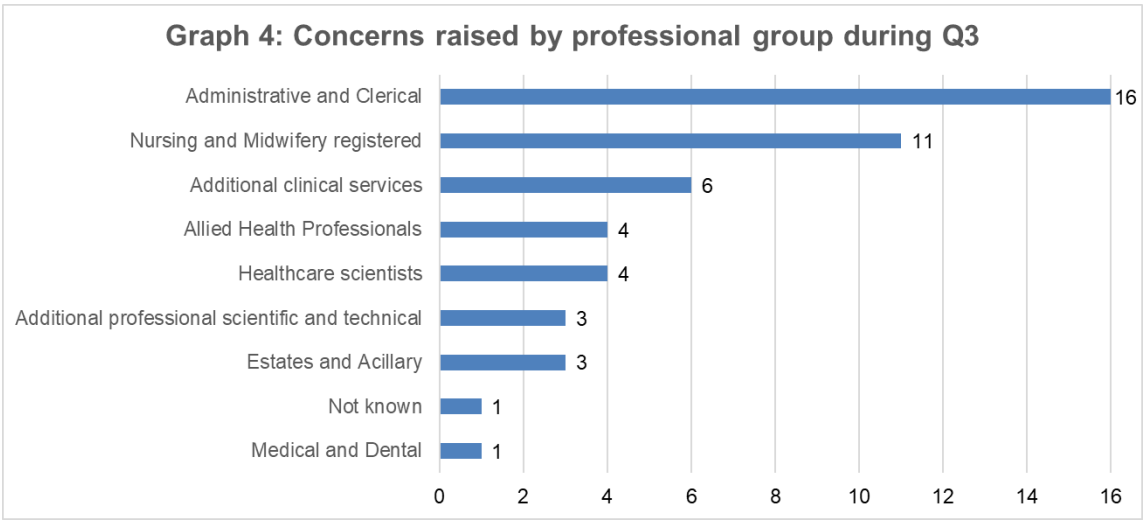
The FTSUG reports on individual contacts received from members of staff, students, trainees and volunteers, to the Trust committees including the Group Trusts Boards-in-Common, Workforce Education and Culture Committee in Common and to the Audit, Risk and Governance Committee in Common.

Graphs 1, 2, 3 and 4 below summarise the Q3 and year to date data:




Graph 2: Individual contacts to FTSUG since 2017/2018 to 2023/2024
120
100
80
60
40
20
0
17
23
29
24
71
100
112
2017/2018
2018/2019
2019/2020
2020/2021
2021/2022
2022/2023
2023/2024
Q1 Q2 Q3


Graph 3: Q3 themes of concerns raised
General support
Patient safety
HR process involving person
Bullying and/or harassment
Worker safety
Inappropriate behaviour
Concerns about workload
Poor working relationships
Concerned about role
Concerns about service delivery
10
8
8
6
4
3
3
3
3
1
0
1
2
3
4
5
6
7
8
9
10


Graph 4: Concerns raised by professional group during Q3
Administrative and Clerical
Nursing and Midwifery registered
Additional clinical services
Allied Health Professionals
Healthcare scientists
Additional professional scientific and technical
Estates and Acillary
Not known
Medical and Dental
16
11
6
4
4
3
3
1
1
0
2
4
6
8
10
12
14
16

Themes, comments and learning:

- During Q3 the number of individual concerns received by the FTSUG increased further to 49. This is the highest number of individual concerns reported to the FTSUG in a quarter since the role was implemented. In comparison with the same reporting period in previous years: 2022/2023 (31 concerns), 2021/2022 (25 concerns) and 2020/2021 (6 concerns).
- The overall number of concerns brought to the FTSUG during Q1, Q2 and Q3 increased to 112 and therefore has already exceeded the annual total number of concerns during 2022/2023 (100).
- Only one of the concerns during Q3 was reported anonymously to the FTSUG via a non-Trust email account. The FTSUG offered options to the anonymous individual to escalate their concern, but did not receive a response.
- The highest number of reasons for staff approaching the FTSUG were general concerns (10) and included several approaches related to improvement ideas and concerns about policy breaches and issues outside of the staff member's immediate department.
- During Q3, the FTSUG received an increase in the number of Administrative and Clerical and Additional Clinical Services (staff directly supporting those in clinical roles and have significant patient contact as part of their role) reporting concerns.
- The FTSUG received one concern related to a student's experience at the Trust; raised indirectly on behalf of the student. This was escalated appropriately by the staff member contacting the FTSUG.
- The FTSUG and Head of Learning and Organisational Development have identified an opportunity to provide support and supervision to the leadership teams of the Staff Networks. This is to ensure the Staff Networks are supported when dealing with individuals reaching out for support with speaking up. An initial informal discussion will take place to plan the support group in early 2024.
- The FTSUG has received a small increase in staff reporting concerns raised in their capacity as a patient or relative. This falls outside of the remit of the FTSUG and discussions will be held with the Patient Experience team to discuss the different ways staff are able to speak up.

4. FTSUG activities during Q3 2023/2024

A high level summary of the activities of the FTSUG during Q3 are detailed below:

- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan. A progress report against the improvement and strengths action plan is included as Appendix 1 to this report.
- Invited to present and discuss speaking up at the Senior Nurses meeting for Medicine Health Group.
- Invited to present and discuss speaking up at the Clinical Leads meeting for Medicine Health Group.
- Activities during national awareness month for freedom to speak up:
    - Face to face staff drop in sessions at both Hull Royal Infirmary and Castle Hill Hospital.
    - Virtual staff drop in sessions – taking place both within office hours and on an evening to support staff who are unable to access the FTSUG during traditional office hours.
    - Manager drop in sessions (MS Teams) – supporting teams to speak up.
    - Joint staff drop in session with Jo Ledger, Interim Chief Nurse.
    - Ward walk around at Hull Royal Infirmary with Jo Ledger, Interim Chief Nurse.
    - Promotional stalls jointly with the HILS Nursing Simulation team and Patient Safety Team to encourage near miss reporting of incidents.
- Delivered introductory presentations to different staff inductions. This included several induction events for the newest cohorts of Internationally Educated Nurses and to the first cohort of Internationally Educated Midwives.
- Continued support to the Zero Tolerance to Racism circle group and support to the development of the Zero Tolerance to LGBTQ+ discrimination framework.
- Introductory meeting with the Education and Development Advisor for Staff SEN support to discuss cross referrals and partnership working.
- Attended and provided a market stall to raise awareness at the Staff Disability Network conference.
- Provided a market stall to raise awareness at the Healthcare Professionals conference.
- Joint drop in sessions with the York and Scarborough NHS Teaching Hospitals NHS Trust FSTUG held for Scarborough Hull and York Pathology Service staff; offered at both Hull Royal Infirmary and Castle Hill Hospital.
- Introductory meeting with the FTSUG for Haxby Medical Group; to discuss partnership working and sharing of best practice.
- Attended and provided a market stall to raise awareness at the Staff BAME Network conference.

5. Additional updates

5.1 Regional and national information and data

The FTSUG continues to be part of the Yorkshire and the Humber regional network of FTSUGs and accesses monthly meetings. From 2024 onwards the Yorkshire and the Humber region will merge with the North East for quarterly meetings, in order to continue to share best practice and learning.

The FTSUG submits information to the National Guardian Office on a quarterly basis and on 16th November 2023 the Annual Report of the National Guardian for the NHS was laid before Parliament, including the data from HUTH. The report highlights the work of the FTSUGs and has shared learning that indicates that more work in needed for speaking up. There are currently over 1000 FTSUGs across the healthcare sector in England and during the 2023/2024 year 25,382 cases were logged with FTSUGs. This represented a 25% increase nationally on the previously highest record in 2021/2022.

5.2 Group leadership structure

The HUTH FTSUG has an existing partnership with Liz Houchin, NLAG FTSUG and this will continue to strengthen with the creation of the Group leadership structure.

Both FTSUGs held a joint working session in January 2024 to discuss aligning future plans, including:

- The majority of the work areas undertaken by the HUTH and NLAG FTSUGs are already largely consistent.
- In the areas of reporting where there is national guidance; the FTSUGs are already reporting consistently. Where there are gaps in national guidance; the FTSUGs have established there are similarities between current reporting but the FTSUGs have agreed a consistent approach to be implemented with effect from the new 2024/2025 reporting year in Q1 and the establishment of the Care Groups. This includes minor changes to the concern codes that each FTSUG used to report the types of concerns received by staff.
- The FTSUGs have commenced working to ensure that each Trust report for future committees is consistent.
- The FTSUGs will present at Group Committees in Common each report at the same meetings.
- It is proposed that a joint Group Freedom to Speak Up Strategy is created for implementation in Q2 2024/2025.

6. Conclusions

The Trust continues to support the FTSUG role and it is positive that the number of individuals approaching the FTSUG continues to increase. The total number of concerns year to date for 2023/2024 is 112 and this has already exceeded the 2022/2023 annual total (100). The FTSUG continues to work to build networking and relationships with key individuals and teams across the Trust and with external FTSUGs, to strengthen partnership working and sharing good practice.

The FTSUG has continued to promote speaking up arrangements at HUTH during Q3, including supporting the national awareness month and offering a number of different ways that staff can contact the FTSUG.

7. Recommendation

The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Frances Moverley
Head of Freedom to Speak Up - HUTH
February 2024

Appendix 1:
Summarise of high-level development actions:

Development areas to address in the next 6–12 months	Target date	Action owner	Progress update
1. Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead	**Action completed** • Repeat self-assessment of the Board self-reflection will be scheduled no longer than two years from the previous assessment (February 2023). Executive Lead committed to ensuring this has been completed.
2. Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG	**Action in progress** • 6 further Speak Up Champions recruited and trained during March, April, May, June and July 2023. • List of local Speak Up Champions continually updated on staff intranet Pattie and bimonthly network meetings for all Champions providing peer support and development are in place. • Private workspace on Pattie set up for Champions to provide a central resource for key updates and resources. • Recruitment to being a Speak Up Champion continues to be promoted at local induction events e.g. internationally educated nurses, junior doctors. • At 29.01.24. 24 active Speak Up Champions trained and further 4 are booked on training.
3. Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/03/24	FTSUG	**Action in progress** • Bimonthly training dates booked until end of 2023. • Bimonthly training dates for 2024 are in place.
4. Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.	**Action completed** • New national speak up policy has been personalised and circulated to stakeholders. The Workforce Transformation Committee on 20th July 2023 was cancelled – currently seeking ratification through email approval to progress the policy. • Joint drop in session with the York and Scarborough NHS Teaching Hospitals NHS Trust held for SHYPS staff took place 27th July 2023. Further dates will be scheduled to provide further opportunities to speaking up. • The new Group CEO circulated communications in reflection of the recent national media coverage into the conviction of a neonatal nurse and the importance of speaking up in the NHS. • Joint drop in session with the FTSUG and Chief Nurse scheduled for 31st August 2023. • Attendance planned to provide a market stall to raise awareness of speaking up at the Staff Disability Network conference in October 2023.

			• Repeated communications and bulletins from the Group CEO promoting a speaking up culture at HUTH and the FTSUG role. • During speak up awareness month in October 2023, a timetable of activities was promoted across the Trust including joint drop in sessions and walk arounds with the Interim Chief Nurse and FTSUG. • Ad hoc communications e.g. Daily Update linked to speaking up, circulated Trust-wide. • Future - 2024 Communications Plan to be developed, where possible in conjunction with the NLAG FTSUG.
5. Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances. • A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.	31/03/23	FTSUG	**Action in progress** • Question about whether the individual had experienced positive behaviours when speaking up considered and included in the feedback survey. • Question about referral route and awareness of the FTSUG role included in the feedback survey. • Free text box included in the survey to include permission to share stories of speaking up. • Final amendments to the feedback survey to be made – Digital Communications team confirmed in work plan. • Questions related to protected characteristics approved by Equality, Diversity and Inclusion Committee 18.01.24. Final checks in progress and feedback survey will commence.
6. Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	31/03/24	Head of Learning and Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss incorporating existing Health Education England e-learning into line manager development. • PACT embedded into all of the leadership programmes and how to speak up. Programmes will be reviewed with the move to the group leadership model but speaking up with remain with any new/revamped programmed. • January 2024 - Head of Learning and Organisational Development confirmed looking at opportunities to include speaking up content in future leadership training. Requested an extension to the target date. • FTSUG met with OD Facilitator to discuss including a bespoke speaking up module within the new Inclusion Academy.
7. Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an “internal consultant” to bring expertise into bespoke work design.	31/03/24	Head of Learning and Organisational Development	**Action in progress** • The Maternity reporting tool is now live and Cardiology is currently in progress.

			• FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised. • Cardiology incivility reporting tool launched on 10th November. • FTSUG continues to be involved in the monthly circle groups.
8. Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	31/03/24	Head of Learning and Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss what indicators and data could be appropriately used for a Trust wide group. • This action needs further thought as more reporting tools are made live. Zero tolerance to ableism launched October 2023 in addition to the existing zero tolerance to racism. • LGBTQ+ framework and circle group are due to go live February 2024. • Head of Learning and Organisational Development have identified a potential support/supervision need for staff network leadership teams – informal meeting to discuss further the scope of this work in February 2024.
9. Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	31/03/24	Head of Learning and Organisational Development	**Action in progress** • PACT "Professionalism and Civility Training" launched from late August 2023 onwards, alongside a marketing campaign to allow us to reflect on how "Bad Behaviour Doesn't Work – Time to Change". • PACT has been delivered to approximately 150 leaders and is currently on hold for a group roll out as needed. PACT is also delivered in the new format to all new starters and this includes a FTSUG contacts and how to report concerns. • Currently on hold subject to the Group leadership structure.
10. Implementation of the new NHS England speaking up policy. To include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.	31/12/23	FTSUG	**Action completed** • National policy transferred into HUTH template and personalised. • Policy could not be ratified due to Workforce Transformation Committee on 20th July 2023 being cancelled. Approval sought via email approval. • Approval via email confirmed. Policy now published live on Pattie (reference CP451).
11. Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG	**Action completed** • Draft policy sent to internal stakeholders for information/comment. Including Executive Lead, Director of Workforce, Head of Workforce, Head of HR, Disability Staff Network Chair, BAME Staff Network Chair, LGBTQ+ Staff Network Chair, JNCC Chair, LNC Chair, Equality Diversity & Inclusion Trust Lead.
12. Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the	31/05/23	FTSUG	**Action completed**

programmes of delivery.			• Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training.
13. Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8 above.	31/03/24	FTSUG	**Action in progress** • FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports. • January 2024 – initial discussion with NLAG FTSUG to discuss best practice and different ideas for triangulation.
14. Review the self-reflection and planning tool outputs from at least two other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.	31/12/23	FTSUG	**Action in progress** • Self-reflection and planning tool reviewed and shared with NLAG FTSUG. • HUTH FTSUG has contacted other FTSUGs working in similar sized acute Trust's across the region to discuss sharing. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • HUTH results compared to NLAG. Copies of improvement plans requested from two other acute NHS trusts for comparison. • Contact made with Mid Yorkshire Teaching NHS Trust and Group (Kettering General Hospital and Northampton General Hospital).
15. Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.	31/03/23	FTSUG	**Action completed** • Ongoing feedback requested as appropriate
16. Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/03/24	FTSUG	**Action in progress** • Initial work underway to develop a draft strategy; including reviewing other Trust's strategies. • January 2024 – discussed with NLAG FTSUG to propose a joint Group. NLAG current strategy due for renewal August 2024.

Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner	Progress update
1. Share speak up arrangements with other Trusts. To include: recruitment and ring fenced time for the role, locally agreed absence arrangements, creation of the speak up champions network, involvement with other services across the Trust and being an ally of each staff network.	30/09/23	FTSUG	**Action completed** • Self-reflection and planning tool reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • FTSUGs at three other Trust's across the region have requested observing the training the HUTH FTSUG provides to Speak Up Champions to gather best practice ideas. • HUTH FTSUG to present training videos produced at the Trust by the FTSUG at the next regional FTSUG meeting due to interest from other Trusts.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No:BIC(24)021

Name of the Meeting	**Trust Boards in Common**
Date of the Meeting	8 February 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 - NLaG
Executive Summary	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
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:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(24)021

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

Report for meeting of the Trust Boards to be held on:	8 February 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 for first 2/3 of meeting, due to Executive Director diary conflicts

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 10 January 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 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)

*[*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 Committee agreed the following matters for reporting / escalation to the Trust Boards:

a. Trustees were concerned that the Committee was not quorate in respect of Executive Directors 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 requested additional assurance on the following items of business:

Not applicable

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 has proposed the following change(s) to the risk rating or entry:

Not applicable

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- Note the report
- Note that the HTF 2022/23 Annual Report and Accounts were approved at the January 2024 HTF Trustees Committee meeting and were submitted to the Charities Commission

Neil Gammon, Independent Chair of Health Tree Foundation Trustees Committee

27 January 2024

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)022

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Sean Lyons, Group Chair
Contact Officer/Author	Wendy Booth, Interim Governance Advisor
Title of the Report	Chair of the NLaG Health Tree Foundation Trustees' Committee – Extension of Tenure
Executive Summary	The report confirms that Neil Gammon's tenure as Chair of the Health Tree Foundation Trustees' Committee is due to come to an end at the end of March 2024. Neil has expressed an interest in continuing in the chair role and the report proposes asking him to continue for a further three-year term to the end of March 2027. The report also confirms that minor changes have been made to the committee's terms of reference and advises of the plans of the Health Tree Foundation Patron to stand down during 2024. The NLaG Trust Board is asked to: • approve the proposed three-year extension to Neil Gammon's tenure as chair of the Health Tree Foundation Trustees' Committee to the end of March 2027; • note the plan for Neil Gammon to attend the April 2024 trust board meeting to present the revised terms of reference for the Health Tree Foundation Trustees' Committee and to provide a brief year-end update on the work of the committee; • note the position in respect of the Health Tree Foundation Patron.
Background Information and/or Supporting Document(s) (if applicable)	None
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:

NLaG Health Tree Foundation Trustees' Committee

1. Background & Introduction

1.1 As part of the approval of the proposed governance & decision-making arrangements for the HUTH : NLaG group model (Option 7), the board of both trusts agreed in 2023 that the quality, finance, workforce, audit and remuneration committees of each board should meet 'in-common'. A new Capital & Major Projects Committee-in-Common is also being convened. However, it was also agreed that the arrangements in respect of charitable funds should remain separate and unchanged in each organisation.

1.2 Within HUTH, charitable funds are managed on behalf of the trust by the WISHH Charity. Within NLaG, charitable funds are managed on behalf of the trust by the Health Tree Foundation and the trust has in place a Health Tree Foundation Trustees' Committee.

1.3 This paper covers the NLaG Health Tree Foundation Trustees' Committee.

2. Chair of the Health Tree Foundation Trustees' Committee

2.1 The Health Tree Foundation Trustees' Committee is chaired by Neil Gammon, who has a long-standing relationship with the Trust; having previously served as a non-executive director for 9 years between 2010 to 2021 and having chaired the committee since 2017.

2.2 Neil Gammon's tenure as Chair of the Health Tree Foundation Trustees' Committee is due to come to an end at the end of March 2024. Neil has expressed an interest in continuing in the chair role and it is proposed, subject to board approval, to ask him to continue for a further three-year term to the end of March 2027.

3. Terms of Reference for the Health Tree Foundation Trustees' Committee

3.1 At its meeting held on Wednesday, 10 January 2024, the Health Tree Foundation Trustees' Committee reviewed its terms of reference and work plan. Minor amendments only are suggested; not least to reflect the move to group and changes to titles. The revised terms of reference are currently being updated to reflect the proposed changes and, subject to ratification by the committee, will be submitted to the April 2024 board meeting for final approval.

3.2 It is proposed to ask Neil Gammon to attend the April 2024 board meeting to present both the revised terms of reference and to provide a brief year-end update on the work of the Health Tree Foundation Trustees' Committee.

4. Health Tree Foundation Patron

4.1 The Board is asked to note that the Health Tree Foundation Patron, Sir Reginald Sheffield, is due to step down at some point during 2024. The

Health Tree Foundation Trustees' Committee will therefore be giving consideration as to a successor and would welcome any suggestions which the board may have in this regard.

5. NLaG Trust Board Action Required

5.1 The NLaG Trust Board is asked to:

- approve the proposed three-year extension to Neil Gammon's tenure as chair of the Health Tree Foundation Trustees' Committee to the end of March 2027;

- note the plan for Neil Gammon to attend the April 2024 trust board meeting to present the revised terms of reference for the Health Tree Foundation Trustees' Committee and to provide a brief year-end update on the work of the committee;

- note the position in resect of the Health Tree Foundation Patron.

NHS
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)018

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer/Author	Rebecca Thompson, Head of Corporate Affairs – HUTH Wendy Booth, Interim Governance Advisor – NLaG
Title of the Report	Board Assurance Frameworks – HUTH & NLaG
Executive Summary	The HUTH & 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 new strategic objectives for the group have been agreed and the Board Assurance Frameworks have been aligned. The report provides the separate Board Assurance Frameworks for HUTH & NLaG as at Quarter 3 (2023/24). Both Board Assurance Frameworks were reviewed at the Group Executive led Risk & Assurance Group meeting held on 8 January 2024. The next executive review is scheduled for Monday, 5 February 2024. From the executive review on 8 January 2024, the following changes were proposed to risk ratings, as follows: <u>HUTH</u> • BAF Risk 3.2 (Patient Harm): reduce from 25 to 20 to reflect the improvement actions which have been implemented. BAF Risk 5 (Partnerships) was increased to 20 to bring it in line with BAF risk 3.2 The proposed changes in risk rating were endorsed by the Quality & Safety Committee-in-Common at the meeting held on Thursday, 25 January 2024 • BAF Risk 2 (Staffing): reduce from 16 to 12 to reflect the improved nursing establishment and vacancy position. The proposed change in risk rating was endorsed by the Workforce, Education & Culture Committee-in-Common on Tuesday, 30 January 2023 <u>NLaG</u> • BAF Risk 3.1 (In-Year Financial Target): reduce from 20 to 16 to reflect the improved financial position. The proposed reduction in risk rating was endorsed by the Performance, Estates & Finance Committee-in-Common at the meeting held on Wednesday, 24 January.

	<u>Recommendations</u> The HUTH and NLaG Trust Boards are to: • review and approve the proposed risk rating reductions for the respective trusts; • note that, as part of the development of the group model, work will be undertaken in due course to align the strategic objectives of the two trusts and, in turn, the BAF. As a first phase, both Trust BAFs have been produced in a new, streamlined, and consistent format.
Background Information and/or Supporting Document(s) (if applicable)	Strategic Objectives – HUTH & NLaG
Prior Approval Process	None
Financial implication(s) (if applicable)	As outlined, where appropriate, within the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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

Boards in Common
Board Assurance Framework Q3 2023/24

1. Purpose of the Report

The purpose of the report is to present the HUTH Q3 Board Assurance Framework to the Boards in Common for approval.

2. Background

The HUTH Board agreed at its meeting in May 2023 that the 2022/23 Q4 risks would be carried over into 2023/24 due to the Group Model development and potentially new strategic objectives.

3. Current Status of the Board Assurance Framework

An overview of all HUTH BAF risks is provided in the table below. The risks are considered, discussed and challenged at the appropriate Board Committees in Common. The full Board Assurance Framework is appended to this report.

Q3 Risk Ratings

The table below shows all risks and risk ratings for Q3 2023/24. Section 5 in this report gives a brief overview of the risks. A graph detailing risk movement is attached at Appendix 1.

Table 1

Risk	Inherent Risk (L x I)	Current Risk (L x I)				Target Risk	Risk Appetite
BAF 1 - The Trust does not make progress towards further improving a positive working culture this year	5 x 4 = 20	Q1 4 x 4 = 16	Q2 4 x 4 = 16	Q3 4 x 4 = 16		3 x 4 = 12	Low
BAF 2 - The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust	4 x 5 = 20	Q1 4 x 4 = 16	Q2 4 x 4 = 16	Q3 3 x 4 = 12		3 x 4 = 12	Low
BAF 3.1 – There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating.	4 x 4 = 16	Q1 4 x 4 = 16	Q2 4 x 4 = 16	Q3 4 x 4 = 16		3 x 4 = 12	Low
BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED and Patients with No Criteria to Reside require partnership working to determine improvement plans.	5 x 5 = 25	Q1 5 x 5 = 25	Q2 5 x 5 = 25	Q3 4 x 5 = 20		4 x 4 = 16	Low
BAF 4 - There is a risk to access to Trust Services following the residual impact of Covid	5 x 5 = 25	Q1 4 x 5 = 20	Q2 4 x 5 = 20	Q3 4 x 5 = 20		4 x 4 = 16	Low
BAF 5 - That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery, primary care and social care constraints	4 x 4 = 16	Q1 3 x 4 = 12	Q2 3 x 4 = 12	Q3 4 x 5 = 20		2 x 3 = 6	Moderate
BAF 6 – There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	4 x 4 = 16	Q1 3 x 4 = 12	Q2 3 x 4 = 12	Q3 3 x 4 = 12		2 x 4 = 8	Moderate

BAF 7.1 - There is a risk that the Trust does not achieve its in-year financial plan	5 x 4 = 20	Q1 4 x 4 = 16	Q2 4 x 4 = 16	Q3 4 x 4 = 16		2 x 4 = 8	Moderate
BAF 7.2 - There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year	4 x 5 = 20	Q1 4 x 5 = 20	Q2 4 x 5 = 20	Q3 4 x 5 = 20		4 x 5 = 20	Low
BAF 7.3 - There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4 x 5 = 20	Q1 3 x 5 = 15	Q2 3 x 5 = 15	Q3 3 x 5 = 15		2 x 5 = 10	Moderate

Risk Appetite Matrix

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

4. Actions Update

A number of actions have been taken in Quarter 3 and these are shown in the Appendices.

5. Risk ratings

Following discussions at each of the Committees and with the Executive leads the following Q3 risk ratings are proposed:

BAF 1 – Honest, caring and accountable culture

The Staff Survey has been circulated for completion and the response rate has increased to 50% against a national average of 34% (December 2023 figures).

A senior leadership event has been organised relating to the new Group Model and Care Group changes. This will be held at the University of Hull in early 2024.

Work has begun around the new Group values and a number of workshops have been added for staff to have their say. The new values will be launched in April 2024, following a number of events.

Both Trusts have been updated regarding the Group Executive appointments.

Due to the ongoing culture work and the yet unknown Staff Survey scores the Group Chief People Officer proposed that the risk rating remain at 16 but reviewed in Q3 when the Staff Survey scores are known.

BAF 2 – Valued, skilled and sufficient staff

The Trust's vacancy rate has reduced to 2.2% in Q3 and sickness has reduced from 4.4% in Q2 to 4% in Q3.

Despite the growth in Trust establishment during the year, the Trust retains some capacity and demand challenges. This includes delivering external screening programmes for the region.

Due to the positive staffing position the Group Chief People Officer proposed that the risk be reduced to 3 x 4 = 12.

BAF 3.1 – High Quality Care
During Q3 the CQC action plans for ED and Maternity have been scrutinised by the Quality Committee and the progress is being presented to every Board meeting. ED have made good progress against their action plan but there is still work to be done in Maternity and the section 31 is still in place.

There have been a number of deep dives undertaken by the Quality Committee in Q3, in particular Falls and Tissue Viability. The Falls Team have a number of initiatives in place including a weekly patient safety summit and can demonstrate a sustained reduction in falls.

The Interim Chief Nurse has recommended that the risk rating remains at 16 for Q3, as although action plans are in place and being implemented, sustained improvements are not yet being displayed.

BAF 3.2 – Harm Free Care
The risk was increased to 5 x 5 = 25 in Q1 due to the major issues relating to over-crowding in ED and access to services.

There have been improvements in performance, particularly in respect of ambulance handover following constructive joint rapid improvement work with YAS and a marked reduction in inpatient safety incidents, particularly in the respect of harm.

Work on the new Urgent Treatment Centre has commenced and this is due to open in January 2024. This programme is being aligned with the Ground Floor re-modelling, Same Day Emergency Care initiatives and AMU HOB. It is hoped that these new ways of working will go some way to ease the pressures in ED and increase flow.

New cancer trajectories have been submitted to the ICB and further funding has been received from the Cancer Alliance.

A number of improvement actions are now underway and the Group Chief Medical Officer proposed that the risk be reduced to 4 x 5 = 20.

BAF 4 – Great Clinical Services
The key issues that remain include patients with no criteria to reside, ambulance handovers and flow through the hospital meaning that the 4 hour target is still not at the required standard of 76% and the Trust is in the bottom quartile nationally. The numbers of patients with no criteria to reside have risen slightly in Q3 and there is still an issue with crowding and flow through the hospital.

There have been 5 catastrophic incidents reported in ED in November and these are being investigated under the new Patient Safety Incident Investigation process.

The Duchess of Kent Day Surgery has now closed and preparations for the new Urgent Treatment Centre have commenced. The revised Ground Floor model is being developed and aligned with the UTC being built.

Cancer delivery is still challenged and the Trust failed to achieve all cancer standards with the exception of the combined Faster Diagnosis Standard.

104 week waits are currently at zero and there were 8 breaches of patients waiting 78 weeks.

The Group Chief Delivery Officer recommended that the risk rating remains the same for Q3 until sustained improved performance can be delivered.

BAF 5 – Partnerships
The Trust is fully engaged with the ICS as well as the development of the Group Model with Northern Lincolnshire and Goole NHS Foundation Trust. Work is progressing through the Joint Boards and Group Development Committees in Common.

The Humber Acute Services Review consultation is at the mid-way point and a number of events and drop in sessions have been undertaken across Grimsby, Hull, Scunthorpe and the East Riding. Collaborative work continues between HUTH and NLAG.

The HASR pre-consultation business case has been submitted to the ICB and an operational lead has been identified.

Work has begun regarding the Community Diagnostic Centres, but a number of risks including planning permissions, cost increases and staffing remain.

It was agreed at the Group Cabinet Risk and Assurance Committee that this risk should be aligned to BAF risk 3.2 due to the ongoing system pressures. Therefore the Group Chief of Strategy and Partnerships proposes a BAF risk of 20 which is an increase from 12.

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

Development of the Group RDI Strategy continues in Q3.

The Group Chief Medical Officer recommended that the Q3 risk rating remains at 16 due to the lack of investment/funding required.

BAF 7.1 – Finance
The Trust reported an in month surplus for month 7 of £1.5m which is £2.1m better than plan. The Income and Expenditure forecast outturn is £7.2m deficit. This is in line with the 2023/24 plan.

The Trust delivered £24.8m in CRES against a target of £27.5m. The forecast is to deliver £47.5m against a plan of £53.9m.

At month 9 the Committees in Common is asked to review the in-year position and decide whether the risk is being mitigated and should be reduced.

The Group Chief Financial Officer proposed that the risk remains at 16 in Q3.

BAF 7.2 – Underlying Financial Position
The underlying deficit will be monitored monthly at the Performance and Finance Committee. The key issues are linked to in-year pressures and un-identified CRES. Additional funding was available for the ICS and changes had been made to the ERF target to reflect the ongoing impact of the industrial action.

The underlying deficit for the year end is still £52.7m in Month 8.

The Group Chief Financial Officer recommended that this risk remains at 20 for Q3.

BAF 7.3 – Capital and Infrastructure
The risk will be monitored at the Performance and Finance Committee against the 2023/24 capital plan.

Capital expenditure is £17.9m, against a year to date plan of £23.3m. Actual capital expenditure to 30th November was £24m, £2.8m behind plan. Main variances relate to Day Surgery, however this was due to delays in the approval process of the Phase 2 Business Case. Expenditure is expected to come back in line in the coming months.

The Group Chief Financial Officer recommended that the risk remains at 15 for Q3.

6. Timetable
The Committees will continue to review the risk ratings and the Trust Board will review the outcomes of the discussions and any risk movement at every meeting.

7. Corporate Risk Register

Attached at Appendix 2 is a snapshot of the Corporate Risks for information and review. This is attached to ensure the Board and Committees can see the high level risks, risk movement and where they are being managed and mitigated.

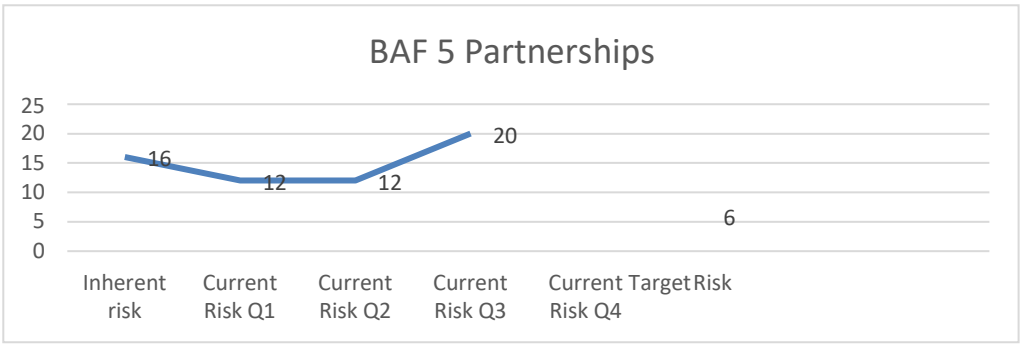
8. Recommendations

The Boards in Common are asked to approve the following proposals:

- BAF Risk 2 (Staffing) risk reduced to 12 from 16 due to the staffing and sickness positions
- BAF Risk 3.2 (Patient Harm) risk reduced from 25 to 20 due to the improvements to ambulance handovers and reduction in patient safety incidents. The Quality and Safety Committees in Common to monitor these improvements for sustainability
- BAF Risk 5 (Partnerships) risk increased from 12 to 20 to align it to BAF Risk 3.2

Rebecca Thompson
Head of Corporate Affairs
February 2024

BAF Risk movement throughout 2023/24


BAF 5 Partnerships
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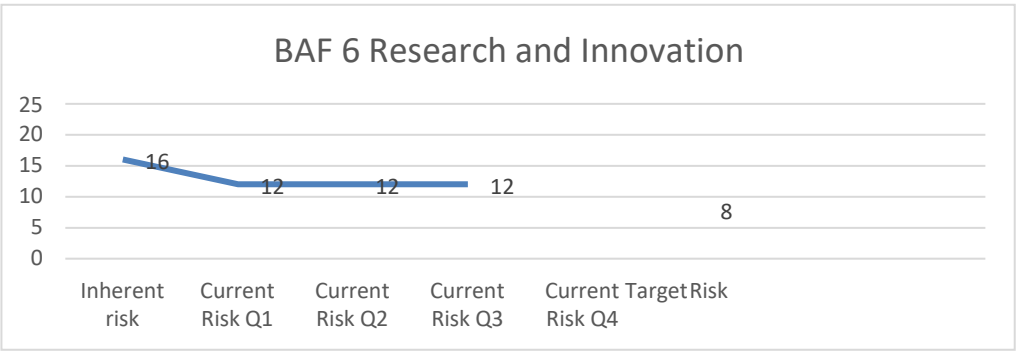
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Target Risk Risk Q4


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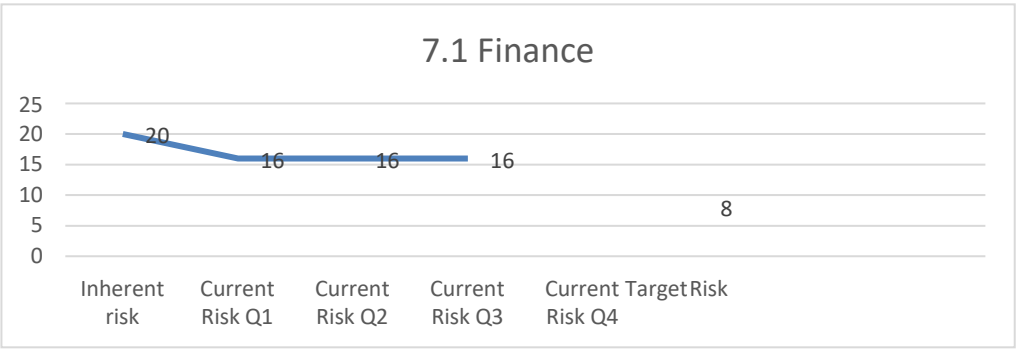
Current Risk Q3
Current Target Risk Risk Q4


7.1 Finance
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Inherent risk
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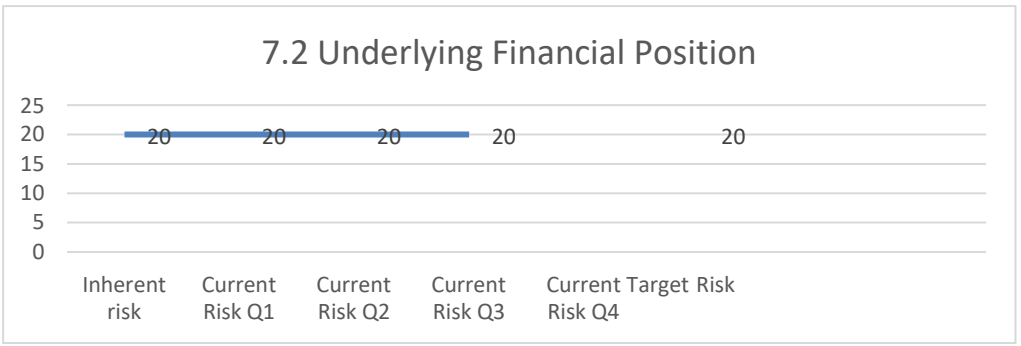
Current Target Risk Risk Q4


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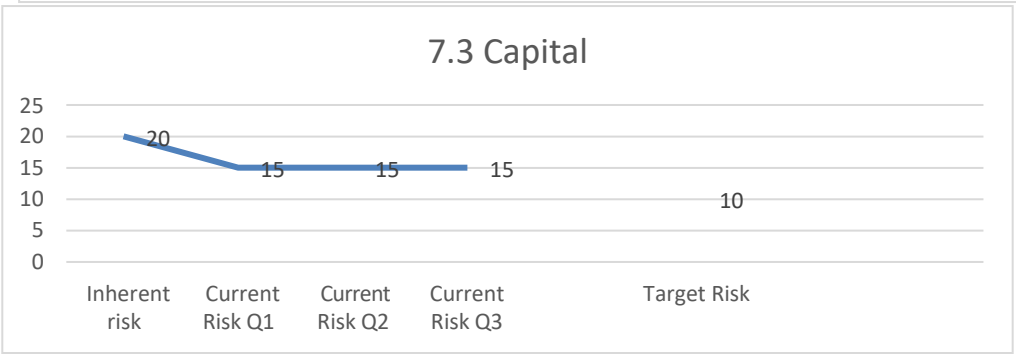
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Target Risk Risk Q4


7.3 Capital
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Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Target Risk

BAF Alignment with the Corporate Risk Register

*** Date added to risk register and reviewed in line with the relevant policy**

BAF Risk	High Level Risks	Health Group	Risk Description	Date on Risk Register*	Inherent Risk S x L	Current Risk S x L	Target Risk S x L	Committee/meeting where risk is reviewed	Risk Movement
BAF 1 Culture **Executive Lead: Simon Nearney** **Risk Appetite: Low**	No high risks on the Corporate Risk Register								
BAF 2 Workforce **Executive Lead: Simon Nearney** **Risk Appetite: Low**	3439	Emergency Medicine	Crowding in the Emergency Department	04/09/2019	25 5 x 5	25 5 x 5	6 3 x 2	ED Monthly Risk/Performance and Finance Committee/Board	⇔
	4166	Trustwide	Risk to patient safety and achievement of organisational falls	16/01/2023	20 4 x 5	20 4 x 5	9 3 x 3	Quality Committee/Falls Committee/Operational Risk and Compliance Sub-Committee	⇔
	3044	Family and Women's	Shortage of Breast Pathologists	18/01/2023	16 4 x 4	16 4 x 4	8 4 x 2	Breast Governance/Health Group Governance/Operational Risk and Compliance Sub-Committee	⇔
BAF 3.1 Patient Harm **Executive Lead: Kate Wood/Jo Ledger** **Risk Appetite: Low**	3994	Trustwide	Discharges and patient flow with impact on quality and safety	09/09/2021	20 4 x 5	16 4 x 4	6 3 x 2	Performance and Finance Committee	⇔
	2982	Family and Women's	Lack of Anaethetic Cover for Under 2's out of hours	19/08/2016	20 4 x 5	20 4 x 5	10 5 x 2	Health Group Governance/Operational Risk and Compliance Sub-Committee	⇔
	3997	Emergency Medicine	Persistant failure of A&E 4 hour target	09/09/2021	25 5 x 5	25 5 x 5	10 5 x 2	ED Monthly Risk/Performance and Finance Committee/Board Risk increased 03/11/25	⇑
	3998	Trustwide	Quality issues identified due to handover delays	09/09/2021	20 5 x 4	20 5 x 4	9 3 x 3	Quality Committee/Performance and Finance Committee/Operational Risk and Compliance Sub-Committee	⇔
	4211	Family and Women's	Patient safety risks due to multiple factors in the Antenatal Day Unit	26/04/2023	20 5 x 4	15 5 x 3	3 3 x 1	Quality Committee/Operational Risk and Compliance Sub-Committee Risk Increased 14/07/2023	⇑
	4048	Clinical Support Health Group	Risk to continuity of service due to the ageing Radiotherapy Linac (Bunker 6)	09/03/2022	25 5 x 5	15 5 x 3	3 3 x 1	Health Group Governance/Operational Risk and Compliance Sub-Committee	⇔
	3439	Emergency Medicine	Crowding in the Emergency Department	04/09/2019	25 5 x 5	25 5 x 5	6 3 x 2	ED Monthly Risk/Performance and Finance Committee/Board	⇔

BAF 3.2 Quality **Executive Lead: KateWood/Jo Ledger** **Risk Appetite: Low**	4179	Trustwide	Delivering the Operational Plan requirement to reduce the backlog of long-waiting patients	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee	
	4178	Trustwide	Delivering the improvement trajectories for screening programmes delivered by the Trust	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee Elective Recovery Group	
	4180	Trustwide	Risk of avoidable harm for patients who have waited 63+ days for a 1st definitive cancer treatment	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee	
	4166	Trustwide	Risk to patient safety and achievement of organisational falls	16/01/2023	20 4 x 5	20 4 x 5	9 3 x 3	Quality Committee/Falls Committee/Operational Risk and Compliance Sub-Committee	
BAF 4 Performance **Executive Lead: Shaun Stacey** **Risk Appetite: Low**	3439	Emergency Medicine	Crowding in the Emergency Department	04/09/2019	25 5 x 5	25 5 x 5	6 3 x 2	ED Monthly Risk/Performance and Finance Committee/Board	
	4179	Trustwide	Delivering the Operational Plan requirement to reduce the backlog of long-waiting patients	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee	
	4178	Trustwide	Delivering the improvement trajectories for screening programmes delivered by the Trust	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee Elective Recovery Group	
	3994	Trustwide	Discharges and patient flow with impact on quality and safety	09/09/2021	20 4 x 5	16 4 x 4	6 3 x 2	Performance and Finance Committee	
	2982	Family and Women's	Lack of Anaethetic Cover for Under 2's out of hours	19/08/2016	20 4 x 5	20 4 x 5	10 5 x 2	Health Group Governance/Operational Risk and Compliance Sub-Committee	
	3997	Emergency Medicine	Persistant failure of A&E 4 hour target	09/09/2021	25 5 x 5	25 5 x 5	10 5 x 2	ED Monthly Risk/Performance and Finance Committee/Board Risk increased 03/11/25	

	3998	Trustwide	Quality issues identified due to handover delays	09/09/2021	20 5 x 4	20 5 x 4	9 3 x 3	Quality Committee/Performance and Finance Committee/Operational Risk and Compliance Sub-Committee	⇔
	4166	Trustwide	Risk to patient safety and achievement of organisational falls	16/01/2023	20 4 x 5	20 4 x 5	9 3 x 3	Quality Committee/Falls Committee/Operational Risk and Compliance Sub-Committee	⇔
	4211	Family and Women's	Patient safety risks due to multiple factors in the Antenatal Day Unit	26/04/2023	20 5 x 4	15 5 x 3	3 3 x 1	Quality Committee/Operational Risk and Compliance Sub-Committee Risk Increased 14/07/2023	⇑
	4048	Clinical Support Health Group	Risk to continuity of service due to the ageing Radiotherapy Linac (Bunker 6)	09/03/2022	25 5 x 5	15 5 x 3	3 3 x 1	Health Group Governance/Operational Risk and Compliance Sub-Committee	⇔
BAF 5 Partnerships **Lead Executive: Ivan McConnell** **Risk Appetite: Moderate**	4179	Trustwide	Delivering the Operational Plan requirement to reduce the backlog of long-waiting patients	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee	⇔
	4178	Trustwide	Delivering the improvement trajectories for screening programmes delivered by the Trust	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee Elective Recovery Group	⇔
	3997	Emergency Medicine	Persistant failure of A&E 4 hour target	09/09/2021	25 5 x 5	25 5 x 5	10 5 x 2	ED Monthly Risk/Performance and Finance Committee/Board Risk increased 03/11/25	⇑
	4180	Trustwide	Risk of avoidable harm for patients who have waited 63+ days for a 1st definitive cancer treatment	14/02/2023	20 4 x 5	12 4 x 3	6 3 x 2	Performance and Finance Committee	⇔
BAF 6 Research and Innovation **Executive Lead: Kate Wood** **Risk Appetite: Moderate**	No high risks on the Corporate Risk Register								
BAF 7.1 Achievement of Year-End Financial Target **Executive Lead: Lee Bond** **Risk Appetite: Moderate**	No high risks on the Corporate Risk Register								
BAF 7.2 Underlying Financial Position **Executive Lead: Lee Bond** **Risk Appetite: Low**	No high risks on the Corporate Risk Register								

BAF 7.3 Achievement of Capital Plan **Executive Lead: Lee Bond** **Risk Appetite: Moderate**	No high risks on the Corporate Risk Register

Strategic Theme: Culture
Appetite: Low
Risk: 1

Strategic objective: Honest, caring and accountable culture
Assurance Committee: Workforce Education and Culture Committee
Executive Lead: Group Chief People Officer
CQC Domain: Well-Led
Enabling Strategies/Plans: People Strategy

Risk to Objective						Progress/Timescales
Strategic risk: Condition: The Trust does not make progress towards further improving a positive working culture this year. Cause: Staff behaviours Low staff engagement Workforce engagement with ICS/HASR Consequence: Trust unable to achieve Outstanding CQC rating and Well Led domain	Trust People Plan 2019/22 approved and in place Work being carried out around recruitment and retention Staff Development programmes Leadership Development programmes Staff wellbeing services during the recovery phase Positive relationships with JNCC and LNC (Trade Unions) Monthly Health Group Performance and Accountability meetings to ensure workforce targets are being met Health Group and Directorate management manage workforce KPIs Wellbeing Centre opened at CHH – September 2021 Freedom to Speak up Zero Tolerance Policy Established BAME network Diversity in recruitment implemented	Staff survey – engagement scores have reduced	Workforce, Education and Culture Committee Workforce Transformation Committee Rise and Shine programme – emerging leaders to commence 2021/22 Disability Network established 8 staff referred themselves into the Staff Support Psychology service in July and August 8 TRiM incidents in July and August resulting in 43 staff receiving Traumatic Incident briefing, and 8 staff requesting and accessing a Trauma Risk Assessment CIRCLE Group established to review reported negative behaviours – Representatives from HR/FTSU and OD Capital Team working with the Disability Network to review access facilities. Capital Development Manager is now a core member of the EDI steering group. Process mapping has taken place to break down all elements of the recruitment process to ensure it is more inclusive of BAME and disabled staff. Group Values to be set by 1st April 2024	Long term effects of Covid Recovery processes – returning to business as usual Flexible working must be embedded (work/life balance) Junior Doctor Training Line managers creating the right environment – culture issues Trust is not meeting its target for Turnover Staff Survey 2022 Staff Survey 2023 launched in Autumn 2023 ICU - development of a Clinical Supervision model and Nursing leadership development ED – Supporting Nursing leaders with Professionalism and Cultural Improvement	Review and relaunch of the staff charter. This is well underway and will be ratified at Workforce Transformation Committee Relaunching the PACT training. This will be mandatory for all staff. All staff will receive a 90 minute session on civility, the relaunched staff charter and expectations of managers. The session contains a new section on how to raise concerns and challenge behaviours. We are identifying staff to deliver the training including clinical and medical leaders. Briefing all 700 B6/B7+ managers at the trust in a series of sessions throughout July and August on the staff charter and PACT training. This will set out, clearly, expectations of managers in challenging and dealing with poor behaviours. Launching a reporting tool (piloted in maternity and cardiology). This will be rolled out across the Trust and has input and support from HR, FTSUG, and OD.Staff can report anonymously or 'on the record' and receive support for tackling issues. Marketing campaign – BAD BEHAVIOUR DOESN'T WORK – to go out in the next couple of months, promoting the charter, the reporting tool and highlighting poor behaviours and their impact.	Q1/Q2 – CEO staff bulletin issued to staff every Friday Ask the CEO – monthly virtual open meeting Core Brief – issued on a monthly basis for dissemination by managers. Staff support psychology are providing 2 hour online training on stress management and how to improve sleep Senior Manager PaCT (Professionalism and Culture Transformation) briefings are now being delivered online 106 staff have completed Great Leaders Programmes in FY 2023/24 to date with a further 234 actively progressing through. Ongoing delivery of culture workshops on 'Kindness, Professionalism and Compassion within Maternity Services' from January 2023 – January 2024 Workshops will expand in October 2023 to invite all staff within Maternity services. Incivility Reporting tool has been launched to enable staff to report negative behaviours BAME Conference held on the theme of 'Achieving equity in our diverse workforce' **Q3** **Group Executive Recruitment is underway and on track** **Group leadership event organised at Hull University – January 2024** **New Care Group proposals launched November 2023**

							Staff Values workshops – December 2023
	Risks from Risk Register: There are no direct risks on the Corporate Risk Register			**Metrics:** Performance against People Strategy Quarterly and National Staff Survey Results People Report monitoring/ Board and Workforce committees Independent / semi-independent: NHSE/I CQC Internal Audits Trust attendance target for 2023/24 is 96.1% (sickness not greater than 3.9%)	**Outcomes:** Staff Survey 2022 37% of staff (3160) completed the survey compared with 2021 (44%) Staff Survey response rate 2023 (50%) The Trust is below the national average for all of the 9 key themes in the Staff Survey 2022/23 Staff sickness for 2022/23 was 4.4% 325 staff have reported as Disabled on ESR; an increase from 272 staff (2022)	Managers are being encouraged to improve the response rate for the Staff Survey 2023. Aim is for 60%. 50% achieved. Development of Registrar to consultant development programme and SAS Doctors leadership programme Development of Inclusion Academy Development of Registrar to Consultant development programme and SAS doctors leadership programme Development of a PNA/PMA (Professional Nurse/Midwife Advocate) network across HUTH Midwifery Leadership Team participating in development activities which involves a team development programme and individual 1-2-1 exploratory meetings Zero Tolerance to Ableism to be launched in Autumn 2023 Virtual Values sessions linked to Barrett Values – Jan 2024 Focus Groups/virtual sessions to discuss values survey results – Feb 2024 Launch new values April 2024.	

Inherent Risk			**Risk position as at 31.12.23 (Q3)**			**Planned target risk position by 31.03.2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Strategic Theme: Workforce
Appetite: Low
Risk: 2

Strategic objective: Valued, skilled and sufficient staff
Assurance Committee: Workforce Education and Culture
Executive Lead: Group Chief People Officer
CQC Domain: Safe, effective, well-led
Enabling Strategies/Plans: People Strategy

Risk to Objective						Progress/Timescales
Strategic risk: **Condition:** The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand **Cause:** National and international shortages Impact of Brexit on availability of international workers Covid impact on staff health including long term trauma and burnout **Consequence:** Insufficient staff to deliver services **Risks from Risk Register:** 2789 – Capacity in the intra-vitreal injection service 3439 – ED staff recruitment 3990 - Shortage of staff is a serious issue in the department of cardiothoracic surgery 3044 – Consultant Pathologist shortages (Breast Pathology) 4110 – Pharmacy Aseptic staffing issues 4178 – Screening Programmes staffing issues	People plan in place which sets out the changing workforce requirements Remarkable People, Extraordinary Place brand – targeted recruitment Golden Hearts, Moments of Magic rewards Monthly monitoring of Health Group plans – Performance and Accountability meetings Nurse safety brief to ensure safe staffing Guardian of Safe Working reports to the Workforce Committee and Board Focus on staff wellbeing Workforce planning forms part of business plan to understand and predict workforce trends Freedom to speak up International nurse PINs due by the end of August New University registrants on last placement & will start Sept, with their PINs being gained by the end of October	Medical staffing levels including Junior Doctors Variable (agency and overtime) pay Absence of WiFi in educational buildings Maintenance of time for training for both trainees and trainers in the light of service recovery Sickness/absence levels Continuity of Carer – challenges around pay uplifts, number of midwives required, upskilling of midwives.	Monitoring of Workforce assurances through the Workforce Transformation Committee and Workforce Education and Culture Committee Vacancy position reported in every Board meeting	Certain medical specialities struggle to recruit due to national/international shortages Managers thinking innovatively about new roles to new ways of working (ACP/PA) Obstetric workforce risk – 3 consultants recruited Nurse safe care briefings held 4 times per day Late Matron pastoral role now in post to support staff and help on wards, Mon-Fri Task and finish group set up to facilitate Ward Sisters being involved in staffing decisions Trust wide Same Task and finish group also reviewing how we can facilitate Sisters to work weekend shifts on a rota basis, to support and carry out wellbeing checks with staff	People Strategy Refresh Lets get Started` Induction programmes for RN`s & 'Where Care Begins' for the Nursing Assistants. Keep in touch days for all newly qualified/International Nurses throughout the year Matron late shift (till 10pm Mon – Fri) to visit wards and deliver pastoral care/support to staff Non Registered Development Programme/Induction and Preceptorship Programme Clinical Lead Physiotherapy – Integration of Critical Care and Surgery Therapy Services to create joint services and a shared vision. Work is ongoing to expand the project across the services. Review of the Preceptorship Policy and package to match the NHSEI Preceptorship Framework and a Task and Finish Group has been set up to support the implementation of the Framework within the Trust. Group Executive recruitment continues in Q3/Q4	Q1/Q2 100 work experience opportunities booked up to November 2023. Requests are coming in for 2024. Work is onging with Hull, East Riding and North Lincs to review a health career engagement programme working with the local school. Mandatory training – the Trust is 4.7% above the Trust target (July 2023 data) **Q3** **Sickness has reduced from 4.2% to 4.1%.** **The overall Trust vacancy position is 2.9% (November 2023)** **Nursing and Midwifery vacancies =0%** **Consultant vacancies = 4.1%** **The Widening Participation team is working closely with schools and colleges to ensure all students in the region receive a fair and equitable opportunity to engage with health careers advice and guidance** **The Trust currently has 258 colleagues on live apprenticeship programmes** **Care Group proposals launched November 2023**
			Metrics: Staff Survey People Performance Report **Independent / semi-independent:** CQC	**Outcomes:** Q1 Trust adjusted vacancy rate = 2.1% Turnover 11.9% against a target of 9.3% Less than 1 year leavers = 21.3%		

				NHS England/Improvement Internal Audits	Consultant job plans = 77.8% Sickness = 4.5% Appraisals Medical = 92.9% Appraisals AFC staff = 68.4% Q2 September vacancy rate = 2.2% Turnover 11.8% against a target of 9.3% Less than 1 year leavers = 22% Consultant job plans = 76.6% Sickness = 4.4% Appraisals Medical = 90.4% Appraisals AFC staff = 85.2% Q3 December vacancy rate = 2.9% Turnover 11.8% against a target of 10.7% Less than 1 year leavers = 22.5% Consultant job plans = 74.7% Sickness = 4% Appraisals Medical = 83.9% Appraisals AFC staff = 83.9%		

Inherent Risk			Risk position as at 31.12.23 (Q3)			Planned target risk position by 31.03.2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	4	12	3	4	12

Strategic objective: We will achieve a rating of 'Good' in the next 5 years
Assurance Committee: Quality Committee
Executive Lead: Group Chief Medical Officer/Group Chief Nurse
CQC Domain: All/Well-led
Enabling Strategies/Plans: Quality, Patient Safety, Improvement

Strategic Theme: High Quality Care
Appetite: Low
Risk: 3.1

Risk to Objective						Progress/Timescales
Strategic risk: **Taken from the Trust's strategy:** *The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas* **Condition:** There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of an 'outstanding' rating. **Cause:** The Trust does not develop its patient safety culture and become a learning organisation Insufficient focus, resource and capacity for continuous quality improvement for quality and safety matters Poor governance arrangements That the Trust is too insular to know what outstanding looks like **Consequence:** Patients do not receive the level of care and clinical outcomes that we strive to provide	Quality committee structure & work-plans Health Group Governance Performance Management Meetings Patient Safety Specialist role IPC arrangements Safeguarding processes Fundamental Standards programme Quality Strategy/Quality Improvement Plan Serious Incident Management Clinical Audit programme CQC improvement plans External agency register and process Horizon scanning Integrated Performance Report – BI Reporting Support from the Health Groups via the Weekly Patient Safety Summit (WPSS) in the support of timely completion of Rapid Review Reports (RRR) and early identification of statement providers/memory capture and immediate Safety Oversight Group CQC Action Plans in place	Greater scrutiny required for clinical audits, improvement plans and outlier reports VTE Compliance Mental Health Services Ambulance turnaround times and the impact on patients ED Crowding NCTR wards – extra staffing required Increase in Falls in December – Falls Committee reviewing whether this is due to patients having multiple falls and increased length of stays PALS increased activity continues, the main themes are delays, waiting times and cancellations TV CQUIN challenged Q3	Management assurance: Reports to Quality Committee Quality/outcome data Self-assessments Infection Control Annual Report Quality Accounts Associate Director of Quality appointed Operational Risk and Compliance Committee Learning from Deaths Reports CQC Inspection Internal Audit Reports Assurance reviews TAVI review outcome report from the Royal College to be received in 2023 Development of a Medical Examiner's Office Power BI Dashboard Yellow falls risk bracelets now across the Trust – Nov 2023 Digital lying and standing risk added to Nervecentre – Nov 2023 Extended visiting across the Trust for patients with higher falls risk Q3 AFLOAT observation assessment tool being implemented 2023 Task and finish group established for wound discharge planning Q3	CQC Report – Requires Improvement rating ED, Medicine and Surgery inspections result 'inadequate' for safe CQC Maternity Inspection – Section 31 imposing conditions on the Trust's registration Medicine Health Group have not yet completed audit of medical cover CQC IR(ME)R inspection of CDC CT service at CHH 30.08.23. Initial feedback is positive, a draft report is expected September 2023 (Report received/positive review and action closed). Maternity requests for support • Entry on the Maternity Safety Support Programme – supported by QIG in May 2023 – notification that the Trust can join July 23 • Regional Chief Midwife and team support – commenced. Claire Keegan has visited the Trust to provide support for the team. The fresh eyes has been really helpful with ideas for solutions to issues identified • External representation on PMRT panel – agreed; however, not represented at every meeting – awaiting update from ICB following the July HUTH QIG meeting • Request for the LMNS to support the training needs analysis • System support at times of escalation • System support in agreeing that all women, at the time of booking, will be informed that they may have their baby in another unit if this is the safer option Falls Training compliance is demonstrating a month on month improvement	Transition to PSIRF from April 2023. Targeted work with HGs regarding complaints is ongoing. Implementation of new PHSO complaints framework underway Development of a CQI public facing website commenced Development of Human Factors Hub to commence and launched in April 2023 Tissue viability – eLFH modules 1 and 2 have been added to HEY 24/7 and a draft template has been developed for each directorate to report to the Safer Skin Committee to identify actions to reduce pressure damage incidents CQC ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. However, sufficient training has not yet been provided. The competency sign off and training started from a 0% position. Trajectory for 90% by the end of May 2023. This was achieved. ED3.2: This action was not completed as stated because the staff were moved to H130 as part of opening additional capacity for patients with no criteria to reside. Once the intermediate discharge unit is in place, this action will be reviewed. ED5.4: The task and finish group was up and running from December 2022 as per the action. It was decided to keep this action under review due to the vast amount of work being undertaken. An update report was presented to the February 2023 Quality Committee. If Board members would find a copy	Q1/Q2 ED CQC Action Progress - Development of a high observational unit and operational plan to release capacity in resus - Ground floor model to be in place by January 2024 (EMC July update) - Trust-wide MCA/DOLS/Safeguarding work stream to be developed - Review of vulnerable patient's food and balance charts to be shared from July 2023 onwards - ED Safety champions continue to receive and scrutinise the performance against the outcome measures highlighted on the ED action plan Surgery CQC Action progress - Baseline review of the matron handbook audits are underway - Theatres migrating to electronic observations has been delayed due to priorities in ED - Nerve centre roll out has been delayed due to priorities in ED - Focussed work on resuscitation training is ongoing - A medicine management plan is being developed - NICE guidance to be a standing item on Specialty governance meetings - A Surgery specific patient information group to be established - Chaplaincy team to provide quarterly reports on referral rates. Maternity CQC Actions update August 2023 • Women in ADU were appropriately rag rated and

				TV discharge checklist onto Nervecentre Q3 HAPU appointed Q3	Develop of the virtual ward and staff to support the falls team is being developed	of this useful, it can be found in the upload from February 23 in the shared area. The following actions have been undertaken since the implementation of the digital task and finish group: All ED Digital Nursing Records reviewed and revised, now in live with integrated clinical notes populating clinical record: • ED Safeguarding • Mental Health Triage • ED Nursing Assessment • ED Infection • ED Moving & Handling • Purpose -T [pressure ulcer prevention • SPACES – Intentional rounding • Acuity • Sepsis Introduction of Clinical Dashboards • ED Overview • ED Safety Huddle • ED Sepsis Clinical Escalations is planned to be rolled out in ED by the end of April 2023 [automated escalations of NEWS2 score to ED Safety Dr and ED Safety Nurse] Manchester Triage – currently in test with plan to review mid-April. All of the above work has been supported by appropriate training and support for staff. The following action has been completed as planned; however, there is a further update to add and is reported below. ED5.5: This relates to the cohorting of patients waiting with an ambulance crew. This action was completed as planned; however, a further update to this and following the ICB assurance review in ED was for the glass in the Atrium to be frosted, this has now been completed. Medical QI Leads – Junior Doctors together celebration event is due to take place April 2024	were in the correct waiting areas for their rag rating • Electronic triage form in place and used correctly in ADU • Staff in ADU were able to articulate the plan of care for the women waiting • The midwives in ADU have introduced a new system: a midwife is allocated to a bay to see women and the coordinator allocates the women to the bays this is very similar to BSOTTs system and is working extremely well • Resuscitation trollies had been checked September 2023 • Women were appropriately rag rated - a suggestion from the team now would be to further separate the women into RED and Amber in the waiting area for observational purposes • All rooms that were not in use had their treatment rooms locked. All medicines were stored securely Falls Falls prevention team to be established in September 2023 National Falls Prevention Week 18-23 September **96** QIPs have been shared and registered with the CQI team. The majority of projects registered are from Junior Doctors who are required to undertake improvement projects a part of their career progression. It is expected that engagement with QIPs will increase following their induction in August. Regular communications are sent out inviting staff to share their projects and success stories along with submitting case studies via the CQI website to share learning and spread improvement. Improvement week to take place in September 2023 incorporating the Patient Safety Day Conference **Q3** **Falls presentation to the Quality Committee in November 2023 – current direction is downwards although the level of harm was causing some concern. Weekly patient safety summit now in place.** **Tissue viability patient scenarios uploaded to HEY 247** **TV collaborative clinical working with nurse director team** **Triangulation meetings with the CHCP TVN**

						Development of the new digital solution, AMaT to enable efficient review and will support completion of compliance against NICE statements and calculate if an action plan is required to achieve compliance is required.	**TV video prepared for ED covering the use of glide sheets.** **GIRFT deep dives in Q3 Head and Neck – awaiting report and recommendations** **CQI Team supporting with the launch of the Hydration Improvement Programme.** **Band 6 TV nurses attended the Wound UK Conference in November 2023** **National ED Patient Safety Award** **CQC Internal Audit report received – reasonable assurance**
	Risks from Risk Register: 3460 - Availability of Radiology Support for Paediatric & Neonatal Services. 3282 - Failure in the Trust systems to ensure requested test results, pathology and radiology, are reviewed & actioned by the requester 3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses			**Metrics:** National Audit Benchmarking Harm Free Care Patient Experience Survey **Independent / semi-independent:** CQC inspections Internal audits External reviews (e.g. NHSEI)	**Outcomes:** Q1 PSIRF now in place – the weekly patient safety summit continue to meet to review patient safety incidents. Q2 QSIR training programme ongoing PSII new process underway and report presented to the September 2023 Trust Board HSMR and SHMI remain within the 'expected' limits Target of 80% of complaints closed within 40 days not yet achieved Q3 CQC Actions ED/Maternity scrutinised by the Quality Committee monthly and presented to each Board meeting CQC – ED urgent actions – 42 out of the 43 have been completed (Nov 23) CQC – maternity Section 31 still in place. At Dec 23 3 actions have been evidenced and assured with a further 10 delivered, pending evidence to assure the are embedded QSIR programme transferred to AQUA (external non-profit organisation)		

					Target of 80% of complaints closed within 40 days not yet achieved, however has improved in December 2023. Both the number of complaints outstanding to respond to and number received has reduced markedly in Q3 Overall SHMI remains within 'expected' limits The Trust is an outlier in HSMR with higher than expected deaths PSII/After Action Reviews are underway Q3 – Learning will be reported to the Quality and Safety Committees in Common		

Inherent Risk			Risk position as at 31.12.23 (Q3)			Planned target risk position by 31.03.2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	4	16	3	4	12

Strategic objective: We will increase harm free care
Assurance Committee: Quality Committee
Executive Lead: Group Chief Medical Officer/Group Chief Nurse
CQC Domain: Safe
Enabling Strategies/Plans: Recovery Plan and work-streams, Patient Safety

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

Risk to Objective						Progress/Timescales
Strategic risk: *Taken from the Trust's strategy: The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* **Condition:** There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED, Ambulance handovers and Patients with No Criteria to Reside require partnership working to determine improvement plans. **Cause:** Delayed access to services due to the increased waiting lists as part of the pandemic, patient flow, human error, clinical guidance not adhered to, poor compliance with fundamental standards. **Consequence:** Deterioration of conditions for patients, poor quality of life, loss of sight. Patient experience, clinical outcomes, timely access to treatment and regulatory action.	Clinical harm review process Prioritisation of P1 patients Fundamental Standards programme CHCP Community Beds Patient Access Team Weekly Patient Safety Summit Quality Strategy Integrated Performance Report	Clinical Harm Reviews – not possible to review every patient Crowding in ED/Flow Radiology capacity issues 104 week waits performance 52 week waits performance Ophthalmology experiencing a delay in meeting outpatient appointments Cardiology staffing – plan for 4 wte HUTH and 4wte NLAG Obstetrics staffing Complaints backlog The ED targets and the ambulance handover times Patients with no criteria to reside CHCP Bed model still being agreed Cancer 2ww referrals have increased by 6.6%	**Management assurance:** Reports to Quality Committee Clinical harm data and reports Performance Reports to the Performance and Finance Committee CQC Reports Rossmore new build opened to full capacity on 10 August 2023, however significant capacity remains in the facility Emergency Care Intensive Support Team (ECIST) providing support to the Trust September 2023 – review of patients who would be appropriate for alternative provision Work has begun on UTC – HRI Day Surgery unit closed September 2023	Diagnostic waiting times GP Capacity and increased referrals The RTT trajectory **CQC Report actions** HUTH Flow Model (Bristol Model) implemented. RAT and Epic role fully embedded in department and positive feedback from staff. Board rounds are completed every 4 hours, There is an awareness of who is in ambulances and the escalation and board are working well. Additional work identified to ensure no loss of oversight of medical in-reach patients 60 bedded area for patients with no criteria to reside being built on the old helicopter site – due to be opened July 2023 Targeted speciality meetings continue to support the achievement of a Trust internal milestone of no patient waiting more than 70-weeks at 31 March 2023 (national target is zero +78-week at 31 March 2023). Capacity alerts in x6 pressured specialities are live – with monitoring arrangements to consider the effectiveness and impact (2x specialities – referrals have increased) Clinical Admin Service continue to proactively contact patients with TCIs/appointments to	Q1 Transition to PSIRF from April 2023 will transform the approach to patient safety investigations Confirm outstanding competency check requirements for ED staff Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved. Continue with the close monitoring of the delivery of the fundamentals of care in a timely response Tissue Viability Nurses to review the impact of any delayed skin assessments on patient outcomes Continue with the interim support arrangements from the Deputy Chief Nurse Continually review the impact of the HOB opened on the 13th floor and agree the requirements for a HOB on the Acute Assessment Unit Continue with the plans to introduce the 90 day plan of the ground floor model designated mental health assessment area adjacent to ED now open Q2 Datix incident reporting form under review in line with the national changes Thematic review of both Radiology and ED incidents has begun.	Q1/Q2 Trajectory set to close the legacy Serious Incidents declared prior to April 2023 by the end of September 2023 12 PSIIs declared between June 2023 and August 23 PSIRF information and investigations toolkit is now available on Pattie The Weekly Patient Safety Summit continues to meet to discuss patient safety incidents for learning. Sepsis and Pneumonia Steering Groups continue to provide insight data and have action plans in place. August – over 500 Registered Nurses have viewed the Tissue Viability Improvement video – this is monitored by the Safer Skin Committee TV Matrons and Nurses are now involved in all pressure ulcer after action reviews. Fallsafe training numbers are demonstrating a month on month improvement – 2 new appointments to the Falls team will commence September 2023 Falls Weekly Patient Summit has been introduced. Rossmore accepting NCTR patients from July 2023 Ambulance Handover Quality Improvement programme in development, due to commence September 2023 ED - Sustained improvement in the number of lodged patients moved by 10am and 2pm. Focus is now moving to the movement of patients between 2pm and 5pm.

					check they are attending/if treatment is still required – small number of removals Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities	Enhanced Falls training for Non-Clinical and HCP staff to be developed. Implementation of AFLOAT (Avoiding Falls Level of Observation Assessment Tool) Patient Safety team and the Patient Experience team, are organising an Improvement Week in the run up to the Patient Safety Day Conference which is scheduled to take place on Friday 29 September 2023. Aim to grow the Patient Safety Champion network and number of Learning Response Leads Discharge to assess model pilot to commence September 2023 Trajectory of achieving zero 78 week waits by the end of September 2023 Q3 Cultural work between ED and Acute medicine ongoing UEC GIRFT Deep Dive December 2023 Direct admissions to wards – work with 111 Frailty SDEC staffing to provide 70 hours per week over 7 days	**Q3** **UTC on the HRI site being developed, due to open January 2024** **Ground floor model - Planned work to use the Manchester Triage Tool – Q4** **SDEC plan to relieve the lodged patients in ECA to be commenced** **AMU HOB went live 20 November 2023** **Frailty SDEC go live 27 November 2023** **Cancer performance was received at the Performance and Finance Committee which detailed the revised trajectories for Cancer Faster Diagnosis Standard (FDS), 62-day RTT and +63-day backlog to March 2024; the trajectories have been developed linked to the further investment of £1.3m received from the Cancer Alliance during November 2023.** **The +63-day backlog revised trajectory was submitted to the ICB on 22 November 2023 as a formal change to the planning trajectory.** **There have been improvements in performance, particularly in respect of ambulance handover following constructive joint rapid improvement work with YAS and a marked reduction in inpatient**
	Risks from Risk Register:			**Metrics:** Patient Safety incidents Waiting list numbers Reduction in Trust preventable infections and complications **Independent / semi-independent:** CQC inspections Internal audits – Waiting lists, recovery included in schedule	**Outcomes:** **Q1** 4 hour performance = 66.6% Waiting list = 69,263 104 week wait = 0 380 over 60 minute ambulance handovers 167 breaches - 12 hour trolley waits		**safety incidents, particularly in the respect of harm.**

					patients per day with no criteria to reside = 209 78 week breaches = 77 The number of patients waiting to start treatment on 62 pathway has reduced to 1,325 1 of 9 cancer standards were met in April 2023 Q2 4 hour performance = 64.7% against a target of 67% for type 1 and 3 activity Waiting list 72,623 (August 2023) Ambulance handover position 97% (August 2023) The Trust failed to achieve all cancer standards with the exception of the combined Faster Diagnosis Standard (75.5%) 104 week wait = 0 78 week wait = 14 Patients with no criteria to reside = 148 218 x 12 hour trolley breaches in August 2023 1 Never Event reported since April 2023 Q3 4 hour performance = 60.1% against a target of 71% for Type 1 and 3 Waiting list 72,597 against a trajectory of 67,311 Ambulance handover position 88.5% (October 2023) The Trust failed to achieve all cancer standards with the exception of the combined Faster Diagnosis Standard (75.5%) 104 week wait = 0 78 week wait = 8		

					Patients with no criteria to reside = 183 482 x 12 hour trolley breaches in October 2023 1 Never Event reported since April 2023 5 catastrophic incidents reported in ED in November 2023, 15 year to date		

Inherent Risk			Risk position as at 31.12.23 (Q3)			Planned target risk position by 31.03.24		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	5	20	4	4	16

Strategic objective: Great Clinical Services
Assurance Committee: Performance and Finance
Executive Lead: Group Chief Delivery Officer
CQC Domain: Effective
Enabling Strategies/Plans: Operating Plan

Strategic Theme: Performance
Appetite: Low
Risk: 4

Risk to Objective						Progress/Timescales
Strategic risk: There is a risk to access to Trust services **Condition:** There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance Planning guidance being released in stages across the year **Cause:** Delayed access to services **Consequence:** Deterioration of conditions for patients	Performance and Accountability meetings Clinical harm reviews taking place Partnership working with ICS/HCCP Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance and diagnostics where available whilst awaiting first appointment Trust Escalation Policy The 4-hour delivery action plan continues to be further developed, and associated service change will be implemented rolled out alongside an implementation plan for an UTC type facility on the HRI site. Ground Floor re-modelling UTC on HRI site to open January 2024	Mismatch between demand and capacity Flow through the ED department Patients with NCTR Ambulance handover position Cancer performance 12 hour trolley wait standard changed to 12 hours from arrival in ED leading to an increase in breaches. Increase in GP referrals - referral triage and Advice and Guidance in place RTT - Impact of Industrial Action IPC risks including VRE Patient Choice and willingness to accept alternative providers	Monthly performance report to the Performance and Finance Committee Bi-monthly Board Report Health Group Performance and Accountability meetings monitor recovery plans in place Reduction in patients with No Criteria to Reside Ground Floor presentation to the Performance and Finance Committee in November 2023 Interim Director of Performance and Winter appointed	Trust Recovery Plans Paragon Suite rehabilitation facility Waiting list **Q2** Ambulance handover performance deteriorated in July 2023 Continued/escalating industrial action by medical colleagues may impact both on Time in ED and flow across the Trust. Rossmore new build opened to full capacity on the 10 August 2023 however significant capacity remains in the facility. The operational team are working together to ensure there is an increase in the daily volume of patients able to move to the facility. Referrals are up 1.8% on the previous year 65 week delivery At 11 September 2023, there are 1,589 patients waiting for a 1st out-patient appointment that will be 65 week risks at the end of March 2024. Based on the NHSE letter of 4 August 2023, 673 are undated and will need to be dated/seen by 31 October 2023, and a further 29 are dated into November 2023 that need to be brought forward. **Cancer** LGI Lower GI – introduce nurse front end triage go live could be delayed until October 2023 due to time take to release nursing resource. Breast present findings and develop service improvement plan with the service meeting scheduled 29 September 2023 Urology Haematuria backlog clearance - exploring	Continued focus at speciality level of patients dated and/or risks now focussed to achieve and maintain zero 104-week waits. Clinical Admin Service continue to proactively contact patients with TCIs/appointments to check they are attending/if treatment is still required – small number of removals Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will need recurrent support from the 23/24 & 24/25 growth for cancer Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged; locally at +60% which continues to be monitored and on-going discussions with primary care planned to further improve uptake by GPs Improvement work from the Joint Handover event between paramedics and clinicians in ED to be implemented from 27th November 2023 A co-ordinator was based on the 13th Floor in Q3 to help improve flow between the area and Rossmore 65 week delivery – 1st Outpatient Appointments Gynae – 96 patients will be seen by 30 November 2023 Recovery of elective activity in October 2023 against the operational plan delivered: ➢ New Activity 101% ➢ Follow up Activity 107%	Q2 August 2023 • Recovery of elective activity in August 2023 against the operational plan: ○ New Activity 92% ○ Follow up Activity 99% ○ Day Case Activity 89% ○ Ordinary Elective Activity 79% ED Continued delays in flow and discharge are a significant impediment to an improvement in the initial assessment and majors' area; with some impact on ECA as rooms are occupied for an extended period. There has been sustain improvement in the number of lodged patients moved by 10.00 and 14:00 – Focus is now moving to movement of patients between 14:00 and 17:00. Mental Health Streaming facility became operational from 19 June 2023 the operational teams are now working together to increase the number and timeliness of patients able to use this facility. **Q3** **UTC on the HRI site being developed, due to open January 2024** **Ground floor model - Planned work to use the Manchester Triage Tool – Q4** **SDEC plan to relieve the lodged patients in ECA to be commenced** **AMU HOB went live 20 November 2023** **Frailty SDEC go live 27 November 2023** **Cancer performance was received at the Performance and Finance Committee which detailed the revised trajectories for Cancer Faster Diagnosis Standard (FDS), 62-day RTT and +63-day backlog to March 2024; the trajectories have been developed linked to**

					opportunity for additional clinical resource via mutual aid to clear remaining backlog. Urology Results clinic capacity and demand - awaiting date from service to meet to progress Referral rates since April 2023 have remained constant 2,500 patients per month which is significantly above 22/23 baseline and plan for 23/24 High profile patients and national cancer awareness media coverage result in an influx of referrals Histology tracking systems implemented locally to prioritise long-wait patients – skin and Gynae continue to receive reasonable turnaround times Radiotherapy delivery continues to be a considerable challenge Review of late IPT referrals by the Cancer Alliance to increase the number received by Day 38 **Elective Recovery Fund** On-going anaesthetic staff shortfalls – rolling recruitment in place and development of Anaesthetic Assistant roles Elective activity and elective bed base is not ring-fenced through winter or Covid surges OPFU continue to be in excess of 75% of 19/20 baseline at March 2023 Speciality capacity risks: Gynaecology (capacity for complex endometriosis) Ophthalmology (corneal transplant donor material) Colorectal Surgery (complexity x2 surgeon robotic cases)	➢ Day Case Activity 92% ➢ Ordinary Elective Activity 94% **Elective Recovery Fund** The target has been revised from 106% to 104% to reflect the strikes, and further reduced to 103% in November 2023, to reflect the impact of industrial action in Q3. PAF received an update in December 2023 that the Trust is at 99% ERF at month 7.	**the further investment of £1.3m received from the Cancer Alliance during November 2023.** **The +63-day backlog revised trajectory was submitted to the ICB on 22 November 2023 as a formal change to the planning trajectory.**
	Risks from Risk Register: 3439 - There is an issue that patient care is compromised due to the emergency department being crowded 3960 - Risks associated with Mental Health patients managed in the Emergency Department			**Metrics:** Health Group recovery plan trajectories **Independent / semi-independent:** NHSE/I CQC	**Outcomes:** Q1 Waiting list 69,263 Ambulance handover position 64.9% in less than 30 minutes		

	3994 - There is a risk to quality of care and patient safety as a result of delayed discharges and poor patient flow 3997 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E 3998 - Quality issues identified due to handover delays 4000 - HGB - Maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral 4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing 4110 - There is a risk to patient safety as a result of the Pharmacy aseptic unit being unable to meet the required service demands			Internal Audit External Audit	104 week wait = 0 78 week wait = 77 Patients with no criteria to reside = 209 per day 1 out of 9 cancer waiting times national standards achieved Q2 Waiting list 72,623 (August 2023) Ambulance handover position 68% The Trust failed to achieve all cancer standards with the exception of the combined Faster Diagnosis Standard (75.5%) 104 week wait = 0 78 week wait = 14 Patients with no criteria to reside = 148 218 x 12 hour trolley breaches in August 2023 Q3 4 hour performance = 60.1% against a target of 71% for Type 1 and 3 Waiting list 72,597 against a trajectory of 67,311 Ambulance handover position 88.5% (October 2023) The Trust failed to achieve all cancer standards with the exception of the combined Faster Diagnosis Standard (75.5%) 104 week wait = 0 78 week wait = 8 breaches (October 2023) Patients with no criteria to reside = 183 482 x 12 hour trolley breaches in October 2023 5 catastrophic incidents reported in ED in November, 15 year to date		
Inherent Risk			**Risk position as at 31.12.23 (Q3)**			**Planned target risk position by 31.03.2024**	

Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	5	5	25	4	4	16

Strategic Theme: Strategy
Appetite: Moderate
Risk: 5

Strategic objective: Partnerships and Integrated Services
Assurance Committee: Trust Board
Executive Lead: Group Chief of Strategy and Planning
CQC Domain: Well-led, Effective, Safe
Enabling Strategies/Plans: Trust Strategy

Risk to Objective						Progress/Timescales
Strategic risk: **Condition:** That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System and Humber Clinical Collaborative Programme due to recovery constraints **Cause:** The recovery programme slows down the progress to become an Integrated Care System **Consequence:** Reputational damage Relationships with other care providers are not forged	Acute Workforce Maternity models Models delivering improvements for Constitutional and Clinical standards Assurance Reviews Digital enablers	Delays and timing of implementation of services/deliverability of models Out of hospital programme at various stages of development New Hospital Fund not a reliable source Backlog maintenance demands challenging EPR, sterile services, linen services, PET/CT, residential accommodation and renal dialysis all have serious capital implications Development of business cases to replace sections of existing estate (SGH and HRI) to be considered. CDC Risks Build timing – there has been a delay to the planned opening time till July 2024 given delays in planning permission – this has been discussed with NHSE National and Regional team in the weekly assurance meetings • Cost overruns – the business case was limited to a capital allocation of £20m with £19.4m being allocated. The tenders received for the build are in excess of the capital allocation. The gaps is being closed by - £1.3m contribution from N Lincolnshire Council Towns Fund and also a reallocation of £1m from the Grimsby CDC spoke. It is also important to note that the cost forecast has a contingency included with an additional optimism bias element. • Staffing – there is a risk that it will not be possible to recruit radiography staff in particular for the Hub. Actions have been put in place through operational and Place teams to work on a	Bi-monthly reports detailing progress to the Committees in Common Group Development Committees in Common Joint Board meeting 28 June 2023 Updates are received at the Group Development CIC and will be discussed at the Capital Developments CIC in 2024	Out of hospital care Impact of displacement to neighbouring areas/systems Travel and accessibility of services Cost and resourcing of multiple business cases Cost of external support e.g financial and legal Political challenge Lack of ability to influence Programme resourcing will require dedicated operational/financial and analytical support Potential for challenge Media management – intensive support will be required Capital availability CDC build timelines and go live dates are impacted by planning permissions and site access timelines CDC building costs are increasing General Election will impact on the HASR consultation and progress	**Cardiology** Cardiac CT working group established and work plan under development NLAG validation to prevent duplicate/repeat echo requests now embedded Agreement to progress with Heart Failure workstream with project team support **Dermatology** Service Strategy approved at FWHG and Medicine Divisional Board Activity profile and baseline metrics for 2022/23 received **ENT** Development of specialty level Delivery Group and Operational Groups to mobilise planned activities Time out to be arranged for HUTH and NLAG clinical, nursing and operational teams. **Gastroenterology** Scoping meetings held with NLAG and HUTH clinicians QIP to review current processes for suspected cancer pathways HCCP programme and governance structures to be redefined CDC SGH/DPOW – Capital funding confirmed, revenue model to be confirmed CDC Hull – Business case to be submitted. Work ongoing with the Council to confirm location of proposed development.	Q2 Humber Acute Services Review - Pre-consultation business case submitted to the ICB - Public approval to progress to consultation - NHSE Gateway 2 Review - Joint Health Overview Scrutiny Committee Operational lead identified Evidence base prepared, engagement strategy prepared ICB lead in place Priority programmed mapped **Q3** **HASR consultation update received at the Group Development Committees in Common – A number of drop in sessions and online discussions have taken place** **Travel routes to and from all of the sites are being reviewed** **CDC developments are ongoing across Hull, Scunthorpe, Grimsby and the East Riding**

			number of programmes to avoid any recruitment delays. These include an international recruitment campaign, making use of the National Insourcing contracts for staff as per the condition applied on approval and also looking to build our workforce more locally in the longer term • Additional land availability – we are still working with N Lincolnshire Council regeneration and development teams on the release of a parcel of land to the side of the CDC site. This parcel of land currently has a sport club cited on it. The site needs to be vacated to allow ingress/egress from the CDC as approved. The timing of release of this parcel of and impacts upon the forecast build completion timelines.				
	Risks from Risk Register: There are no direct risks on the Corporate Risk Register			**Metrics:** Recovery rate Outcomes of Service Reviews **Independent / semi-independent:** NHS E/I CQC ICS HASR Acute Collaborative	**Outcomes:** April 2023 Humber Clinical Collaborative Programme decoupled from HASR HASR April stocktake commenced December 2023 – HASR consultation is half way through CDC building works have commenced		

Inherent Risk			Risk position as at 31.12.23 (Q3)			Planned target risk position by 31.03.24		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**4**	**16**	**4**	**5**	**20**	**2**	**3**	**6**

Strategic Theme: Research and Innovation
Appetite: Moderate
Risk: 6

Strategic objective: Research and Innovation
Assurance Committee: Quality Committee
Executive Lead: Group Chief Medical Officer
CQC Domain: Safe
Enabling Strategies/Plans: Research and Innovation Strategy

Risk to Objective						Progress/Timescales
Strategic risk: There is a risk that R&I support service is not delivered operationally to its full potential due to lack of investment **Cause:** Funding is unavailable **Consequence:** Impact on R&I Investment Impact on R&I capacity	Strengthened partnership with the University of Hull Infection Research Group ICS Research Strategy	Reduction in support services due to activity delivery Loss of commercial research income as well as other income as non-Covid activity was paused Additional research due to Covid without additional investment in staff The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities. This is being addressed on a national level by DHSC and NIHR but local strategies are needed. Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have the burden of additional workload into early 2022-23. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities. 2021-22 has shown our staff have worked incredibly hard to ensure our recovery from a 'COVID legacy' is ahead of trajectory. Service pressures resulting in issues with the recruitment and retention of staff. Opportunities for staff to join research teams via secondments ad other shared models is becoming increasingly difficult, creating challenges for the deployment of suitable staff across research vacancies. Capital developments will need to ensure research and innovation activities can be accommodated and staff appropriately housed. Demand for IT and Digital innovation is increasing. This brings an inevitable increase in the demand for the	Successful portfolio of Covid studies managed in 2020/21 2316 patients involved in clinical research as at August 2021 Continuing working with HYMS and the ICS	Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan Funding availability Consideration of the development and implementation of an agreed R&I investment strategy covering the next 3 years (protected research time for staff, providing core budgets for increased admin and other costs) is critical in taking the next step on this journey of development and supporting the research collaborations as a leading partner in the Humber and North Yorkshire Health and Care Partnership. Major risk is that without investment we will reach a ceiling point in our capacity which in turn will limit new activity from collaborators and this could spark a decline in activity in the coming years as we are forced to decline participation in studies. This is not the current position in Q2 but is something we are monitoring closely. Demand for IT and Digital innovation is increasing. This brings an inevitable increase in the demand for the associated skills in the workforce and from our dedicated H-Digital Teams.	Q1 Joint RDI working between HUTH and NLAG Joint strategy to be agreed Q2 Development of the Group strategy Combined Group RDI Strategy to be developed Joint working with NLAG being developed	Q1/Q2 There has not yet been a definitive change to secure recurrent investment/funding from the Trust to underwrite research and innovation activities. This is compounded further by anticipated financial pressures for the Trust in 2023-24 and the likely continuation of clinical pressures stretching the already limited resources and associated delivery and support services. The risks of maximising our delivery capacity, reduced digital and IT resources remain. In addition, we will see the introduction, this year, of potential performance-related funding (with a particular focus on delivering our commercial portfolio). As a result we will need to optimise our commercial output to ensure sustained funding and therefore sustained delivery. This position is being monitored and is not yet a tangible threat. **Q3** **Joint strategy discussions have commenced with the Group Chief Medical Officer and the Group Chief of Strategy and Partnerships**

			associated skills in the workforce and from our dedicated H-Digital Teams.				
	Risks from Risk Register: No risks highlighted			**Metrics:** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	**Outcomes:** **Q2** Capacity issues remain **Q3** Capacity issues remain, no extra funding available.		

Inherent Risk			**Risk position as at 31.12.23 (Q3)**			**Planned target risk position by 31.03.2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**4**	**16**	**3**	**4**	**12**	**2**	**4**	**8**

Strategic Theme: Financial
Appetite: Moderate
Risk: 7.1

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: Group Chief Finance Officer
CQC Domain: Effective
Enabling Strategies/Plans: Financial Plan 2023/24

Risk to Objective						Progress/Timescales
Strategic risk: **Condition:** Expenditure incurred exceeds income by greater than agreed control total **Cause:** Health Groups and Corporate Departments do not deliver services within agreed budgets and do not achieve Cash Releasing Efficiency Savings Capped and block contract arrangements limit scope for payment Additional activity delivered may not result in increased income; due to levels of activity or coding issues **Consequence:** Impact on investment in quality Inability to meet regulatory requirements Reputational damage Impact upon recruitment	Health Group Budgets in place 2023/24 Financial Performance Review meetings in place with Health Groups Monthly scrutiny of the Balance Sheet by the Performance and Finance Committee Realistic and achievable plan in place developed with staff input and sustainability funds identified	Ongoing development of accountability of Health Groups – further improvements required Gap in identified CRES schemes and required level Industrial Action	Performance Committee and Boards Finance Performance Reviews with Health Groups	Divisional awareness of spend within new structures as budget centres have shifted Clarity of ownership of schemes Pace of delivery The struggle to identify efficiency schemes Junior Doctor operational pressures Locums in Clinical Support (Oncology and Haematology) Lung Health check Pay issues - £2.1m of the pay variance relates to the cost of covering industrial action. Whilst there are some non recurrent vacancies within Health Groups that are helping address some of the CRES shortfalls, there are also a number of pay pressure areas; Anaesthetics medical staffing premium pay, Obs, Gynae and Paediatric consultants in Family and Women's, premium pay in the Emergency Department and within the Clinical Haematology Department. Clinical Admin pressures driven by support for elective recovery and industrial action. Pay award – clinical income is above plan due to the accrued pay award funding.	Key actions to achieve financial plan/targets in 2023/24: Balance Sheet review CRES planning – short and medium term Bed configuration review across Surgery HG Developing a MTFP at Trust and System level Health Group Key Actions Surgery • Further work to develop additional CRES, including focus on theatre productivity and endoscopy. • Maximise benefits from new Day Surgery capacity available, with potential for ERF gains. Clinical Support • Advert out to pursue substantive recruitment opportunities (particularly in Haematology) to mitigate continued pay premia for agency consultants. • Activity levels in Oncology and Haematology on elective work are currently above plan. Work being undertaken with teams to review ongoing pressures. • Work ongoing with Divisions to identify CRES schemes. Continue to work on replacing non recurrent schemes	Q2 The indicative ERF position to M5 is 95% of 2019/20 value, versus an adjusted overall target of 104%. Trust 2019/20 baselines have been amended for counting & coding changes and service transfers and profiled on 23/24 working days, based on NHSE methodology. The ICB report a £0.3m overspend at month 3, with a forecast breakeven position by the year end. The Trust is forecasting that it will deliver its plan, however, this includes unaddressed risk of £5.3m. £3.5m of this relates to the £10m stretch target and £1.0m relates to the shortfall in funding to cover the agenda for change pay award. The Trust has forecast an additional pressure on equipment disposals of £170k. **Q3** **The indicative ERF position year to date is £1.7m below plan. Month 7 was 101% delivery. The Trust target is now 102% but the shortfall is offset by Advice and Guidance funding.** **At month 6, the ICB reported a breakeven position, and a forecast £30m deficit at year end, which is consistent with plans.** **The Trust reported an in month surplus for month 7 of £1.5m, £2.1m better than plan.**

						with recurrent opportunities. Family and Women's • Comprehensive review of medical variable pay to mitigate pressures in both junior doctors and consultant level across specialties. • Continue recruitment for AfC staff to reduce reliance on overtime, bank and agency; focus on midwifery and supporting roles within maternity. • Focus on identifying and progressing recurrent benefits in productivity and efficiency. Medicine • Focus on productivity and reduced LOS to address CRES shortfall. • Ensure all outpatient procedures are accurately coded and associated ERF funding gains realised by the HG. Cardiology • Ensure agreement of procurement outcomes are expedited with anticipated savings contributing to non pay spend and CRES requirement. Emergency Medicine • Rotas continued to be managed effectively. IA having a major impact. • Fortnightly review of Nursing Establishment. Controls in place around overtime/Bank. Continuation of control of agency usage. Rotas reviewed to assess hours of	

						patients in the department is met by the staffing. • Review of all areas of spend, to achieve recurrent savings. • Non Pay controls in place, additional levels of authorisation, to scrutinise expenditure requests.	
	Risks from Risk Register: No direct risks on the Corporate Risk Register			**Metrics:** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Q1 Deficit of £1.7m reported at month 1, £1.4m worse than plan Q2 Deficit £1.3m, £1m adverse against plan I&E forecast outturn = £10.4m deficit The Trust delivered £16.7m in CRES against a target of £18.4m. The forecast is to deliver £46.8m against a plan of £53.9m. The Trust cash balance at 31st August 2023 was £41.4m and is forecast to be £33.3m by the year end. The Trust has spent £12.2m on agency and bank pay to August. This is £2.6m more than the same period in 2022/23. Q3 Deficit £7.8m, £5.5m adverse against plan I&E forecast outturn - £7.2m deficit. This is in line with the 2023/24 plan The Trust delivered £24.8m in CRES against a target of £27.5m. The forecast is to deliver £47.5m against a plan of £53.9m. The Trust cash balance at 31st October 2023 was £31.0m, £1.8m below the cash plan. The year end forecast is £33.3m.		

					The Trust has spent £16.8m on agency and bank pay to October. This is £3.1m more than the same period in 2022/23.		

Inherent Risk			Risk position as at 31.12.23 (Q3)			Planned target risk position by 31.03.2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

Strategic Theme: Finance
Appetite: Low
Risk: 7.2

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: Group Chief Finance Officer
CQC Domain: Effective
Enabling Strategies/Plans: Financial Plan 2023/24

Risk to Objective						Progress/Timescales
Strategic risk: **Condition:** There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year. **Cause:** Lack of achievement of sufficient recurrent CRES or make efficiencies Impact of Covid-19 finances and recovery planning **Consequence:** The Trust does not achieve its Financial Plan or make efficiency savings	Financial Plan NHS Finance sees performance being measured at a system (ICS) level CRES Schemes Balanced Financial plan	Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews CRES delivery	Regular update reports to the Performance and Finance Committee	Lost income due to Junior Doctors strike Industrial Action – Medical Staff CRES Delivery Bed Pressures ERF Delivery Capital expenditure profile of EPR v funding CQC /quality issues – may require investment Awaiting confirmation of Health Education England contribution to medical pay award funding gap	Ongoing development of accountability of Health Groups Developing granular detail for the underlying position. The Trust has identified £24.8m of its £27.5m year to date target (90%) with year end forecast of £47.6m (88%), £6.4m short on plan. This includes £3.2m remaining shortfall on the £10m stretch target. The Trust is forecasting 82% delivery on Health Group and corporate areas. The Trust is using Model Hospital and GIRFT reviews to identify potential savings opportunities with reviews of specialties identified as having the biggest opportunities. This will be reported and managed through the Productivity and Efficiency Board. The Key drivers to achieve the savings target are identified as: • Improving Length of Stay in Medicine and Surgery to enable release of beds (Medicine) or earn additional ERF (Surgery) • Improve Theatre Productivity to earn additional ERF or release costs. • Reduce Follow-up activity to free up capacity for New Outpatients (Potential to earn ERF) • Use of Digital technology to release clinical administration costs	Underlying funding will be received in 2024/25 but the ICB has requested to show this as a recurrent problem as funding is non-recurrent beyond that. The underlying position will be refined over the next few months as latest positions are updated **Q3** **NHSE agreed additional funding of £17.3m for HNY ICS and further changes to the ERF target to reflect the ongoing impact of the Strike.** **Following receipt of an additional £6.3m funding and reduced ERF target of 2% (£3.4m improvement) the Trust has assessed that it has remaining unaddressed risk of £2.3m. This includes potential repayment of the CNST maternity contribution and winter pressures.** **The Trust assessment is that this remaining risk can be managed and the Trust will achieve its planned deficit of £7.2m.** **As per NHSE guidance the above position assumes no further strike action in 2023/24. There would be further risk of £2m costs and lost activity if industrial action recommences from December 23 onwards.**

	Risks from Risk Register: No direct risks on the Corporate Risk Register			**Metrics:** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent/semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Q1 reported deficit of £1.7m at month 1, £1.4m worse than plan Q2 The Trust underlying deficit is £51.2m. This is unchanged from month 4. Q3 The Trust underlying deficit is £52.7m in month 8		

Inherent Risk			**Risk position as at 31.12.23 (Q3)**			**Planned target risk position by 31.03.2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**5**	**20**	**4**	**5**	**20**	**4**	**5**	**20**

Strategic Theme: Financial
Appetite: Moderate
Risk: 7.3

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: Group Chief Finance Officer
CQC Domain: Effective
Enabling Strategies/Plans: Capital Plan 2022-2025

Risk to Objective						Progress/Timescales
Strategic risk: **Condition:** There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability **Cause:** Lack of sufficient capital and revenue for funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment. **Consequence:** Lack of capital funding impacting on services Lack of investment impacting on patient and staff safety	Capital programme in place and risk assessed Comprehensive maintenance programme in place Capital Resource Allocation Committee in place to allocate funds Service level business continuity plans in place	Supplier price increases and delays to building works to be managed Energy and Decarbonisation funding not yet secured	Monthly updates to the Performance and Finance Committee Regular updates to the Board	Building works impacting on patients and staff There have been delays in the approval process for the Day Surgery Phase 2 Business Case which has caused delays to the main scheme. Expenditure is expected to come back in line in the coming months.	Capital Plan Phase 1 of Day Surgery Scheme The Trust Digital Strategy is being refreshed, due to be complete by end of Autumn 2023. The revised strategy will be a joint HUTH and NLAG Strategy within the framework of the ICS Digital Strategy. HUTH and NLAG initial focus remains on the future EPR solution as a replacement for Lorenzo and WebV and the strategy will be based around this central requirement. The Trust Digital Strategy is being refreshed. The revised strategy will be a joint HUTH and NLAG Strategy within the framework of the ICS Digital Strategy. HUTH and NLAG initial focus remains on the future EPR solution as a replacement for Lorenzo and WebV and the strategy will be based around this central requirement. The Digital Programme Board and the digital team have identified the key work priorities for the remainder of 23/24.	Q1 Capital funding for 2023/24 is £58m. This has changed from the original plan of £50.7m by £7.4m. This variance mainly relates to the confirmation of additional PDC funding for UTC £2.8m; CDC £3.5m (23/24) & £12.5m (24/25) and IRT £1.6m. There is also a £3m reduction due to the re-profiling of expected PDC relating to the Day Surgery scheme into 24/25. In addition, the Trust is currently holding £2.5m ICS CDEL Slippage. Q2 Actual capital expenditure to 31st August was £8.2m, £4.4m behind plan. The backlog maintenance work is continuing, with the forecast spend in line with capital plan. The Equipment Management Group has identified priorities to be funded, a number of orders have already been placed including £0.5m for a Neuro Microscope. Discussions are ongoing with the ICS in terms of managing CDEL allocations across years. The ICS has £2.5m slippage which is currently included in the HUTH forecast spend to ensure CDEL is balanced, until providers assess forecasts and ability to bring forward schemes from 24/25. This will be updated at month 6. **Q3** **The Trust capital funding for 2023/24 is £50.1m, a net reduction of £0.6m from initial plan.** **There has been additional PDC allocated for UTC £2.8m; IRT £1.6m and most recently £0.8m Public Health Equipment and £0.6m Endoscopy equipment. £3.0m of Day Surgery funding was re-profiled into 24/25.** **This has been offset by slippage relating to Donated Income £2m. This will be available in the 24/25 Capital Programme.**

							In addition, the Trust has agreed ICS slippage of £1.6m (£1m Harrogate and £0.6m NLAG), this is fully repayable in 24/25. **Actual capital expenditure to 30th November was £24m, £2.8m behind plan. Main variances relate to Day Surgery, however this was due to delays in the approval process of the Phase 2 Business Case. Expenditure is expected to come back in line in the coming months.** **The backlog maintenance work is continuing, with the forecast spend in line with capital plan.** **The Equipment Management Group has identified priorities to be funded, a number of orders have already been placed with commitments totalling £2m.**
	Risks from Risk Register: 4078 - In year achievement of the Capital plan 1747 - Backlog maintenance issues impacting on Clinical Service Delivery			**Metrics:** Capital performance and expenditure against the plan **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Month 5 Capital expenditure is £8.2m, against a year to date plan of £12.6m Month 8 Capital expenditure is £17.9m, against a year to date plan of £23.3m		

Inherent Risk			Risk position as at 31.12.23 (Q3)			Planned target risk position by 31/03/2024		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**5**	**20**	**3**	**5**	**15**	**2**	**5**	**10**

Appendix 5

		Impact Score				
		1	2	3	4	5
Likelihood Score	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Likelihood Descriptions		Score
Rare	This will probably never happen / recur. Not expected to occur for years.	1
Unlikely	Do not expect it to happen / recur but it is possible it may do so. Expected to occur at least annually.	2
Possible	Might happen or recur occasionally. Expected to occur at least monthly.	3
Likely	Will probably happen / recur but it is not a persisting issue. Expected to occur at least weekly.	4
Almost Certain	Will undoubtedly happen / recur, possibly frequently. Expected to occur at least daily.	5

Impact Domains	Impact Score and Examples of Descriptions				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / Equality / Complaints / Audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory Duty / Inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Business Objectives / Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including Claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service / Business Interruption / Environmental Impact	Loss/interruption of >1 hour Minimal or no impact on the environment No impact on other services	Loss/interruption of >8 hours Minor impact on environment Impact on other services within the Division	Loss/interruption of >1 day Moderate impact on environment Impact on services within other Divisions	Loss/interruption of >1 week Major impact on environment Impact on all Divisions	Permanent loss of service or facility Catastrophic impact on environment Impact on services external to the Trust
Information Security / Data Protection	Potential breach of confidentiality with less than 5 people affected Encrypted files	Serious potential breach of confidentiality with 6 – 20 people affected Unencrypted clinical records lost	Serious breach of confidentiality with 21 – 100 people affected Inadequately protected PCs, laptops and remote device	Serious breach of confidentiality with 101 – 1000 people affected Particularly sensitive details (i.e. sexual health)	Serious breach of confidentiality with over 1001 people affected Potential for ID theft

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2023 / 24

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber and North Yorkshire (HNY) Integrated Care System (ICS) ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber and North Yorkshire Integrated Care System (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Board Assurance Framework - 2023 / 24

The Trust's risk appetite is:

• For risks threatening the safety of the quality of care provided – low (4 to 6)

• For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)

• For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Context

Healthcare organisations like NLaG are by their very nature risk averse, the intention of this risk appetite statement is to make the Trust more aware of the risks and how they are managed. The purpose of this statement is to give guidance to staff on what the Trust Board considers to be an acceptable level of risk for them to take to ensure the Trust meets its strategic objectives. The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated below.

NLAG is committed to working to secure the best quality healthcare possible for the population it serves. A fundamental part of this objective is the responsibility to manage risk as effectively as possible in the context of a highly complex and changing operational environment. This environment presents a number of constraints to the scope of NLAG's risk management which the Board, senior management and staff cannot always fully influence or control; these include:

• how many patients need to access our services at any time and the fact our services need to be available 24/7 for them whether we have the capacity available or not
• the number of skilled, qualified and experienced staff we have and can retain, or which we can attract, given the extensive national shortages in many job roles.
• numerous national regulations and statutory requirements we must try to work within and targets we must try to achieve
• the state of our buildings, IT and other equipment
• the amount of money we have and are able to spend
• working in an unpredictable and political environment.

The above constraints can be exacerbated by a number of contingencies that can also limit management action; NLAG operates in a complex national and local system where the decisions and actions of other organisations in the health and care sector can have an impact on the Trust's ability to meet its strategic objectives including its management of risk.

Operating in this context on a daily basis Trust staff make numerous organisational and clinical decisions which impact on the health and care of patients. In fulfilling their functions staff will always seek to balance the risks and benefits of taking any action but the Trust acknowledges some risks can never be eliminated fully and has, therefore, put in place a framework to aide controlled decision taking, which sets clear parameters around the level of risk that staff are empowered to take and risks that must be escalated to senior management, executives and the Board.

Risk Appetite Assessment

Risk Assessment Grading Matrix					
Likelihood of recurrence	Severity / Impact / Consequence				
	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25
RISK	Green Risk Score 1 - 3 (Very Low)	Yellow - Risk Score 4 - 6 (Low)	Orange - Risk Score 8 - 12 (Medium)	Red Risk Score 15 - 25 (High)	

Risk Management

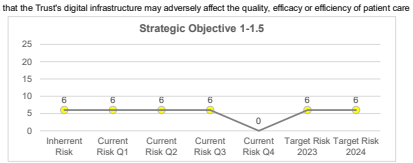
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using their feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Board Assurance Framework - 2023 / 24

Strategic Risk	High Level Risk Description and Risk Consequence / Likelihood Assessment	Risk Appetite	Owner	Committee
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard 	Low	Chief Medical Officer and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets 	Low	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy 	Low	Director of Strategic Development	Trust Board
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate 	Low	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care 	Low	Chief Information Officer	ARG / Trust Board
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope 	Low	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients. 	Low	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities 	Moderate	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital 	Moderate	Director of Strategic Development	Trust Board
SO4	The risk that the Trust is not a good partner and collaborator	Moderate	Director of Strategic Development	Trust Board
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives 	Moderate	Chief Executive	WC

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: 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.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5	5		5
Likelihood	3	3	3	3		3
Risk Rating Score	15	15	15	15		15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 October 2023, 8 January 2024

Lead Committee: Quality and Safety Committee

Risk Owners: Chief Medical Officer and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan 2022/23
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Place Quality Meetings - N Lincs, N E Lincs, East Riding
- SI Collaborative Meeting with ICB, with Place Representatives
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare Live
- Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group
- Nursing Metric Panel Meeting
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing and Midwifery & AHP Board
- NICE Guidance implementation monitoring and reporting processes
- Learning from deaths process
- Mortality Improvement Group
- Vulnerabilities Group
- Incident control group chaired by NHSE to support Paediatric Audiology service.

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board, Learning from deaths annual and quarterly reports.
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- NICE Guidance Assurance Report to Q&SC
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Nursing assurance safe staffing framework NHSI
- Audit Outlier Report to Quality Governance Group
- 15 Steps Accreditation Tool
- CQC action planning, monitoring and assurance of action completion processes

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance
- NHSE External Review of Safe Staffing Establishment and Recommendations - February 2022
- Maternity Birth Rate Plus Review - 2022
- Internal Audit - CQC action plan compliance – Significant assurance
- Improved ratings in CQC inspection (Dec 2022 report) with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement
- Maternity CNST standards compliance submission
- Health Scrutiny Committees (Local Authority)

Planned Actions

Action	Quarter / Year	Assurance
Continue to develop metrics as data quality allows	Ongoing	Green
Delivery of deteriorating patient improvement plan	Q4 2023/24	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q3 2023/24	Green
Implementation of the Learning From Patient Safety Events incident reporting requirements. Testing phase - Completed	Q2 2023/23	Blue
Review and implement changes to Audiology Service	Q3 2023/24	Amber
15 steps Star Accreditation Programme commenced	Ongoing	Green
Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas.	Q4 2023/24	Green
Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients	Q4 2023/24	Green

Future Risks

- Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train.
- Transition from SI reporting framework to PSIRF approach.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Gaps in Controls

- Estate and compliance with IPC requirements B12- see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust
- Paediatric audiology service

Gaps in Assurance

- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Safety and delays on cancer pathways
- Patient safety risks increased due to longer waiting times. (Refer to SO1-1.2)

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
No 2347 Deteriorating patient risk, Surgery = 15
No 2992 Lack of Changing Places facility at SGH = 16
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3114,Delays in children being reviewing in Paediatric Endocrine Service, may lead to failure to treat and manage the child's condition, leading to significant physical, mental issues, that could be life limiting = 20
No 3144, Paediatric Audiology Service, risk of harm to babies where hearing loss diagnosis is delayed or incorrect = 16
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16 (Risk closed on Ulysses due to incorrect risk rating).
No 3196, Breast imaging service loss of capacity, will impact on delivery of 2ww service and delay patient pathways = 15
No 3221, Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 9 (previously 15)
No 3226, Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: 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.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5	5		5
Likelihood	4	4	4	4		3
Risk Rating Score	20	20	20	20		15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 October 2023, 8 January 2024

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)
- Emergency Department and Medicine Specialties Quality & Safetly Groups
- Planning and Performance

Assurance (internal & external)

Internal:

- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, A&E Delivery Board, MDT Business Meetings, System-wide Ambulance Handover Improvement Group, PCIP, PFIG, Planning and Performance
- Integrated Performance Report to Trust Board and Committees.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:

- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2022-23

External:

- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- NHSE Intensive Support Team
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- ECIST & GIRFT Support Team Visits Scheduled for Nov 2023

Planned Actions

Action	Quarter / Year	Assurance
Progress with implementation of General Internal Medicine/Frailty Model and the link as a wider integrated frailty model across Northern Lincolnshire	Q2 2023/24	Yellow
	Q3 2023/24	
Review of clinical pathways linked to HAS programme 1 Humber Clinical Collaborative Programme (HCCP), seven specialties	Q2 2023/24	Amber
	Q3 2023/24	
Validation of all RTT Clock Stops back to 100%	Q2 2023/24	Amber
		Blue
Develop divisional dashboards	Q2 2023/24	Yellow
	Q4 2023/24	Amber
Consultant job plans to be signed off for 2023-24	Q2 2023/24	Red
	Q3 2023/24	
Completion of theatre refubishment programme	Q2 2023/24	Green
		Blue
Implementation of 2023/24 Outpatient Clinic Configuration aligned to 2023/24 Activity Plan and NHS Operational Planning Guidance, reducing follow up activity and increasing capacity for new patients	Q2 2023/24	Green
	Q3 2023/24	Yellow
Implementation of Gynaecology Service Review including the support the Integrated Acute Assessment Unit (IAAU) model of care	Q3 2023/24	Green
Expansion of Community Discharge and Admission Alternative Development workstreams (Virtual Ward capacity, Short Term care capacity and OPAT capacity)	Q3 2023/24	Green
Implementation of Criteria to Admit within ED to support reduction in admissions and use of alternative pathways	Q4 2023/24	Green
Review of pathways for High Intensity Service Users	Q4 2023/24	Green
	Q4 2023/24	Green
Implementation of Clinical Frailty Score in ED	Q3 2023/24	
Review Dementia pathways in ED	Q4 2023/24	Green
Implementation phase 3 of AAU business case	Q4 2023/24	Green
Cancer Transformation Programme with detailed improvement plans agreed with Divisions to deliver Best Practice timed pathways, plus joint pathway work with HUTH for cross-organisational elements of pathways	Q4 2024/25	Yellow

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 64 weeks, 62 days and 104 days breaches.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to inability to access scanner and reporting teams externally
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS requires significant system change. Early adopters from July 23, with mandatory submission from July 24
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - not meeting constitutional standards and impact on diagnostic capacity
- Risk of no contracting for independent sector work
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Replacement of ward A1

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- High levels of staff sickness
- High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas.

Gaps in Assurance

- Quality of reports to board assurance committees
- Quality and timeliness of data
- Recruitment and development of Consultants, specialist nurses

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2773, Lack of scanning capacity s leading to a risk of delayed diagnosis = 16
No 2949, Oncology Service = 20
No 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3201, Clinical capacity within colposcopy = 15
No 3204, One year wait for new referrals to see a Consultant Paediatrician into the ADHD post diagnostis support service = 15
No 3217, Breast Imaging Workforce Depletion, and delays to deliver care occuring to cancer standards = 15 20
No 3196, Breast Imaging Service loss of capacity = 15
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 3045, Medical Workforce Vacancies in Gastroenterolgy = 16
No 3114, Delays in Children being reviewed in DPOW Paediatric Endocrine Service = 20
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2775, Scunthorpe MRI scanner past end of 7 year life, lack of capital availability, impact will be reduced capacity to deliver scans for some cancer pathways = 20
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: 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.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4	4	4		4
Likelihood	3	3	3	3		2
Risk Rating	12	12	12	12		8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 24 October 2023, 8 January 2024

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2023/24
- Humber and North Yorkshire Integrated Care System
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS)
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board (JDB)
- Committees in Common (CIC)
- Patient Safety Champions

Assurance (internal & external)

Positive:
- NHSE Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC
- Humber and North Yorkshire Integrated Care System
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
• CIC / NED / Governor reviews	Q4 2022/23	Blue
• Evaluation of the models and options with stakeholders	Q4 2022/23	Blue
• Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
• Citizens Panel reviews	Q2 2023/24	Green
• To undertake continuous process of stocktake and assurance reviews NHSE and Clinical Senate review	Q1 2023/24	Blue
•Joint OSC - reviews	Q2 2023/24	Blue
• To undertake continuous engagement process with public and staff	Q2 2023/24	Blue
• Stakeholder Mapping	Q1 2023/24	Blue
• Public Consultation (launched 24 Sept 23 - 5 Jan 24)	Q2/Q3 2023/24	Green
• NHSE Gateway review (pre-consultation)	Q2 4 2023/24	Blue
• ICB Executive Assurance Board / IC Board Approval	Q4 2023/24	Green
• Final report from Clinical Senate review (due Q1)	Q1 2023/24	Blue
• HAS Risk Workshop with ICB Executives (30 May 23)	Q1 2023/24	Blue
• Case studies for each proposed service change	Q3 2023/24	Green
• Public exhibition events	Q3 2023/24	Green
• Decision Making Business Case	Q3/4 2023/24	Green
• NHSE Gateway review (post-consultation)	Q4 2023/24	Green
• Capital short form business case	Q4 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts
- Decoupling maternity/neonates from HAS programme (impact on paediatrics)

Strategic Threats
- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning and Digital Strategy

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: 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.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5	5		5
Likelihood	4	4	4	4		4
Risk Rating	20	20	20	20		20

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 7 July 2023, 8 January 2024

Lead Committee: Finance and Performance Committee

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24	Red
Complete refurbishment of old SGH ED (completion end of Q43)	Q3 2023/24	Red
Complete BLM 23/24 programme	Q4 2023/24	Amber

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
•Grimsby 21% CIR of the BLM
•Goole 11% CIR of the BLM
•Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance:Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: 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.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	3	3	3	3		3
Likelihood	2	2	2	2		2
Risk Rating	6	6	6	6		6

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 30 October 2023, 8 January 2024

Lead Committee: Audit, Risk and Governance Committee / Trust Board

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Positive Assurance:

- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Planned Actions

Action	Quarter / Year	Assurance
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Pkus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23.	Q4 2023/24	Green
IPR - further review of current the IPR to align with how the Group model evolves. (ie. adding digital, finance and estates)	Q4 2023/24	Green
Ongoing work to secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Depending when NHSE EPR digitisation funding is made available which is likely to be in Q3/Q4 2023/24	Q4 2023/24	Amber
The Data Warehouse with core activity data sets will be completed and running on the new platform by Feb 2024 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q4 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q2 2023/24	Blue
Continuing work on reconfiguration of local Digital Services functions to align to group structure increasing resilience and its ability to deliver strategic change.	Q4 2023/24	Green

Future Risks

- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Achieve DSP Toolkit compliance - currently approaching standards.

Gaps in Assurance

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training (critical that operational managers across all divisions ensure that staff completed the training)

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership
- Approved funding to procure a Single Enterprise EPR, cloud hosted for the NLaG and HUTH.

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: 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).

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4	4	4		4
Likelihood	3	3	3	3		2
Risk Rating						8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 October 2023, 8 January 2024

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group.
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- IPC protocols implemented including mask wearing and rapid testing process
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)
- Industrial action planning (Strategic & Tactical Group)
- Emergency Preparedness, Resilience and Response Steering Group
- Bank Holiday Planing Group
- Executive Led Bed Occupancy and Length of Stay Review

Assurance (internal & external)

Internal:

- National and Regional exercises testing emergency plans, business continuity and planning assumptions (e.g. Artic Willow, Mighty Oak)
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP, Strategic & Tactical Group, Emergency Preparedness, Resilience and Response Steering Group, Bank Holiday Planning Group, Executive Led Bed Occupancy and Length of Stay Review

Positive:

- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance

External:

- Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core Standards rated substantial compliance for 2022/23
- NHSE review of emergency planning self-assessment 2021/22 rated substantial compliance
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance
- EMAS Audit of Trust CBRNe/HAZMAT arrangements with no recommendations (2022/23)

Planned Actions

Action	Quarter / Year	Assurance
Relaunch of loggist training and provision (previous action was Green)	Ongoing	Blue
Review of Evacuation Plan (previous action was Yellow)	Ongoing	Blue
Continuous Review of Evacuation Plan	Ongoing	Yellow
Planning for and response to industrial action (multiple unions)	Ongoing	Green
Inclusion of details of BC plans tested/implemented duirng exercises/incidents documented in reports.	Ongoing	Green
Rolling Schedule of annual business continuity plans	Ongoing	Green
Major Incident table top exercises underway with new Strategic Health Commanders	Ongoing	Green
Review of Major Incident Plan and Critical Incident Plan	Q2 2023/24	Green
NHSE Core Standard for EPRR 2023/24 compliance and assurance	Q2 2023/24	Green
Flu / COVID Public Health campaign for Vaccinations	Q3 2023/24	Green
Roll out of new Major Incident Triage Tool (MITT)	Q4 2023/24	Green
Winter Planning Group commenced for 2023/24	Q4 2023/24	Green

Future Risks

- COVID-19 surge.
- Availability of clinical consumables, equipment and some medications post EU Exit / Ukraine
- Costs and timeliness of deliveries due to EU Exit / Ukraine
- Additional patients with longer waiting times RTT, Cancer and Diagnostics.
- Increase in seasional outbreaks (influenza, norovirus) impacting on bed capacity.
- National industrial action Medical Staff within healthcare and other sectors impacting on workforce levels and elective recovery plan
- Increased risk of cyber attacks due to sanctions imposed on Russia.
- Risk of energy supply disruptions over winter period
- Risk to delivery of EPRR Work and Training Programme due to ongoing industrial action workload

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2023/24.
- Lower than expected uptake of influenza vaccination.

- BC Plans that are tested or implemented during exercises/incidents are not specifically named or captured within reports to evidence testing.
- Challenge in releasing workforce to attend specialist training (e.g. CBRN/HAZMAT).
- Recruitment pipeline to address medical staffing shortfalls and reduce reliance on agency.
- Recruitment pipeline to address nurse staffing shortfalls and reduce reliance on agency.

- No 2562, Constitutional A&E targets = 20
- No 3164, Nurse staffing = 20
- No 2976, Registered nursing vacancies = 25
- No 3063, Doctor vacancies = 16

- Closer Integrated Care System working.
- Provider collaboration.
- Participation in national, regional and ICS/LRF exercising and testing of emergency plans.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	5	5	5	5		5
Likelihood	3	4	4	4		3
Risk Rating	15	20	20	20		15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 24 October 2023, 8 January 2024

Lead Committee: Workforce Committee

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recrutiment and retention group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- People Directorate - People Strategy Annual Delivery Implementation Plan 2023/24
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Workforce Development Portfolio Governance Boards, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board.

Positive:
- IPR decreasing trends
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year	Assurance
Develop and care for our own staff to improve retention (People Plan 23/24)	Q4 2023/24	Green
Develop the attraction and development of new staff (People plan 23/24)	Q4 2023/24	Green
Continue to improve our culture and staff engagement (People Plan 23/24)	Q4 2023/24	Green

Future Risks

- Pockets of low staff morale impacting turnover
- Seasonal illness may impact available workforce numbers
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Change impact of HASR and Group plans on NLaG clinical and non clinical strategies.
- Reliance on international pipelines to reduced vacancy position. Further local succession planning and future talent identification required.
- Increased demand on people services due to significant volumes of staff recruitment - potential for delays
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda
- National strike action driven by pay detracts from local ability to deliver cultural satisfaction.

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Attract, recruit, retain staff to work in the geographical area.
- Culture and staff engagement.

Gaps in Assurance

- Vacancy postion reducing overall
- Consultant vacancy position remains high. remain high particulary in medical areas
- Agency spend remains high
- Turnover reducing, but above target remains high.

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3209, Risk to Junior Medical Cover - Recruitment Delays to Acute TG CT = 16
No 3217, Breast Imaging Workforce Depletion, and delays to deliver care occuring to cancer standards = 15

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment
- Place based educational collaboratives

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber and North Yorkshire Integrated Care System.

Risk to Strategic Objective 3 - 3.1: 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.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5	4		5
Likelihood	4	4	4	4		2
						10

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 July 2023, 8 January 2024

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls	Assurance (internal & external)	Planned Actions	Quarter / Year	Assurance	Future Risks
• Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital. • National benchmarking and productivity data constantly reviewed to identify Cost Improvement Programme (CIP) schemes. • Engagement with Integrated Care System on system wide planning • Monthly ICS Finance Meetings • Operational and Finance Plan 2023/24 • Counter Fraud and Internal Audit Plans • Trustwide Budgetary Control System	**Internal:** • Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings • Non-Executive Director Highlight Report (bi-monthly) to Trust Board **Positive:** • Internal Audit Reports - Internal Control - significant assurance **External:** • Approval received at ICS Level for 2023/24 capital plan • Internal Audit Reports - Internal Control - significant assurance • Agreed Financial Plan at ICS Level for 2023/24 • Monthly meetings with NHSE Regional Team as a successor to Financial Special Measures regime.	**Action** • There is specific workforce planning ongoing - linked to Workforce committee (refer to SO2) • Review of nationally specified control actions currently underway with a view to introduction. • Exercise to identify and complete CIP planning process also underway • HAS business case planned to go to public consultation • Develop workforce plans for non-registered nursing and medical staffing	 Q2 Q2 Q3 Q2	Green Green Green Green Red	• COVID-19 further surges and impact on finance and CIP achievement • Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme • Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems • Vacancy levels in medical and nursing driving an unplanned level of spend • Inability to transform planned care pathways, including outpatient follow-ups and theatre productivity
					Strategic Threats • ICS Future Funding • Integrating Care: Next Steps • System wide control total
• Cost Improvement Programme not fully formed. • Delivery plan to support activity targets no fully formed. • Clinical strategy required to inform Finance Strategy • As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process • Month on month adverse variants against operational budgets •Inability to recruit and retain staff to meet financial plannnig assumptions • Have we systems in place to facilitate level of recruitment • Systems and processes in place to facilitate reduction in turnover rate • Uncertainty of existing systems to recruit and retain staff.	• Trustwide Budgetary Control System, not working to deliver financial balance with current plans • Recurrent delivery of Cost Improvement Programme Plan • Management of financial risks arising from the lack of flow • Individual organisational sustainability plans may not deliver system wide control total • No assurance recruitment or retention will improve • Not meeting productivity targets for theatres and outpatients	No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20 No 3174, Trust doesnot receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE = 15 No 3202, Non-delivery of Medicine Divisional Finance CIP = 16 No 3221, Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 15 No 3226, Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16			• Closer ICS working • Provider collaboration and formation of the Group • System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: 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.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5	5		5
Likelihood	3	3	3	3		3
						15

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 24 October 2023, 8 January 2024

Lead Committee: Trust Board

Risk Owners:
Chief Financial Officer and
Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE - HAS Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- NHSE attendance at AAU / ED Programme Board
- CiC Minutes
- Place Boards

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23 Q1 2024/25	Yellow
Review and seek if there are ways of applying for future rounds of PSDS funding	Q2 2023/24	Green
Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies	Q4 3 2023/24	
Capital short form business case for HAS models	Q4 2023/24	

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

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- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber and North Yorkshire Integrated Care System (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

Risk to Strategic Objective 4: 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.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4	4	4		4
Likelihood	3	3	3	3		2
Risk Rating						8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023, 24 October 2023, 8 January 2024

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY ICS.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common
- Acute and Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)
- Place Boards

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process
- Consultation Institute Review
- Place Boards and Place Working Groups established

Internal:
- Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams
- Place Boards and Place Working Groups established
- Collaborative of Acute Providers Board

Planned Actions

Action	Quarter / Year	Assurance
HAS Programme:		
• Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
• Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Blue
• Joint OSC - reviews	Q2 1 2023/24	Blue
• NHSE Gateway review	Q2 2023/24	Blue
• ICS Board approval	Q2 2023/24	Blue
• Public Consultation (launched 24 Sept 23 - 5 Jan 24)	Q2/Q3 2023/24	Green
• Decision Making Business Case	Q3/4 2023/24	Green
• HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Blue
Collaborative of Acute Providers:		
• Development of H&NY Planned Care Strategy/Framework	Q3 Q1 2024/25	Yellow

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts Decoupling maternity/neonates from HAS programme (impact on paediatrics)

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 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.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	4	4	4	4		4
Likelihood	3	3	3	3		2
Risk Rating	12	12	12	12		8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 12 July 2023, 24 October 2023**, 8 January 2024**

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS, Leadership and Culture Transformation Committee
- CQC and NHSE Support Teams
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders, VB Leadership Development, LIDA
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSE Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair, Chief Executive, Chief Financial Officer, Chief Information Officer, Interim Chief People Officer, Interm Director of Strategic Development and Interim Director of Estates and Facilities with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System.

Assurance (internal & external)

Internal:
- Leadership Strategy
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS, Leadership and Culture Transformation Committee.
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Board and Committee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:

External:
- NHS Staff Survey.
- CQC Report
- ICB Leadership forum

Planned Actions

Action	Quarter / Year	Assurance
Delivery against the Trust Leadership Strategy (2020 - 2024)	Q4 (23/24)	Green

Future Risks

- Funding for all leadership programmes is non-recurrent
- National policy changes.
- Impact of HASR and Group plans on NLaG clinical and non clinical strategies.

Strategic Threats

- Non-delivery of the Trust's strategic objectives
- Higher turnover of staff due to poor levels of leadership
- CQC rating and recommendations
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No ongoing investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration - particular focus on local education providers
- System wide collaboration to meet control total
- Group model and wider access to leadership development.

Board Assurance Framework - 2023 / 24	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated yellow - in progress, off track, with mitigation, and could pose a risk to the strategic objective being delivered
Green	Actions rated green mean they are on track to deliver.
Blue	Closed action which supports the progress towards the delivery of the strategic objective

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)024

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Sean Lyons, Group Chair
Contact Officer/Author	Wendy Booth, Interim Governance Advisor
Title of the Report	Trust Boards' Aligned Board Business Reporting Framework
Executive Summary	The report provides the updated Aligned Board Business Reporting Framework. Minor changes only have been made to reporting periods and / or reporting frequencies and to reflect those policy & other documents requiring boards' approval. <u>Recommendations</u> The HUTH and NLaG Trust Boards are asked to: • approve the updated Aligned Board Business Reporting Framework.
Background Information and/or Supporting Document(s) (if applicable)	Aligned Governance & Decision-Making (Option 7) / Corporate Governance Workstream
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:

Updated Version January 2024
(to be read alongside the Board Development Programme once drafted)

Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospital NHS Trust

Aligned Board Reporting Framework 2023/24 and 2024/25

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Core / Standing Business Items														
Board Site Visits	To receive feedback on board member site visits & issues for escalation	Verbal	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Group Chair's Opening Remarks	To welcome board members to the meeting and to note any apologies for absence	Verbal	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	√	Noting
Declarations of Interest	To note any conflicts of interest on specific agenda items or any changes to Directors' Interests	Verbal	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
	To review and note any changes to the Register of Directors' Interests	Written	N/A	Group Chair	Annually				√					Assurance
Fit & Proper Person Test: Annual Declaration	To receive assurance that all board members remain compliant with the Fit & Proper Person requirements	Written	Remuneration Committees	Group Chair	Annually				√					Assurance
Minutes of the Previous Meetings	To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained	Written	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	√	Approval
Matters Arising & Action Tracker	To ensure all agreed board actions are completed	Written	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	√	Noting
Patient Story	To receive direct feedback on the experience of patients including both good practice and areas for improvement	Verbal	N/A	Group Chief Nurse	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Group Chief Executive's Briefing ***(Note 1)***	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	Written	N/A	Group Chief Executive	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Integrated Performance Report ***(Note 1)***	To brief the boards on key performance metrics & priorities, risks to delivery & mitigations	Written	All Committees	Group Chief Strategy & Partnerships Officer / Group Director of Performance	Bi-monthly	√	√	√	√	√	√	√	√	Assurance

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Group Development														
Group Vision, Strategy & Objectives	To approve the Group Vision, Strategy & Objectives & any relevant sub-strategies **(see later section)** and to receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services (the latter as part of the Group Chief Executive's Briefing)	Written	N/A	Group Chair & Group Chief Executive	Initial approval June / July 2024 / Bi-monthly updates thereafter				√					Approval
Group Values	To approve the Values for the Group and any subsequent changes	Written	Workforce, Education & Culture Committees-in-Common	Group Chief Executive	Initial approval/ As required thereafter			√						Approval
Group Operating Model / Care Group Structure	To approve the Group Operating Model & any subsequent changes including changes to the group governance arrangements and assurances in respect of the effectiveness of these arrangements (the latter to also come via the audit committee route and reporting)	Written	N/A	Group Chief Executive & Group Chief Delivery Officer	Initial approval February 2024 / As required thereafter	√ (Draft)	√ (Final)	**To be added to the agenda as required thereafter**						Approval
Group Memorandum of Understanding	To approve the Memorandum of Understanding for the Group & any subsequent changes	Written	N/A	Group Director of Assurance	Initial approval April 2024 / As required thereafter			√						Approval
Group Brand	To approve the Group brand	Written	N/A	Group Chief Executive	Initial approval TBC / as required thereafter			√						Approval
Group and Trust Priorities	To agree the annual priorities for each trust and wider group	Written	N/A	Group Chief Executive	Annually			√						Approval
Group Data Sharing Agreement & Privacy Notice	To agree the data sharing agreement and privacy notice for the group	Written	N/A	Group Chief Strategy & Partnerships Officer	Annually		√						√	Approval
Engagement with External Stakeholders ***(Note 2)***	To receive updates from engagement with stakeholders to include HASR etc	Written	N/A	Group Chief Executive	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Audit, Risk & Governance														
Trust Boards' Aligned Business Reporting Framework	To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements	Written	N/A	Group Director of Assurance	Annually	√ (Draft)	√ (Final)						√	Approval
Trust Board & Committee Meeting Cycle	To approve the Trust Board & Committee meeting cycle	Written	N/A	Group Director of Assurance	Annually		√						√	Approval
Trust Boards' Development Programme	To agree and approve the Board Development Programme in response the outcome of the board skills assessment	Written	N/A	Group Chair	Annually			√						Approval

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
NHS Provider Licence Self Certification	To undertake and agree the annual Trust Board self certification of compliance with the NHS Provide Licence	Written	N/A	Group Director of Assurance	Annually				√					Assurance
Trust Boards' Annual Review of Effectiveness	To undertake an annual review of effectiveness and agree the need for any additional external assurance and / or development needs	Written	N/A	Group Chair	Annually				√					Assurance
Trust Board Committees' Annual Review of Effectiveness	To receive the outcome of the annual review of committee effectiveness and any changes or improvements required including any required changes to Terms of Reference & Work Plans	Written	All Committees	NED Committee Chairs	Annually							√		Assurance
Trust Board Committees Terms of Reference & Work Plans	To approve the changes to board committee terms of reference and work plans following	Written	All Committees	NED Committee Chairs	Annually	√						√		Approval
Board Assurance Framework & Strategic / High Level Risk Register	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Written	All Committees	Group Director of Assurance	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees-in-common and the issues which the committee wish to escalate to the Trust Board and to agree the actions required	Written	Audit, Risk & Governance Committees-in-Common	NED Committee Chairs	Quarterly + Annual Report & Accounts		√		√	√		√	√	Assurance
Standards of Business Conduct	To approve the Trusts' policies on standards of business conduct ensuring that guidance is available to all staff across the two trusts and that conflicts of interests are minimised	Written		Group Director of Assurance	3 Yearly				√					Approval
Annual Accounts - Delegation of Authority, if necessary	To delegate authority to the Audit Committee for the preparation of the Annual Accounts	Written		Group Chief Financial Officer	Annually								√	Approval
Annual Report & Accounts including Going Concern and Audit Letter	To approve and adopt the Annual Report & Accounts	Written		Group Chief Financial Officer	Annually				√ (NLaG)	√ (HUTH)				Approval
Annual Governance Statement (including HoIA Opinion)	To approve the Annual Governance Statement and note the assurances in support of that statement and any significant risks & planned mitigations	Written		Group Director of Assurance	Annually				√ (NLaG)	√ (HUTH)				Approval
Trust Constitution & Standing Orders	To approve amendments to the Trust Constitution & Standing Orders (and any requirement to vary or suspend Standing Orders)	Written		Group Director of Assurance	3 Yearly (or as required)			√						Approval
Scheme of Delegation & Powers Reserved for the Trust Board / Standing Financial Instructions	To approve the Scheme of Delegation including the Schedule of Powers Reserved to the Trust Boards and those delegated to committees	Written		Group Chief Financial Officer	3 Yearly (or as required)			√						Approval
Emergency Planning, Preparedness and Response (EPRR)	To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Written		Group Chief Delivery Officer	Annually					√				Approval

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
External reviews & inspections e.g. CQC, royal college, governance reviews, development reviews against the well led framework	To receive reports from external reviews & inspections including where there are significant quality & safety concerns in respect of any of the Trusts' clinical services and progress against the agreed improvement actions	Written	Relevant Committees	Group Chief Executive / Group Executive Leadership Team	As required	**To be added to the agenda as required**								Assurance
Quality & Safety														
Quality & Safety Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees-in-common and the issues which the committee wish to escalate to the Trust Board and to agree the actions required	Written	Quality & Safety Committees-in-Common	Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Quality Priorities	To approve the annual quality priorities	Written		Group Chief Nurse				√						Approval
Maternity & Neonatal Safety Assurance Report (including Ockenden, CNST MIS, safe staffing, incidents / HSIB)	To maintain oversight and receive assurance in respect of the quality & safety of the Trusts' maternity and neonatal services	Written		Group Chief Nurse + Heads of Midwifery	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Maternity Safety: NED Safety Champions Report	To provide reporting and assurance to the Trust Boards, independent of the executive, on the quality & safety of the trusts' maternity services including risks and concerns requiring escalation as well as good practice, improvement and innovation	Written		NED Safety Champions	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Maternity Safety: CNST Maternity Incentive Scheme (MIS)	To approve the Trusts' CNST MIS submissions	Written		Group Chief Nurse + Heads of Midwifery	Annually							√		Approval
Establishment Review of Safe Staffing	To approve the outcome of the bi-annual review of safe staffing and any recommended changes to the establishment	Written		Group Chief Nurse	Bi-annually			√			√			Approval
CQC Statement of Purpose	To approve any required changes to the CQC Statement of Purpose / changes to Trust services	Written		Group Chief Executive	Annually			√						Approval
Annual Quality Account	To approve the Annual Quality Accounts	Written		Group Chief Nurse	Annually				√					Approval
Performance, Estates & Finance														
Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report **(Note 3)**	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Performance, Estates & Finance Committees-in-Common	NED Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Annual Plan: Operational & Financial Plan	To approve the Annual Plan	Written		Group Chief Financial Officer / Group Chief	Annually				√					Approval
Winter Plan	To approve the Winter Plan	Written		Group Chief Delivery Officer	Annually					√				Approval
Premises Assurance Model (PAM)	To approve the PAM submission & note the areas requiring improvement	Written		Group Director of Estates	Annually					√				Approval
Capital & Major Projects														

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Capital & Major Projects Committees-in-Common Highlight / Escalation Report **(Note 3)**	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Quarterly	Capital & Major Projects Committees-in-Common	Group Chief Financial Officer	Quarterly		√	√	√	√	√	√	√	Assurance
Capital Plan	To approve the Capital Plan	Written		Group Chief Financial Officer	Annually								√	Approval
Business Cases	To approve relevant Business Cases in accordance with the Trusts' Schemes of Delegation	Written		Group Chief Financial Officer	**To be added to the agenda as required**									Approval
Workforce, Education & Culture														
Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Workforce, Education & Culture Committees-in-Common	NED Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Freedom to Speak Up Guardian	To receive the FTSU Guardians report including progress with the implementation of the Freedom to Speak Up Strategy and the outcome of relevant audits and other assurances	Written		FTSU Guardian	Quarterly		√		√		√	√	√	Assurance
Gender Pay Gap	To approve the Gender Pay Gar report	Written		Group Chief People Officer	Annually			√						Approval
Modern Slavery Statement	To approve the Modern Slavery Statement	Written		Group Chief People Officer	Annually			√						Approval
Staff Survey	To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements	Written		Group Chief People Officer	Annually			√						Assurance
Workforce Disability Equality Standard (WDES)	To approve the annual WDES submission	Written		Group Chief People Officer	Annually						√			Approval
Workforce Race Equality Standard (WRES)	To approve the annual WRES submission	Written		Group Chief People Officer	Annually						√			Approval
Employee Relations: MHPS & Other Capability & Conduct Cases	To note the current capability & conduct cases / activity	Written (via the Workforce, Education & Culture Committee Highlight / Escalation Report)		Group Chief People Officer / Group Chief Medical Officer	Bi-annually			√			√			Assurance

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Charitable Funds														
Charitable Funds / Health Tree Foundation Committees Highlight / Escalation Report **(Note 3)**	To note the matters considered by the committees and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Charitable Funds / Health Tree Foundation Committees	NED Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	√	Assurance
Health Tree Foundation Annual Report & Accounts	To receive the HTF Annual Report & Accounts	Written							√					Assurance
Remuneration														
Remuneration Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Remuneration Committees	Group Chair	Quarterly		√							Assurance
Pay Framework for Group Executive Directors	To approve the framework & any subsequent changes	Written		Group Chief People Officer	Three Yearly		√		√	√		√	√	Approval
Strategy														
Quality Strategy	To approve the Quality Strategy & any subsequent changes	Written	Quality & Safety Committees-in-Common	Group Chief Nurse	3 Yearly									Approval
Quality Improvement Strategy	To approve the Quality Improvement Strategy & any subsequent changes	Written		Group Chief Nurse	3 Yearly									Approve
Clinical Strategy	To approve the Clinical Strategy & any subsequent changes	Written		Group Chief Medical Officer	3 Yearly									Approval
Mental Health Strategy	To approve the Mental Health Strategy & any subsequent changes	Written		Group Chief Delivery Officer	3 Yearly									Approval
Research, Development & Innovation Strategy	To approve the Research & Innovation Strategy & any subsequent changes	Written		Group Chief Medical Officer	3 Yearly									Approval
People Strategy	To approve the People Strategy & any subsequent changes	Written	Workforce, Education & Culture Committees-in-Common	Group Chief People Officer	3 Yearly									Approval
Equality, Diversity & Inclusion Strategy	To approve the Equality & Diversity Strategy & any subsequent changes	Written		Group Chief People Officer	3 Yearly									Approval
Freedom to Speak Up Strategy	To approve the Freedom to Speak Up Strategy & any subsequent changes	Written		Group Chief People Officer	3 Yearly									Approval
Digital Strategy	To approval the Digital Strategy & any subsequent changes	Written	Capital & Major Projects Committees-in-Common	Group Chief Medical Officer / Group Chief Information Officer	3 Yearly									Approval
Financial Strategy	To approve the Financial Strategy & any subsequent changes	Written	Performance, Estates & Finance Committees-in-Common	Group Chief Financial Officer	3 Yearly									
Estates Strategy	To approve the Estates Strategy & any subsequent changes	Written		Group Chief Financial Officer / Group Director of Estates	3 Yearly									Approval
Green, Carbon and Travel Plans	To approve the Green, Carbon and Travel Plans	Written		Group Director of Estates	3 Yearly									Approval
Risk Management Strategy (including Risk Appetite)	To approve the Risk Management Strategy & any subsequent changes	Written	Audit, Risk & Governance Committees-in-Common	Group Chief Nurse	3 Yearly									Approval

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Other Documents for Approval														
Board approved policies	To approve the relevant policy and any required changes	Written	N/A	Group Director of Assurance	3 Yearly			**To be added to the agenda as required**						Approval
Protocol for Matters Reserved for Private Meetings	To approve the protocol and any required changes	Written	N/A	Group Director of Assurance	3 Yearly						√			Approval
Health & Safety Policy Statement	To approve any required changes to the Health & Safety Policy Statement	Written	Audit, Risk & Governance Committees-in-Common	Group Chief Financial Officer	3 Yearly				√					Approval
Notes:														
1. The Group Chief Executive's Briefing and the Integrated Performance Report will be the route for 'routine' group executive reporting on key operational issues, priorities and metrics. **2. 'Engagement with stakeholders' will be a standing agenda item and will capture updates, developments and board actions, as required, in resect of HASR, CAP / ICS, PLACE etc.** **3. Where items are submitted to the Trust Boards for discussion and / or approval (e.g. strategy, policy or external submission), having first been considered at one of the committees-in-common, there is an expectation that the committee's highlight / escalation report will include the committees' endorsement or any specific concerns.**														
Items for Information **(Where relevant referenced in committee highlight / escalation reports)**														
Safeguarding & Vulnerabilities Annual Report	To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Written	Quality & Safety Committees-in-Common	Group Chief Nurse	Annually							√		Information & Assurance
Infection Control Annual Report & Work Plan				Group Chief Nurse						√				
Patient Experience Annual Report (incorporating complaints and annual in-patient survey)				Group Chief Nurse							√			
Research & Development Annual Report				Group Chief Nurse				√						
Medicines Management Annual Report				Group Chief Medical Officer										
End of Life Annual Report				Group Chief Nurse							√			
Organ Donation Annual Report				Group Chief Medical Officer										
PSIRF / Serious Incident Annual Report				Group Chief Nurse								√		
Medical Appraisal & Revalidation Annual Report			Workforce, Education & Culture Committees-in-Common	Group Chief Medical Officer						√				
Guardian of Safe Working Hours Annual Report				Group Chief Medical Officer										
Audit Committee Annual Report			Audit, Risk & Governance Committees-in-Common	Group Chief Financial Officer						√				
FTSU Guardian Annual Report			Workforce, Education & Culture Committees-in-Common	Group Chief People Officer										

Agenda Item	Purpose of the report (see also Tab 2 for the reference / source for any statutory / regulatory / policy or other board reporting requirements)	Method of Reporting	Committee Oversight	Report Lead	Frequency	Dec	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Security / LSMS Annual Report & Work Plan				Group Chief Finance Officer / Group Director of Estates						√				
Fire Annual Report & Work Plan				Group Chief Finance Officer / Group Director of Estates & Facilities						√				
Health & Safety Annual Report & Work Plan				Group Chief Financial Officer / Group Director of Estates					√					
Documents Signed Under Seal	To receive the record of documents signed under the Trusts' seals	Written	N/A	Group Director of Assurance	Quarterly			√		√	√		√	
Executive and NED Statutory Roles	To note any changes to Executive and Non-Executive Director statutory roles	Written	N/A	Group Director of Assurance	Annually / As required			√						
Committee Minutes	To receive the record of business conducted by the Trust Board committees	Written	All Committees	Group Director of Assurance	Bi-monthly / Quarterly			√	√	√	√	√	√	
Guardian of Safe Working Hours	To note the Guardian of Safe Working Hours Report	Written	Workforce, Education & Culture Committees-in-Common	Group Chief Medical Officer	Quarterly			Q3	Q4	Q1		Q2		

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)025

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Sean Lyons, Group Chair
Contact Officer/Author	Wendy Booth, Interim Governance Advisor – NLaG
Title of the Report	Trust Boards & Committees Meeting Cycle
Executive Summary	The report provides the updated trust boards & committees meeting cycle. Where changes have been made diary invites have been sent or updated. The meeting cycle will require further amendment in due course to reflect the new group Performance & Accountability Framework. Changes will be notified to executive & non-executive directors, as appropriate, at that point. <u>Recommendations</u> The HUTH and NLaG Trust Boards are asked to: • review and approve the proposed risk rating reductions for the respective trusts; • note that further amendments will be required in due course to reflect the new group Performance Management & Accountability Framework
Background Information and/or Supporting Document(s) (if applicable)	Aligned Governance & Decision-Making (Option 7) / Corporate Governance Workstream
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 - V12

	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		07.05.24		02.07.24		03.09.24		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			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		19.06.24 (Wednesday - 9.00 am - 10.30 am) **HUTH ONLY**	25.07.24	15.08.24 (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
Trust Management Board (TMB) (Mondays - 12.00 pm - 2.00 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
Executive Management Committee (EMC) (Wednesdays - 2.30 pm - 4.30 pm)	17.01.24	21.02.24	20.03.24	17.04.24	15.05.24	19.06.24	17.07.24	21.08.24	18.09.24	16.10.24	20.11.24	18.12.24	15.01.25	19.02.25	19.03.25
Performance															
PRIMS - NLAG (Thursdays)	18.01.24	15.02.24	21.03.24	18.04.24	16.05.24	20.06.24	18.07.24	15.08.24	19.09.24	17.10.24	21.11.24	19.12.24	16.01.25	20.02.25	20.03.25
Performance - HUTH (Wednesdays)	03.01.24	07.02.24	06.03.24	03.04.24	08.05.24	05.06.24	03.07.24	07.08.24	04.09.24	02.10.24	06.11.24	04.12.24	08.01.25	05.02.25	05.03.25
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				04.07.24			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)	18.04.24	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

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)026

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8th February 2024
Director Lead	Sue Liburd, Non-Executive Director & Chair of Quality & Safety Committee
Contact Officer/Author	Sue Liburd, Chair of Quality & Safety Committee
Title of the Report	Quality & Safety Committee – December 2023 (NLAG)
Executive Summary	The paper includes the minutes of the Quality and Safety Committee (QSC) meeting for December 2023
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees-in-Common - January 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:

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Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 19th December 2023 from 13:30-16:30
Via MS Teams

Present:

Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Sue Liburd	Non-Executive Director
Kate Truscott	Non-Executive Director

In attendance:

Dr Kate Wood	Group Chief Medical Officer
Richard Dickinson	Associate Director of Quality Governance
Belle Baron-Medlam	Interim Inspection Compliance & Assurance Manager
Vicky Theresby	Head of Safeguarding
Lydia Goldby	Nursing Lead for Quality (ICB)
Dr Asem Ali	Consultant
Simon Buckley	Associate Chief Nurse
Dr Shan Dharmarajah	Clinical Lead for Organ Donation
Nicky Foster	Associate Chief Nurse Midwifery
Jenny Hinchliffe	Deputy Chief Nurse
Jill Mill	Interim ACOO Medicine
Fiona Moore	Head of Quality Assurance
Anthony Rosevear	ACOO – Community & Therapies & Family Services
Dr Aswathi Shanker	Deputy Director of Planning & Performance
Ian Reekie	Governor (observing)
Mich Green	PA to the Group Chief Medical Officer **(minutes)**

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1 Welcome and Apologies for Absence

Apologies for absence were received from: Jonathan Lofthouse, Kishore Sasapu, Shaun Stacey.

2 Opening Remarks

Fiona Osborne welcomed all to the last Northern Lincolnshire and Goole Quality and Safety meeting before going into Committees in Common. It was noted this will also be Fiona Osborne's last meeting.

Agenda changes for the meeting are as follows:

- 8.3 Annual Safe Staffing Review Deep Dive has been deferred to allow the in-depth review to be completed. This to be presented in February 2024.
- 8.7 Quality Priorities & Quality Account including Annual Report is on the workplan to be presented but a discussion took place at the November Committee where it was agreed to continue with priorities from the current year. As a result, there are no changes from the last presentation.
- 8.8 has now been split into (a) and (b) to allow maternity aspects in the Nursing Assurance report to be dealt with together with the Maternity & Neonatal Report.
- There are no Potential Deviations from National Documentation in December.
- 8.13 CNST Action Plans have been added. The information needs to go to a Board Meeting in January 2024.
- Thirlwall information has been circulated and added to the agenda to gain assurance and information.

3 Declaration of Interests

There were no declarations of interest related to any agenda item.

4 To Approve the Minutes of the Previous Meeting held on 28th November 2023

The minutes were approved.

5 Matters Arising

Fiona Osborne thanked all colleagues in NLAG for their professionalism and support over the last 2.5 years and 15 months as Chair of this Committee.

6 Review of action log

Action log updated as below:

- **234/23** - Annual Patient Experience Report incorporating Annual Inpatient Survey – It was agreed to raise a referral to the Workforce Committee for their oversight. Close.
- **253/23** – Pharmacy – Not due. Wil be transferred to Committees in Common.
- **283/23** – Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive - Will go to Committees in Common.
- **297/23** – BAF - Closed. The Executive Team are reviewing the BAF as part of their on-going management.
- **298/23** – CNST Deep Dive - Close as assurance was given in November and the remaining CNST action plans are on the agenda before going to board in January.
- **299/23** - Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive – Close, as information has been included in the report on the agenda.
- **300/23** - Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive - Information requested has now been added to the table. Close.

- **301/23** - Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive - It was agreed that when a 5-point trend was available, it would be included in the report. Close.
- **302/23** - Maternity Safety Oversight (inc Ockendon & Metrics) Deep Dive - SI report not due till end December. Revised due date of January 24.
- **303/23** - Quality Priority Deep Dive: Medicines Safety - KW updated the digital team are working with a company on the RPA to develop the bot. There have been some delays at the digital end and the work will start in the next couple of weeks. Close action as KW now getting weekly updates.
- **304/23** - Nursing & Midwifery Assurance Report (with key focus) - It was felt this does not need to be carried forward as the work to produce the statistic would not give a corresponding benefit. Close.
- **305/23** - Key SI Update incl Maternity - Close item. RD updated this is a pattern of concern, but it is thought the cases aren't linked. There are similar issues of recognition and escalation in previous cases. This is included in the incident response plan now as an area of focus. Controls are in place including training for skills and drills along with activities maternity services are taking to ensure CTG training is done. PMRT process is in place along with the patient safety incident response plan.
- **306/23** – Item to be dealt with in meeting. Closed.
- **307/23** - Mental Health Act and Strategy - Due Jan 2024.
- **308/23** - Mental Health Act and Strategy - Roll over to Jan 2024.

7 Reports from external visits

7.1 Stroke Pathway

The paper was taken as read. It was noted that this paper is coming to the meeting for information following a review commissioned through the stroke network last year prompted by some patient safety concerns regarding a low thrombectomy referral.

Dr Kate Wood updated when a patient has a stroke it is either a bleed or a clot. There is new treatment available through our tertiary service at Hull and this is only available during a restricted time frame. When the time window is 6 hrs if you are in Hull, you have a better chance of thrombectomy than if you are on the South Bank. Hull have raised concerns about the low rate of thrombectomy and whether it was due to transport or other issues. The network has scrutinised the service and the Medicine team are developing an action plan. There is more transformative work once the Trust moves into the Group structure which will streamline the pathways.

Kate Truscott queried with regard to the estate in reference to a business case for HASU beds and appropriate staffing to be developed and implemented, and how it sits with the current bed model. Dr Kate Wood responded we need good flow rather than more beds. We need patients with stroke having it identified quickly and given treatment then moving quickly into a therapy space. We need to look at what we can do differently across the virtual ward to enable an early discharge into their own home with the right, safe ongoing therapy support. Fiona Osborne queried if this is taking place alongside the business planning exercise looking at flow as well as bed modelling. Response was we are in the

process of developing a new operating model for the organisation meaning stroke will be looked at across the North and South bank. It is felt once the new appointees are in post leading the health groups and clinical leads are in post there still needs to be time to understand what is available, meaning there may not be a great change in the bed base for stroke this year. North Lincs have community division in place so is a great place to trial anything.

Kate Truscott queried about staffing and the future for the services in general. There was emphasis in the report about enhancing the number of ACP's and also speech and language therapy. Can the challenges and recommendations in the report be met? Jenny Hinchliffe responses that it is a struggle to recruit speech and language therapists. It is also a struggle to pay them while they are doing 3 years of training. There are conversations taking place with the local universities around speech and language therapist training and the division are also looking at development posts i.e., Training people B3 to B4.

Fiona Osborne raised that in the Community and Therapy report there is talk of a business case being put forward for the 7-day speech and language therapy. Given the current financial situation within the Trust, is this something that needs more emphasis? Response was a 7-day service may help with length of stay and timely assessments.

ACTION 309/23: Community & Therapy Division will progress their business case, however acknowledging the financial position the division should collaborate with Medicine Division to consider the potential reinvestment opportunity related to any positive impact on stroke length of stay and ability to reduce the overall stroke cost base.

It was noted the report was for sharing and the Medicine Division will develop an action plan which will come to the Quality and Safety Committee.

Thanks were given to the team for their production of the report. It was highlighted there is excellent leadership and training of middle grade staff, and the Committee commended the team.

8 Regular Reports

8.1 Annual Organ Donation Report (deferred from Nov)

The papers were taken as read. Dr Shan Dharmarajah updated the numbers are very small for organ donation. The report highlights that as a Trust we are doing what we are tasked to do. Every patient that is eligible to be referred is referred which is a gold rating. Other metrics relate to the Trust and the region as a whole where a suitable patient's family for donation is approached by a specialist nurse. This is successful but it was accepted that further improvement could be achieved.

The trust is tasked to deliver and promote organ donations. All functions have been completed with regular oversight. Meetings take place quarterly to ensure compliance.

Sue Liburd noted the report was interesting reading and queried what might stop our clinicians from approaching this conversation with families? Dr Dharmarajah responded that the success rate of a specialist nurse is much higher. The occasions where conversations have taken place without a specialist nurse have been less successful.

Dr Kate Wood noted that doctors used to do a lot of work in approaching families, but the specialist nurses are far more successful. The Trust is gold for referrals and bronze for the specialist nurse approaching patient families.

Kate Truscott gave congratulations and thanks to the team as it such a specialist area. Kate Truscott queried if something could be done with the comms team to promote the good work, and it was agreed that this certainly needed to be a focus area but would be left for the organ donation committee to progress.

Dr Kate Wood noted that Dr Shan Dharmarajah will be stepping down from the role as clinical lead for organ donation, but there is potential for reviewing the provision of leadership from across the group. It was noted education and training are important. Thanks were given to Shan Dharmarajah, Ian Reekie, and the Critical Care team by the Committee.

8.2 Medicine Deep Dive

It was noted the report received is the Quality Governance Group report which has a lot of performance related data that falls under the responsibility of the Finance & Performance Committee. The Committee noted that the essential assurance for the Quality and Safety Committee could be found in the central part of the report.

Dr Asem Ali updated the main focus of the team is activity progress on CQC actions and moderate to good assurance can be given to the Committee. A quality and safety meeting takes place regularly and recently 40 doctors were given RESPECT training which will improve the end-of-life care for patients in and outside of the hospital. KPI's for medical appraisals are being exceeded. NICE guidance is being implemented in practice and various specialities are working with the group to enable this. There is a close relationship with PALS and complaints performance meaning a timely response. This gives a good patient experience to learn from and share with the physician meeting and in the quality and safety meeting.

Structured Judgment Reviews are taking place and the SHMI is improving (108 to 107), and work is taking place to get this to 100.

There has been an audit on frailty patients in the hospital. There are plans to introduce an integrated frailty service to be at the front door. Education is felt to be very important so the first ever frailty conference was held in the region where 100 team members and stakeholders were in attendance. Pathways have been drafted where doctors, nurses and therapists work together to provide better care for the elderly population.

The Trust are on track to provide the integrated admission unit by January 2024.

15 nurses have been recruited from abroad to join the team and consultants are being recruited including 2 consultant physicians in respiratory medicine. 5 ED consultants posts are being advertised with an end date of March. Home grown middle grades are being helped to progress as there is a national shortage of consultants. Doctors are being employed on the medical training initiative scheme.

An audit has been completed in regard to weighing the patients to reduce the risk of over-prescribing drugs. Improvements are being seen.

Senior board rounds are done on a regular basis for long length of stay. Board rounds have been introduced in every speciality and audits are being done in every ward. This means our length of stay in hospital is much better compared to the region.

Sue Liburd queried the Risk Register information on page 17. There were a number of items overdue for review. Sue asked if the team are sighted on this and when will they be reviewed. Dr Asem Ali responded giving information on each of the risks:

- Oncology is on the risk register because of the delays in synchronising the patient with oncology. This is due to a shortage of oncologists and a timely review of these patients. Close working is taking place with the partner in HUTH to look into this. Recruitments are going ahead, and the division is talking about diagnostics and how to facilitate this so the patient can be seen early.
- Mandatory training is close to the target of 90% at 87%.
- A virtual ward is being utilised which along with the help of the frailty service implementation at the front door will improve long length of stay and the patient experience.
- Collaborative working with HUTH is taking place to find a solution with vacancies. Consultant of the week model is being established. A physician has been introduced into the gastroenterology ward to concentrate on general medicine meaning the gastro specialist can concentrate on gastroenterology.
- Delivery of a balanced financial position including CIP is still working but the strikes and winter pressures are not helping.
- There is a risk of a deteriorating patient not being escalated appropriately but the assurance processes and nursing education will address this.

Fiona Osborne noted the report indicates the high-risk items on the Medicine risk register are not being regularly reviewed as they are highlighted as overdue for review. Dr Asem Ali responded that there is a process within the division for highlighting overdue or risks that are coming up for review on a weekly basis through SMT. These are then reviewed in more detail through divisional governance meetings. Risks are then escalated to the risk owners to update the report. All the risks quoted have since been reviewed and updated.

Kate Truscott queried regarding the 15 steps and the 2 visits resulting in “Requires Improvement. Simon Buckley responded there is a scope of progression within each

rating award. Assurance can be given as there is clear progression against the action plan which is improving standards. Support is being given where wards require improvement.

Fiona Osborne queried regarding the list of papers and the paediatric blood glucose testing as a number of months ago regular reviews were given but were halted once assurance of improvement was given. Current data in the report suggests a step back and Fiona queried if this is due to documentation not being up to date or something wider? Simon Buckley responded there was a reduction in compliance at the point of moving into the new EDs. There was a period of time of reliance on bank and agency staff and the team had tackled this by training of the ad hoc staff around processes and pathways. A process is also in place for validation of non-compliant cases. This has highlighted that the issue is around lack of documentation when a blood glucose level isn't indicated. The cases are being followed through to ensure they have been involved with the paediatric team. Whilst compliance has slipped, poor documentation is indicated but the decision making is appropriate.

Fiona Osborne queried the lack of consultants indicated in the report. Is this translating into an issue with keeping patients safe?

- Simon Buckley responded that from a nursing perspective there is a challenging vacancy position which can be looked at in 3 ways. The current reported vacancy which shows just over 100 whole time equivalent registered nurse posts. There are a group of staff completing supernumerary periods while they prepare to gain a NMC registration. This reduces our vacancy down to about 65 to 70. There has been significant investment in our establishments which has created a bigger vacancy position, and this is where bank and agency nurses are used. There are processes in place at ward level to ensure there is an induction enabling people to understand the pathways and processes. Staffing is reviewed on a weekly basis so issues can be identified and responded to.
- Dr Asem Ali responded that from an ED perspective we are short of consultants but have specialist or locum consultants and a few are progressing towards the CESR route. A letter has been sent to any not progressing to ensure if they have not progressed by March, the Trust will be advertising posts. All existing locum consultants will have the opportunity to apply for these posts if they are progressing well. It is hoped to employ a couple of ED consultants on the North and South bank.

Fiona Osborne responded that the concern is about the impact on patient safety as the recording of weight on EPMA and glucose testing may not be as compliant with more vacancies.

ACTION 310/23: Dr Asem Ali to speak with ED clinical leaders regarding patient safety and update at the next meeting.

8.3 Annual Safe Staffing Review Deep Dive

Deferred.

8.4 Community & Therapies Deep Dive

The paper was taken as read. Ant Rosevear updated that the team are proud of the successes achieved since the report. There is 1 high risk on the divisional risk register which is insufficient speech and language therapy staffing resource. This impacts on stroke pathways with poorer outcomes without this resource. Mitigations are in place regarding impact on patients, outcomes and experience but a speech and language business case is being prioritised for investment in speech and language therapy staffing as part of the divisional 24/25 business plans.

Key issues are staffing capacity, in particular community nursing, staff health and wellbeing. This has now reduced due to a couple of interventions. Pressure remains static but a number of actions and activities are already underway to improve this. Access to paediatric therapies is the key access risk. Work is being undertaken with the ICB partners as this is a regional and national issue. All issues have mitigations in place to maintain patient safety and are escalated to QGG, monthly performance review meetings, North Lincolnshire Health Care Partnership and ICB for support as required.

The main key action is to lead and support the divisions transition into the new operational care group structure and the establishment of effective care group governance. Ant Rosevear asked for the committee to take assurance on the report and to acknowledge and support the case for investment in SLT staffing and to manage the associated risk with the needs of stroke patients.

Sue Liburd noted the report was well written. She queried if this is a group of professionals or individuals that are difficult to recruit due to a national shortage, lack of resource or poor utilisation of resource? Ant Rosevear responded this is a combination of a national shortage and lack of resource. Interventions the division has undertaken in the last couple of years have meant the division has done well attracting colleagues to the services with incentive schemes and rotations. To mitigate risks the team have invested in temporary staffing additional hours. The additional recurrent resource will enable better opportunity to attract colleagues on substantial contracts.

Kate Truscott gave thanks for a well-constructed report and congratulated the team on the health and inequalities work. Ant Rosevear responded the impact on individuals in a short space of time has been very positive. Fiona Osborne queried if the ICB was aware of the positive work that has taken place. Lydia Goldby noted the ICB are aware and have work streams to progress this particular area. The shift in community nursing is being experienced across other areas within the ICB. North East Lincolnshire have 2 community nursing providers and care and nursing homes within place. There has been a shift in numbers of nursing beds required in care homes as care can be delivered in different ways. This means increased activity for community nursing within our place where community nurses need to go into residences to support care differently.

Jenny Hinchliffe updated there is now a community nursing safer nursing care tool. The team are just collecting the second set of data so safer staffing reviews can be incorporated into the annual reports. This data should be available in February.

Aswathi Shanker updated NLAG are taking a piece of health inequalities work going forward with the senior vulnerabilities nurse and the safe hospitals program manager regarding Learning Disability patients. This is working with RDASH cross referencing patients on both systems to ensure they receive the support needed. There are currently 1000 patients. A bid is being put together to sustain that piece of work and multiple comorbidities (top 20% of deprivation) in two practices as a pilot.

Fiona Osborne queried regarding the speech and language therapy resourcing and if work is taking place with the Medicine team on a joint business case. Response was that we will lead it and link in with Medicine to ensure they support what is being done.

The group gave their support to the paper and agreed the Speech and Language Therapist business case should be added to the highlight report for the February Board meeting.

8.5 Learning from Deaths Report

The report was taken as read. Fiona Moore update the SHMI remains within the as expected range. There has been an increase in the HSMR value since December but the last two months there has been a reduction making us comparable to our peers Trust. There is room for improvement, and the Trust are proactively exploring areas for improvement using CHKS. This has identified COPD and the gastrointestinal haemorrhage diagnosis group as requiring additional focus. A quality summit data pack has been commissioned to help with next steps.

A coding review of 10 cases of complication of devices has been undertaken. A meeting took place with the coding team to validate those cases and all 10 cases have been coded correctly based on the medical notes. This highlighted a potential area for learning and improvement in educating medical colleagues over the language that is used as positive language e.g., due to, can lead to different coding to less positive language e.g., may be due to.

Areas for improvement within palliative care coding are being looked into. There is scope for potential improvement in terms of how the team are capturing the coding. This to be explored in the New Year with Information Services.

The majority of SJR reviews are rated good and there have been no regulation 28 prevention of future deaths notifications.

Fiona Osborne queried why the report mentions there isn't a full Q2 picture as there was an issue with September data. Response was this was due to the national data lag.

Fiona Osborne queried in section 6 there is a case that is being flagged as possibly preventable, was the care deemed poor or is it unconnected? Response was this was the SJR and would have been possibly preventable less than 50:50 with an overall care rating as poor as deemed by the first SJR reviews. On the second SJR review it was

found due to the prognosis being poor for the patient further treatment would not have been in the best interest of the patient. The family agreed this at the time.

8.6 IPR

The report was taken as read. Jenny Hinchliffe updated the number of reported falls remains in the expected range. Oversight of repeat falls remains with the matrons and the falls with harm are reviewed by the lead nurse for patient safety. The number of community acquired pressure ulcer incidents has decreased, and preventative work continues with the React to Red team. The hospital acquired pressure ulcers has increased slightly with no particular areas of concern. Moderate harms are reviewed weekly.

Dr Kate Wood updated there are highlights that show the percentage increase of adult observations are recorded on time. Learning from deaths remains as expected. Weights percentages, due to other work, are getting more patient weights being put in to EPMA. It was noted there is a 35% increase on the previous months results. Infection needs to be drilled down and understood more.

Richard Dickinson updated progression with the weights work. A triumvirate approach to be taken to target admission units in a systematic way in January.

Kate Truscott raised a concern within the lowlights on the Mental Capacity Act assessment and best interest recording. This was low at 25% and 0% in September.

Post meeting note: The data is only for assessments complete on WebV, many are still recorded on paper and therefore not captured in this data.

Fiona Osborne raised a question from the governors to the NEDs about the lack of targets on the quality and safety KPIs and whether it is appropriate to set an internal target if there isn't a statutory or wider target to measure progress. Dr Kate Wood responded that was where data is new a baseline targets should be established. This will be reviewed as we move into the new financial year.

8.7 Quality Priorities & Quality Account including Annual Report

Deferred.

8.8 8.8a Nursing Assurance

The paper was taken as read. Jenny Hinchliffe updated Amethyst has 3.8 WTE vacancies and their short-term sickness was high, however this is reducing. Support is being given and staff are being deployed to support as required. Fill rate increased from 93.6% in October. There is still just over 10% of registered nurse and healthcare support worker vacancies. By the end of December, it is hope this will be down to 40 WTE healthcare support worker vacancies and the pipeline for registered nurses should result in a reduction to 100 vacancies. Community nursing continues to do well and will have minimal vacancies once they get their newly qualified nurses into post. There has been

an overview of red flags. There were 21 staffing incidents and 18 red flag incidents reported. Good escalation processes in place. There was one patient fall with moderate harm on ward 23 and two falls with major harm on C2 and B6. All falls had safety huddles done and there were no lapses in care. Formal complaints increase to 36 in October (29%). Complaints remain low with 63% closed complaints in timescale compared to 83% in October. This was due to sickness in the team along with a new sign off process. Performance is now increasing, and we are back up to 80% which will reflect in next month's report. Friends and family test submissions are increasing. Response rates are expected to improve further with full implementation of the new provider. We are performing well with alert organisms and are below the national average on other organisms.

Fiona Osborne congratulated the IPC and nursing teams on the lack of MRSA and MSSA.

Sue Liburd commented on overnight patient moves and high numbers. She queried what needs to happen to reduce the numbers. Jenny Hinchcliffe responded that we need our flow earlier in the day and the operations team are working hard on this. Ideally discharges need to be in the morning and identify patients earlier.

Kate Truscott queried around escalation beds numbers. Response was the narrative needs to be reviewed as the beds that were escalation are now funded in establishments. It is hoped these will reflect in next month's data. Another issue is the wards create additional supernumerary shifts and Jenny advised she is verifying how this impacts the data. Validation has been asked for as these shifts might affect the fill rate.

Fiona Osborne queried regarding red flag review and whether the staffing red flags will have resulted in a change to objective criteria. Jenny Hinchcliffe responded that updated red flags were approved on 14th December. The number of red flags are being reduced and have been made more objective. New versions are to be laminated and discussed at manager meetings along with being added to the agenda for induction and preceptorship so newly qualified and international nurses are aware.

Fiona Osborne queried about Blue Sky at SGH having gone from outstanding to requires improvement on 15 steps and how it happened. Jenny Hinchcliffe responded that in March this year there was a review of the 15 steps and some of the criteria changed. A couple of questions were added to evidence compliance in checking resuscitation equipment. When the team visited Blue Sky the 3 resuscitation trolleys had significant gaps in daily checks and the mobile MRI had no process in place to check the defibrillator was working and the battery was charged. There was also an overuse of gloves and gaps in cleanliness checks. Support will be given to the unit.

8.8b Maternity Oversight

The paper was taken as read. Nicky Foster updated that CNST are on track to submit all 10 safety actions and have achieved compliance for saving babies lives with 71%. Additional papers are regarding safety action 4. CNST guidance is that action plans are

cited with the Committee and an assurance meeting will take place with LMNS in January.

Fiona Osborne queried regarding the compensatory rest and whether it needs a mitigating plan. Nicky Foster responded that the mitigation is that an action plan is in place. We will be working closer with HUTH. Dr Kate Wood has asked the team to look at designing the services differently. Currently the majority of consultants do obstetrics and gynaecology on the same rota so have been asked if there is a way to split the rotas, pull the resources in a different way or staff the service differently. All members of the Committee supported the plan.

Nicky Foster highlighted the exit from the MSSP program is delayed to February due to changes in the Chief Nurse and care group structure. This is still continuing to go through the national governance sign off.

Fiona Osborne queried about the PALS and complaints data. Looking at the obstetric events the data doesn't make sense. Nicky Foster responded that the reports come from the patients experience team and she will update for the next meeting.

Kate Truscott queried safety champions improvement plan have a lot that will roll out on 31st December. Nicky Foster confirmed that there was confidence these will be completed.

Fiona Osborne thanked Nicky Foster for the evidence showing the pastoral midwife role impact. It was noted that the role has made a positive impact on the retention of staff.

Fiona Osborne queried regarding the 3 escalated issues under maternity and neonatal safety champions, and asked who they are escalated to. Nicky Foster responded that the scan capacity has been escalated to Ruth Kent. The issue with Foetal monitoring has gone to the foetal monitoring legal, Linda Keech. The issue about serum bilirubin for babies has gone to Head of Midwifery, Natalie Jenkin who is looking at the feasibility of using it for inpatients as well as in the community.

Fiona Osborne asked for more detail regarding serious incidents where there is a risk listed as lack of resources to complete pathology interface with Badgernet for go live. Nicky Foster responded that is no different to the current risk. Badgernet has an MVP within it. There are issues to be implemented within the second phase. This has been escalated to the maternity information system board and has also gone through pathology department leads.

8.9 Key SI Update incl Maternity

The paper was taken as read. Richard Dickinson updated there are no new maternity cases or SI's. These will be described differently going forward as from 1st December the national requirements have changed. There will also be other methods of investigation for elements such as MDT reviews and after action reviews.

8.10 CQC Framework

The paper was taken as read. Belle Baron-Medlam updated progress has continued. The fall and significant rated actions have increased this month. There are currently 13 actions being approved with divisions or the Exec Team for sign off. Risks to delivery of the plan link to lack of capacity along with industrial action this week which in turn impacts delivery of the plan. Identification of funding and actions which link to other projects i.e. The QI project, have different timescales that have been set within the project. New to the report is items for information. There is a recent reference to the Goole midwifery CQC inspection in which the team did very well. There is information on the new assessment approach by CQC which is coming into force. As more information comes through this will continue to be disseminated throughout the organisation.

Fiona Osborne queried regarding QI projects as the question at the last meeting was around multiple actions had cited lack of data development as holding them up. The 'bottle neck' appears to be lack of BI resource rather than QI projects. Belle Baron-Medlam responded that the section on QI is because there are a number of actions are linked to QI projects. The information team feel they are not the significant risk as there are interim workarounds in place and some basic analysis in the majority of cases. It is recognised that this is not ideal but because there isn't a central report produced it doesn't mean to them it would be a risk. Fiona Osborne challenged QI being listed as the risk area as the QI team have mitigated the risk which has been generated by the lack of BI resource. The risk sits with the digital team, and it is Dr Kate Wood who would decide if a risk is added. Jenny Hinchliffe added she didn't think this was a QI risk. Workarounds have been put in place so there is manual data collection. This potentially introduces a second risk that we have people who aren't data analysts analysing the data that is manually collected. Once the BI team have increased capacity and the BI reports are reintroduced there may be disparity between the manual data collection and what we get out of power BI. Dr Kate Wood added that we are trying to align where the risk sits. Work is progressing. The risk is that work is not completed due to people being taken away from their clinical and improvement work to produce the data. The digital team don't have enough resource due to being pulled to other projects and won't have for a number of months. As an organisation we need to accept there cannot be pace behind progression of our quality priorities and will need to roll over to next year, as has already been agreed, to allow the digital team to catch up and get the metrics in place to move forward. Fiona Osborne challenged that we either need to cite the risk which actually exists in the BI teams or say it is being mitigated by the QI team it shouldn't be on as a key risk to the CQC actions.

ACTION 313/23: Dr Kate Wood to look at risks to determine whether a BI risk exists.

Kate Truscott congratulated the team at Goole with the inspection as it was good to see some positive news.

8.11 Potential Deviations from National Documentation

Deferred.

8.12 Patient Safety Incident Response Framework

The paper was taken as read. Richard Dickinson updated that the Trust are in the position that PSIRF has been taken on in full as of the beginning of December. From this time, the Trust has undertaken 5 MDT reviews. The feedback from consultants is that it is more concise and a beneficial process. Daily navigation huddle meetings are taking place with governance leads from divisions and the central team. Subtle themes are being identified. The Associate Chief Nurse from Surgery has visited after being impressed that we have the system. We are ensuring there are enough of the divisional teams on board with training.

Fiona Osborne queried if any risks have turned into issues. Richard Dickinson responded that all of the risks are being worked through and in the Trusts control with nothing bigger than anticipated.

8.13 CNST Action Plans

For information.

The Committee supported the action plans presented.

9 Highlight Reports (for information)

9.1 Quality Governance Group (QGG)

Mr Kishore Sasapu, Deputy Chief Medical Officer

9.2 Mortality Improvement Group (MIG)

Mr Kishore Sasapu, Deputy Chief Medical Officer

9.3 Patient Safety Champions Group (PSC)

Richard Dickinson, Associate Director of Quality Governance

10 Items for information (Not for printing)

10.1 Quality Governance Group (QGG) minutes

Mr Kishore Sasapu, Deputy Chief Medical Officer

10.2 Mortality Improvement Group (MIG) minutes

Mr Kishore Sasapu, Deputy Chief Medical Officer

10.3 Patient Safety Champions Group (PSC) minutes

Richard Dickinson, Associate Director of Quality Governance

11 Any Other Business

11.1 Thirlwall Enquiry

The paper was taken as read. Dr Kate Wood noted the request for information was sent to all organisations that have a neonatal intensive care unit and came into the Trust on 1st November . This is due to a Thirlwall enquiry that was set up on 19th October as a result

of the Lucy Letby case. The questionnaire had to be submitted by 16:00 on 18th December so has been submitted after having due diligence supported by a number of members across NLAG, including Richard Dickinson and Debbie Bray. Key members of the team have pulled this together, but not exclusively, and it has been scrutinized by an external nonclinical person, Rob Chidlow who is the acting director of clinical governance on the North Bank.

Fiona Osborne noted the policies, procedures and processes included in the submission were something the Committee have already been assured on. She queried if anything had been identified in pulling the pack together that indicated a gap that needs looking at. Dr Kate Wood responded that back in October the Trust reflected at Board level our own thoughts on the Lucy Letby case and talked a lot about speaking up, speaking out, whistleblowing, support for our staff and different routes of escalation. We have very robust mechanisms in place through safeguarding, nursing, safety champion rounds etc. meaning a lot of different routes are available for any concerns to be raised.

Richard Dickinson noted that there has been discussion in forums about what we are doing in response to the Letby case. Richard Dickinson queried if this document could be used in a different way to share with our partners in the healthcare sector to let them know what our systems and processes are. This would also be able to be used to raise awareness within our organisation and teams.

All agreed they were assured.

ACTION 314/23: Dr Kate Wood to query with the Group Executive Team if they are happy with the paper being shared with other partners in the healthcare sector.

12 Matters to Highlight to Trust Board or refer to QGG or Other Board Sub-Committees

- CNST action plans
- Support for speech and language therapists' business case
- Recommendation for an organ donation committee in common

13 Meeting Review

Thanks were given to Fiona Osborne for all the work she has done over the years.

14 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 25th January 2024
Time: 13:30-17:00
Venue: Microsoft Teams

QSC Annual attendance log

Name	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Dr Kate Wood	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	✓	✓	✓	✓	✓
Ellie Monkhouse	x	✓	x	✓	✓	✓	x	✓	x	x	✓	✓	x	✓	x	x
Shaun Stacey	✓	✓	x	x	x	✓	x	x	x	✓	✓	✓	x	x	✓	x
Susan Liburd		✓	✓	✓	x	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
Kate Truscott		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓

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)027

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Una Macleod, Non-Executive Director
Contact Officer/Author	Rebecca Thompson, Head of Corporate Affairs
Title of the Report	Minutes of the HUTH Quality Committee held 18 December 2023
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 are attached for review
Prior Approval Process	Quality & Safety Committees-in-Common - January 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:

Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 18 December 2023, 9-11.30am

Present:	Professor U MacLeod	Chair
	Mrs R Thompson	Head of Corporate Affairs
	Ms J Goode	Chief Pharmacist
	Mr M Robson	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mrs J Ledger	Interim Chief Nurse
	Mrs M Littlewood	Associate Director of Quality
	Mrs C Hughes	Deputy Head of Therapies
	Mrs M Stern	Patient Representative
	Mr G Briggs	HUTH Site Managing Director
	Mr R Chidlow	Interim Director of Quality Governance
In Attendance:	Mr P Sedman	Deputy Chief Medical Officer
	Mrs D Pickering	Head of Patient Safety and Improvement
	Miss L Coneyworth	Head of Patient Experience and Compliance
	Mrs N Sparling	ICB Representative
	Mrs C Richards	Interim Head of Risk and Health and Safety
	Mrs M Carr	Nurse Director, Surgery HG
	Mrs K Harrison	Head of Safeguarding
	Dr D Wearmouth	Consultant in Microbiology
	Mrs G Johnson	Director of Infection, Prevention and Control
	Dr N Sloan	Leadership Fellow
	Miss R Boulton	Compliance Manager (Minutes)

No	Item	Action
1	**Apologies** Debbie Lowe, ICB Representative Kate Wood, Group Chief Medical Officer Shaun Stacey, Group Chief Delivery Officer	
2	**Declarations of interest** None declared.	
3	**Minutes, Action Tracker and Work Plan** **3.1 Minutes of the meeting held November 2023** Minutes of the meeting were agreed as an accurate record.	
	3.2 Matters Arising No maters of arising were raised.	
	3.3 Action Tracking List Actions on the tracker were noted as completed and on-track and that we need to ensure open actions are carried into the new committees in common.	
	3.4 Work Plan 2023/24 UM shared that the new committees in common work plan for 2024 had now been agreed and would be shared with the members at the next meeting.	
4	**Operational Update** JL provided the operational update. The hospital remains under pressure, there were 36 lodged this morning and 5 cohorting. NLAG took diverts over the weekend and patients were moved between sites, there are no IPC issues at present. The ED summit was positive last week and a number of actions agreed with weekly oversight to ensure traction. There was also the recognition that there are actions to be taken internally.	

	The UTC phased opening has been amended and will now open in January taking more activity. The Group Chief Executive expressed his desire to work towards closing the 13th floor to DTA as he is keen for this function to be back within the community, although acknowledges this is not in the immediate future. There is an expectation that the pressure will increase in Q4 as in previous years. NS provided an update following the ICB supportive assurance visit to ED on Friday evening, which included the mental health area and the atrium. There were a couple of main areas raised for discussion including the recognition that staff are tired and how we can ensure staff are restored and resilient. It was noted that the Trust now has Professional Nurse Advocates (PNA) as a dedicated role and delivers training and restorative supervision for colleagues, we do have a clinical supervision policy but not embedded.	
5	**Deep Dive** **Mental Health** KH attended and provided a report to the committee and confirmed that we have positive assurance from partners and good communication. The mental health team continue to undertake training with the ED team to raise awareness. Work is ongoing to embed the understanding of detainment and the regulation needs. There are improvements but we need to understand any themes to avoid illegal detainments. The aim is for 100% compliance. Training is provided by the Legislation team at Humber although staff attending training is challenging, dates for 2024 have already been scheduled. There is to be a discussion at the Steering Group to look at a robust training plan for both the MCA and legislation training for 2024. The HUTH safeguarding team have now met and are building relationships with the NLAG team and ensure learning lessons across the group. It was noted that the issues were resolved in relation to the paediatric position, but there were still issues with the CSAS facility issues. Limited assurance was agreed from the committee and UM suggested a follow up on in the new year.	
	Nutrition MC provided a presentation on Nutrition and Hydration, there are 8 national standards, the trust are compliant 3 of the standards and are undertaking a gap analysis against the remaining standards. The trust is currently working on a strategy and are reviewing NLAG's to adopt across the group for patients, staff and visitors. Our previous supplier for 24/7 vending machines went into liquidation so we are trailing a new supplier and hoping to include hot food. There have been improvements in assurance from the fundamental standards, which has identified themes, the audit has now been altered to ensure the audit is relevant. MC began chairing the Nutritional Steering Group in January and noted that improvements have been seen but also noted that there are still some areas for improvement. A trigger list for reporting incidents to ensure appropriate reporting has also been created. We have noted issues with complex needs and having the expert resource has helped that group of patients, we need to ensure we get a substantive team as this role is only temporary. NS questioned if people with learning disability have anything within their passports about nutritional needs and it was confirmed that it is in the LD passport but need to improve the pathways of the availability and use.	

	It was also noted that hydration is an area of importance and recognised as being critical in other areas eg reduction of blood stream infections caused by dehydration. UM questioned if patients without complex needs but changed needs have sufficient support with dieticians. MC shared that the team have been strengthen but due to the significant change in the acuity of patients despite needing immediate input referrals can take 5 days. AP was pleased to hear the shortages had been addressed and asked if there was a mechanism for being followed up in the community for NG tube or they have to return. It was highlighted that patients requiring home TPN often have longer stays due to the lack of community provision and we have a developed a training packages so patients can manage their own TPN. Bariatric surgery currently have a backlog, as this is not a cancer pathway these are the patients cancelled to create capacity so the pathway for these need to be looked at as the preparation for surgery is substantial. Supporting feeding with patients can be problematic but support as best we can. An analysis is being undertaken on H90 to see what is needed to support at mealtimes. JG suggested that prescribers could also sit on the Nutrition Steering Group and that they were meeting with NLAG in January regarding gaps.	
	Surgery Governance ML provided the committee with an update on the work in Surgery Health Group regarding governance. The health group has 22 specialities across the health group which is a challenge to ensure all working effectively, there has been a lot of observations undertaken and training sessions have commenced. NHS England were also supporting this work but due to restructuring had to withdraw support. Work initially was to establish what good governance is and what the barriers to achieve were. There is also an awareness that there is a restructure to be undertaken and the work so far is the beginning of what is required. The health group also appointed a Quality Safety Manager to support the specialities across the health group. The committee noted that the use of Team Engine was not available across the Trust, it was confirmed that NLAG would also be using Team Engine moving forward but may be available further across the Trust. MR agreed the work was a helpful starting point and that the restructure gives an opportunity to ensure that we get governance right from the beginning. MC reflected that when the work commenced that it was surprising that clinicians were not aware of their responsibilities and we needed to go back to basics to support the clinicians. PS acknowledged that there was a gap in doctor education/ training regarding chairing meetings.	
6	**6.1 External Agencies** LC presented the external agencies paper sharing that it was to receive and note the updates in respect of arrangements in place to provide assurance that actions of inspectorates and regulators are being actioned accordingly. RC highlighted that there are some quite significant regulatory bodies where the Trust has successfully navigated inspection reviews which is positive.	

	UM shared that it was interesting to see the varied amount of visits and acknowledged the volume of work that goes with them. There were no surprises noted within the report as the committee has received reports and information as required. The committee questioned the TAVI review and it was confirmed that the formal feedback is due in January 2024 and an update would be presented at a future meeting.	
	6.2 Maternity CQC Update JL highlighted from the report the progress against the 36 actions and that we expect progress at pace for the 10 actions due in December and 10 in January. The performance for patients RAG rating was good, we continue to monitor breaches and improvements continue to be made, we can now analysis if breaches occur and can ensure that no harm occurred. At the QIG in December we highlighted an indirect maternal death that occurred 5 months after delivery, the mother died at home and will be investigated. Following our resubmission for the CNST Year 4 submission in which declared compliance for 8 out of 10 standards, NHS Resolution have issued a £800k financial penalty and requested that once our Year 5 Submission has been completed we review Year 3. The demand and capacity has been completed for the scanning pathways so will be delivered from January 2024 and is moving in the right direction. Workforce continues to be an improving position, vacancy rate is 1.9 registered midwives however 10 international midwifes will be in the numbers from March 2024, therefore we currently have 12 vacancies. Continue with the capacity and demand and we are having a governance deep dive currently and have had our Birth rate plus refresh and are working with the team to understand what that looks like moving forward. AP noted it was pleasing to hear the improved staffing level and questioned numbers waiting for specific screening, which JL agreed to seek number from the team and feedback. UM confirmed it was moving in the right direction and questioned when we would achieve 95% for those rated red, JL responded we chose a high target but we feel it's important and we strive for this but the data is visible and no harm occurs. JL confirmed that there have been improvements but there is still work to be done.	
	6.3 Thirwell Inquiry UM highlighted to the committee that the report was provided to the committee to approve the submissions on behalf of the Board as the submission was required by 4pm on the 18th. RC shared that the Thirwell Inquiry had issued an information request to all NHS Trusts with Neonatal Units to complete following the convictions on 18 August 2023 of Lucy Letby for seven counts of murder and seven counts of attempted murder. The questionnaire is to gain an understanding of the reality of how neonatal units work. In particular, they are looking to see what practices are effective and where there may be difficulties. The Inquiry Chair requests that a copy of this questionnaire is completed by both the Trust Medical Director and a Non-Clinical Director with responsibility for the Trust's neonatal services. Both submissions have been supported by the services for completion. AP noted that there were 21 perinatal post-mortems in a year and how we compared nationally, RC shared that NLAG have reported 11 in the same time period so there is a difference however it was noted that we have more complex cases being a level 3 unit. AS shared that there is a combination of still births and perinatal deaths, which covers from 24 weeks of pregnancy up to 28 weeks after delivery.	

	The committee stated it was a good report and that it might be worth a follow up regarding lessons to be learnt. The committee confirmed the submission was approved.	
	6.4 Risk Strategy Update CR highlighted from the report that whilst we have had lots of positive engagement and improvements have been seen but these are not consistent or embedded across the organisation and therefore can't provide assurance to the committee as whilst there are positives, significant work is still to be done. The next steps will be to collaborate with NLAG and move towards working as a group with reporting, policies and strategies align. Work is planned to align the corporate risk register with the BAF, which was identified by the Risk Maturity review earlier in the year. RC shared that there is a lot of work to undertake to ensure that the work around risk across the group is consistent and the care groups are supported. The group is able to align the Board Assurance Frameworks between the organisation is because they are owned by the board and are strategic objectives. There will be more ownership of the risks within the care groups in line with the accountability framework moving forward and the central will facilitate and support rather than doing the work.	
	6.5 Patient Safety Update DP presented the paper and provided an updated on the LFPSE paper presented in November. The test environment was now fully functional and able to submit test incidents, work continues on the live environment and expect to go live from the end of January 2024. The trust has now successfully closed all open legacy Serious Incidents following investigation against the 2015 framework and will now just focus on the PSII. There does remain a number of SI actions open, which will be reviewed and addressing before we can say we have fully transitioned to the new framework The committee highlighted that PSIRF updates had focused on the change and would like to also focus on the patient safety aspect within the committee. We hope to see overtime that the learning from incidents has been embedded and that there is a reduction in patient incidents. There is a cultural shift that needs to occur as we are moving away from counting incidents but feedback is that staff like the new way and can be involved in immediately involved in identify learning and actions. The open day was also very successful. NS raised concerns that the actions identified under the 2015 framework, and how the trust will embed the changes especially if the owner actions have changed. JG shared that the open day was a good day and helped networking and that the training days also have been helpful. PS also confirmed that the new reports are easy to read and focused and now need to identify how to easily disseminate the information and look at how best to make them searchable. As they are meaningful and short will help it stick and support cultural change.	
	6.6 Mortality - Learning from Deaths framework (inc. Medical Examiner) PS the paper was presented at last mortality and morbidity group and it is noted that our SHIMI has increased again for the 3rd successive month but is still within the limits, it was noted that our crude mortality hasn't changed. We have decreased our sepsis data from 1.5 to 1.2 so the work around sepsis is having a notable affect. Our concerns at present are around the rising numbers if Stroke after seeing a decrease and a fracture neck of femur, which is a concerning trend and ties in with the concerns within major trauma that were seen. We have now appointed a Geriatric Physician with an interest in ortho-geriatics so hope to make further improvements.	

	AP raised a number of questions in relation to treatment within trauma, which PS acknowledged and responded to whilst reporting that there was a national trend of reduced productivity, patients are more acutely unwell and take longer to anaesthetise and we do need additional acute theatre space, which is being reviewed and on the Trust's radar. ML also confirmed that there is an established weekly group for thoracic rib fracture pain relief for those patients not under the Thoracic Team. MR shared that this piece of work has been impressive and demonstrates the improvements that are being made following the use of the data.	
	6.7 CQUIN – Q2 Update ML provided a paper to the committee for Q2 and highlighted that there were currently two CQUINs which were not being achieved and were seeking clarification around the financial payments for under achieving. CQUIN 12; Assessment and documentation of pressure ulcer risk the annual cost of this CQUIN is £1,084,905. Discussions have been held to with the Interim Chief Nurse and the lead nurse for tissue viability for a plan to progress. CQUIN02- Supporting patients to drink eat and mobilise after surgery, was achieved in Q1 but not in Q2. Work continues to be monitored through the steering group. UM confirmed that the work would link in with the other tissue viability work, which ML confirmed did and that they undertook the audits which were manual.	
	6.8 Infection Prevention Control Requests for Improvements The IPC team presented at the October board development day following which the Group Chief Executive had requested the team to provide an outline of the requirements to address IPC issues at HUTH. The team have provided these requirements which are linked to the risk register as part of a paper to the committee. In total there are thirteen requests, there are four main themes, digital, estates & facilities, IPC service development, infrastructure/ patient services, corporate / governance. The committee was requested to support the requirements and escalate to the board, which the committee confirmed it was in support of.	
9	**Any Other Business** There were no any other business.	
10	**Chair's Summary to the Board** UM thanked all the members for everyone's contribution to the committee, PS also thanked UM on behalf of the committee members. It was agreed to note the IPC paper as a high priority within the summary to the board.	
11	**Date and time of the next meeting:** Thursday 25th January 2024, 1.30 – 5pm	

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)028

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Simon Parkes, Non-Executive Director / Chair of NLAG Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**NLAG Audit, Risk and Governance Committee Minutes – November and December 2023**
Executive Summary	Minutes of the Norther Lincolnshire and Goole NHS Foundation Trust (NLAG) Audit, Risk and Governance Committee held on 23 November and 5 December 2023 and approved at the meeting of the Audit, Risk and Governance Committees-in-Common on 25 January 2024.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 25 January 2024
Prior Approval Process	-
Financial implication(s) (if applicable)	-
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee (ARGC)**	
DATE:	**23 November 2023** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
	Kate Truscott	Associate Non-Executive Director
IN ATTENDANCE:	Lee Bond	Group Chief Financial Officer
	Wendy Booth	Interim Governance Advisor
	Sally Stevenson	Assistant DoF – Compliance & Counter Fraud
	Brian Clerkin	Managing Director (ASM) - External Auditor
	Chris Boyne	Deputy Director of Internal Audit (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	John Roberts	Senior Auditor (Audit Yorkshire) (Observer)
	Nicki Foley	Local Counter Fraud Specialist
	Robert Pickersgill	Deputy Lead Governor (Observer)
	Matt Overton	Associate Director of Central Operations (Item 12.1)
	Ashley Leggott	EPRR Manager (Item 12.1)
	Ivan Pannell	Head of Procurement (Item 12.3 and 12.4)
	Sue Meakin	Data Protection Officer / IG Lead (Item 12.2)

Item 1 11/23 **Apologies for Absence:**

There were no apologies for absence.

Item 2 11/23 **Declarations of Interests**

Simon Parkes asked if there were any declarations of interest and none were made.

Item 3 11/23 **Minutes of Previous Meetings and Highlight Report**

3.1 The public minutes from the meeting held on 20 July 2023 were agreed as an accurate record of the meeting.

3.2 The private minutes from the meeting held on 20 July 2023 were agreed as an accurate record of the meeting.

3.3 The Highlight Report from 20 July 2023 had been provided and was noted.

3.4 Sally Stevenson advised the Committee that the External Auditor's had identified that Robert Pickersgill's name was omitted from the attendee section of the November 2022 meeting minutes, during their review of minutes as part of their year end audit work. Robert Pickersgill was in attendance at the November 2022 meeting, as he was referred to several times in the minutes, and it was therefore agreed to add his name to the minutes for completeness.

Item 4 11/23 **Matters Arising/Review of Action Log**

Action log item updates were as follows:

- Assurance Map – Wendy Booth confirmed that as part of the review of Board sub-committees, a mapping exercise was taking place looking at where all assurances were going to. Simon Parkes offered to have input into this mapping exercise and felt that Jane Hawkard (Hull University Teaching Hospitals NHS Trust (HUTH) Audit Committee Chair) would also wish to do so, given the move to Committees-in-Common (CIC). Wendy Booth commented that the mapping exercise also needed to look below Board sub-committee level and Simon Parkes agreed.

- Junior Doctors Rota's Internal Audit Report – Deferred until Lee Bond joined the meeting.

- Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook – The new edition had not been published at the time of the meeting. Sally Stevenson advised that a further review against the new terms of reference being drafted would be undertaken once the new HFMA Handbook was available. Sally Stevenson confirmed that copies of the publication would be obtained for members and Simon Parkes asked for one to be supplied to the Group Chief Executive also.

- Internal Audit Report – Data Quality – Danielle Hodson provided an update in relation to the query around anonymised data relating to an audit test, advising that she had spoken to Chris Evans, Deputy Chief Information Officer and the audit recommendation had been updated as a result. The Committee discussed the issue of data accuracy and the need for it to be business as usual when running alongside major projects that the Information team were involved in. Action closed.

- Internal Audit – Overdue Recommendations – Simon Parkes advised that he had discussed this with the Chief Executive, who is focussed on ensuring that Executive Directors implement recommendations as agreed. Overdue recommendations will also feature on the agenda for the new operational Risk and Assurance Committee. Danielle Hodson advised that the Chief Executive had requested a monthly list of overdue recommendations. Sally Stevenson advised the number of overdue recommendations stood at three. Action closed.

- Internal Audit – Executive Attendance at ARGC - Simon Parkes updated that the Chief Executive was planning to attend meetings of the ARG Committees-in-Common from January 2024. Action closed.

- Internal Audit – Data Quality – Simon Parkes confirmed that he had discussed this with Fiona Osbourne, Non-Executive Director (NED) as Chair of the Quality and Safety Committee and that committee had looked at it and were assured. Action closed.

- Annual Fire Report 2022/23 – three actions relating to this report, with two confirmed as closed.

- LSMS Annual Report 2022/23 – potential for additional training for staff as a result of Martyn's Law. Simon Parkes advised he would refer this to the Workforce Committee for information.

- Waiving of Standing Orders – issue of return of bariatric beds. Gill Ponder advised that the update addressed the action but didn't consider that it dealt with the controls in place to de-hire such items to ensure such equipment was not being paid for longer than necessary. Agreed to be discussed further when the Head of Procurement joined the meeting later in the agenda.

All other items on the action log were confirmed as closed.

Item 5 Annual Governance Issues 2022/23
11/23

5.1 Annual Governance Statement (AGS) 2022/23

Wendy Booth advised that the AGS had been updated since the last time it was seen by the Committee in July 2023, to bring it up to date and reflect the move to a Group model and the appointment of a joint leadership team. It was submitted for further consideration by the Committee before submission to the Board. There were no comments from the Committee.

5.2 NHS Provider Licence 2022/23

The Committee noted the paper and were content.

Item 6 External Audit (ASM)
11/23

6.1 Audit Planning Report 2022/23

The report, setting out the various planning matters associated with the External Auditors work on the Trust financial statements for 2022/23, had been previously circulated via email to members of the Committee on 30 October 2023. Brian Clerkin confirmed that the work was now complete.

The Committee noted the report.

6.2 Progress Report (verbal)

Brian Clerkin advised the Committee that the Health Tree Foundation (HTF) audit was complete subject to the accounts being signed off by the Chief Executive and Chair of the HTF Committee.

In terms of the Trusts financial statements, the close out meeting had taken place earlier that week with Lee Bond and members of his senior finance

team. There had been a flurry of final information flowing each way to get everything finished. Brian Clerkin advised that the ASM internal quality assurance review would be performed over the next couple of days following which all the necessary formal documents (completion report, opinion, annual auditors report, etc.) would be issued to the Trust and the accounts could be signed off.

Brian Clerkin stated that there were no items of concern arising from the audit. He added that two recommendations had been raised for two control issues, one relating to IFRS16 involving the quality of information relating to leases with other NHS bodies and the need to use estimates in the accounts although this was not an unusual finding throughout the sector. The second recommendation related to HR / payroll controls and some room for improvement in this area.

In terms of their value for money (VFM) work Brian Clerkin informed the Committee that there were no new significant issues but that they would be adding some commentary around forward planning and referencing exiting special measures in May 2023, although this cannot be formally closed off until the 2023/24 accounts are audited given it occurred in May 2023.

Brian Clerkin concluded that the Trust's accounts were clean with no significant changes to them. He added that his team had worked well and were on site for a good proportion of the work, with good cooperation from Trust staff and very good responses to requests for information, etc. and asked to record his thanks for that and assured the Committee that the process had worked well.

Lee Bond joined the meeting.

Simon Parkes thanked Brian Clerkin and his team for picking up the external audit late in the day and getting through the audit process in good order. Simon Parkes also commended the Finance team for making sure that everything was in good order earlier in the year and for responding to the requests for information during the actual audit process recently concluded.

Item 7 11/23 Internal Audit (Audit Yorkshire)

7.1 Internal Audit Progress Report

Danielle Hodson updated that a significant amount of work had been undertaken to bring six 2023/24 reports to the meeting as part of the progress report, with assurance levels of High (1), Significant (3) and Limited (2). In addition there were five 2022/23 reports finalised since the last meeting, although the assurance ratings were previously reported to the Committee in the Head of Internal Audit Opinion 2022/23.

Danielle Hodson reported that 43% of the internal audit plan had been delivered and Audit Yorkshire were on track to deliver the full plan for 2023/24. An additional request had been made to review the Acute Assessment Unit in terms of the business case implementation and benefits realisation. The

Committee approved this additional request, noting that it was a sensible review to be undertaken.

Simon Parkes commented that there was a lot in the progress report, some of which on the face of it was quite troubling. A discussion took place around whether further assurance on some of the reports should be sought from other sub-committees (e.g. Workforce Committee for the Long Term Locums report / Quality and Safety Committee for the Nutrition and Hydration report and Learning from Complaints report). It was considered that other sub-committees were better placed to examine the reports in the context of other issues they were examining. It was agreed therefore that the reports should be brought to the attention of the relevant committee Chairs, and that the ARG Committee's role would be to ensure that management responses were appropriate and that recommendations were implemented as agreed.

Action: Simon Parkes

Simon Parkes was concerned about the Nutrition and Hydration report and the issue of policies not being followed.

The general matter of internal audit reports being circulated to the Chairs of the relevant sub-committees was raised by Gill Ponder and Simon Parkes advised that he would review the audit reports once received upon finalisation and then consider whether any needed flagging to other committee Chairs, and that he would do this in conjunction with Sally Stevenson.

Action: Simon Parkes / Sally Stevenson

Chris Boyne advised that this was a process he saw in other Trusts and raised the issue of whether the relevant Executive Director should be asked to attend the ARG Committee to discuss the findings of their reports.

Wendy Booth advised that on all new Committees-in-Common work plans there was a standing agenda item to review any relevant internal and external audit reports.

Lee Bond noted the good outcomes for four audit reports which the Committee could take assurance on, however he was concerned with the Performance Management report and the Theatre Data Quality report receiving 'limited assurance'. Lee Bond went on to say that in terms of Performance Management, the Trust had quite a good system in terms of the process and documentation, but the point was well made by internal audit around attendance issues and the impact that this had on the PRIMs process when not well attended.

The Committee noted the 'Limited Assurance' level for the Theatre Data Quality report and discussed the concerns identified around the accuracy of theatre data utilisation rates reported internally and externally. In May 2023 externally reported data was showing a lower utilsation rate (71.5%) than internally reported data (80.24%). The audit identified the Trust made changes to the data set in May 2023 and reviewed the data quality, leading to improved accuracy of reporting thereafter. Lee Bond stated that the Theatre

Data Quality review had been specifically requested as there were some concerns around this, and it was acknowledged that there must be one set of numbers as quickly as possible by pulling two disparate processes together. Chris Boyne responded to say that it would have been useful to have the Director present to talk the Committee through the actions to address the issues and how quickly it would be resolved. Lee Bond concurred that implementing the actions was key to ensuring confidence in the data at a national level.

The Committee agreed to invite the Deputy Chief Operating Officer to the next meeting to provide further assurance as to the implementation of the agreed action plan.

Action: Sally Stevenson

It was also agreed to highlight this particular internal audit report to the Trust Board.

7.2 IA Recommendations Follow-Up – Status Report

Danielle Hodson advised that the latest report was produced on 13 November 2023 and showed five overdue internal audit recommendations, however a further two had been actioned since then and the total overdue stood at three. Details are being reported monthly to the Executive team to maintain momentum.

The Committee was content with the progress and pleased to see the actions being taken seriously. It was agreed that this positive progress should be noted on the highlight report to the Trust Board.

7.3 Fit and Proper Persons Test – Audit Requirements

Sally Stevenson explained that the same paper had gone to the HUTH Audit Committee recently where it had been agreed that internal audit (RSM at HUTH) would conduct the necessary review in April 2024, as the first audit from the 2024/25 plan. However, Sally Stevenson advised that on further reflection it would only be necessary for the audit to be conducted once by either NLAG or HUTH's internal auditors as they would be reviewing the same set of Group Directors, etc.

The Committee was content with the planned April 2024 timing of the work, and agreed that it only needed auditing by one set of internal auditors and this was a sensible audit to commence this joint approach.

Action: Sally Stevenson / Internal Audit

Item 8 11/23 Counter Fraud

8.1 LCFS Progress Report

The Committee received a routine progress report from the Trust's Local Counter Fraud Specialist (LCFS) outlining proactive and reactive work performed since the previous meeting in July 2023.

Nicki Foley highlighted the key points for the Committee including:

- 91% compliance with mandatory fraud awareness training;
- A national intelligence bulletin relating to secondary employment on a skilled workers visa;
- Three fraud prevention notices (FPN's) issued by the NHS Counter Fraud Authority involving multiple roles whilst home working, a mandate fraud alert and impersonating a medical professional;
- A Local Proactive Exercise (LPE) following on from an issue identified in the National Fraud Initiative (NFI) exercise resulting in the recovery of £36k from a supplier;
- The latest national headline figure on fraud vulnerability to the NHS (estimated at £1.264billion);
- Recovery of £29k from NFI matches involving duplicate creditor payments;
- A prevented bank mandate attempt of £19,200;
- Four new fraud referrals received;
- One final written warning and one resignation resulting from fraud enquiries that did not progress criminally.

Simon Parkes thanked Nicki Foley for her comprehensive report.

Gill Ponder referred to the duplicate creditor payments and queried the financial controls in place allowing these to be processed. Nicki Foley responded to explain they had resulted from the implementation of the new financial system and some confusion with the new process coupled with the supplier involved changing the format of their invoices. The Trust's outsourced creditor payments provider (East Lancashire Financial Services (ELFS)) have software in place to prevent such issues, but in this particular scenario a number of issues had arisen which resulted in the duplicate payments. Nicki Foley went on to provide assurance that an exercise had been conducted to review all payments to the supplier in question, and a review of other agency suppliers invoice numbers had also been conducted and no similar issues identified.

Kate Truscott noted that allegations of working elsewhere whilst off sick was a recurring theme and queried whether there was anything else the Trust could be doing in this regard. Nicki Foley advised that mandatory training was now in place which includes reference to this type of potentially fraudulent conduct; she was also currently talking to staff whilst out and about during Fraud Awareness Month (FAM) and awareness material was also being issued to staff. Nicki Foley suggested that she could do further comms from Lee Bond or Adrian Beddow (Counter Fraud Champion) to reinforce the messages around this type of fraud.

Action: Nicki Foley

Nicki Foley also clarified that working elsewhere whilst off sick was a national problem, and not unique to the Trust. Lee Bond added that it was also linked to the growth in home working providing a greater opportunity to be tempted to commit such fraud as a result of reduced supervision. The Committee discussed the issue of this being a potential gross misconduct issue and how examples of such sanctions would send a strong message. Nicki Foley

advised that some issues were progressed via the Trust's Just and Learning Culture if considered appropriate by Human Resources.

Simon Parkes concluded that it was not a lack of awareness and staff committing this type of fraud knew what they were doing, so he was not sure what more could be done other than publicising strong sanctions when applied.

It was agreed to highlight this type of fraud and the high level of mandatory training compliance to the Board.

Simon Parkes thanked Nicki Foley for her counter fraud work.

Item 9 11/23 **Board Assurance Framework and Strategic Risk Register – Q2**

Simon Parkes advised that this report was for noting only as the Board Assurance Framework was being reviewed and refreshed in its entirety, but asked members if there was anything they wished to comment on.

There were no comments or questions from the Committee and the report was duly noted.

Item 10 11/23 **Losses and Compensations Report**

Lee Bond referred to the writing off of overseas visitor's debts, albeit low values but high numbers, and advised that he would be reviewing these further to see if there was any way they could be avoided.

The Committee also discussed the persistent problem of lost dentures and hearing aids, noting again that they were not items which could be relinquished by patients for safe keeping and were often lost in bedding / transfers between wards. It was noted that the value of items involved was not high, but that hearing aids were becoming more expensive to replace.

Ivan Pannell joined the meeting.

The Committee recalled the recent internal audit review of this area, and the patient dignity issues associated with the loss of such items.

Lee Bond also advised the Committee that when claims for such lost items were received the claimant was asked for a receipt or alternatively the Trust was replacing the item directly.

Danielle Hodson reminded the Committee that the patients property and monies policy was being updated and changes were being made in the Trust to hopefully make improvements in this area.

It was agreed to highlight this issue to the Board in order to maintain the focus on this.

Item 11 11/23 **Management Reports for Assurance – Items for Approval**

There were no items for approval.

Item 12 11/23 **Management Reports for Assurance**

Due to the meeting running ahead of schedule, the following items were taken out of sequence on the agenda to accommodate ad-hoc attendees.

12.3 Waiving of Standing Orders Report

Ivan Pannell highlighted that there were 23 waivers detailed in the report, adding that this was a standard number.

There were no comments or questions from the Committee and the report was noted.

12.4 Procurement Update Report

Ivan Pannell advised this was the second annual report, detailing procurement activity, in which he had provided up to date information for certain elements (purchase orders and invoices) but had also taken a forward looking approach to the contents of this year's report. Ivan Pannell referred to the new Humber and North Yorkshire Procurement Collaborative, adding that this was the most significant change for procurement since he joined the NHS and was an exciting time, providing the Procurement team with a lot of opportunities to do things better and more effectively in a more joined up and streamlined approach.

Ivan Pannell informed the Committee that a piece of work was underway looking at how the Trust could consolidate invoices (as there is a charge for each invoice processed) to determine how it could be made more efficient and cost effective for both the Trust and its suppliers. Ivan Pannell also advised that they were looking at taking rebates from Trust purchasing cards, a relatively simple thing that can be done but which can generate additional savings for the Trust.

Ivan Pannell advised that one of the biggest opportunities for the Procurement collaborative was the leverage with using collective buying power and structuring the teams in line with categories of activity. Recruitment is under way to fill posts in the new Procurement structure and the pace of progress will move on quickly from the new year and Ivan Pannell reiterated that it was an exciting time for the teams involved. Ivan Pannell referred to the ambitious cost saving targets which they were well on the way to achieving already, certainly in the first year. The Trust's contracts are also now linking into a national system.

Ivan Pannell stated that there was lots to look forward to and be optimistic about and was happy to take any questions from the Committee.

Simon Parkes asked if the new procurement collaborative would give the Trust more heft and influence to avoid issues with the more problematic

suppliers. Ivan Pannell responded to say that it gave the Trust more options if everyone was acting collectively to let a single major contract, which may generate savings but may not prevent legal challenges which sometimes occur.

Gill Ponder welcomed the extra attention being paid in this area particularly if coupled with strengthening contract management so that suppliers are held to account for contracts they had committed to.

Gill Ponder asked to return to the action log item regarding the return of equipment to ensure that the Trust was not paying for hired equipment longer than necessary. Lee Bond responded to say that there was no written procedure for this as far as he was aware and that budget managers are responsible for the return of equipment when no longer needed as they will continue to incur these costs on their budgets until they do, adding that he would like to think that the values involved were not material. Gill Ponder stated that she had experience from elsewhere where managers did not do the obvious thing to remove a cost. Lee Bond stated that he would consider this further with his Procurement team.

Action: Lee Bond

Matt Overton and Ashley Leggott joined the meeting.

Ivan Pannell advised that there is a procedure, whereby the ward will telephone the hire company to say the equipment is no longer needed and it is returned, confirming there is a mechanism for doing this.

Simon Parkes commented that there was a risk that hired equipment could be left without being returned if wards were not diligent and a general reminder to staff about this would not be a bad thing.

Action: Ivan Pannell

Simon Parkes thanked Ivan Pannell for attending.

The Committee broke for a five minute comfort break at this point and then returned to the sequence of the agenda.

12.1 Annual Report for Emergency Preparedness, Resilience and Response (EPRR) for 2022/23

Matt Overton highlighted the key areas from the report, namely the testing and training throughout the year including live incidents responded to; details of the assurance processes last year – noting substantial compliance with NHSE last year, but with a change to the process this year meaning a reduction to a non-compliant rating this year; Audit Yorkshire's three yearly review resulting in substantial compliance and the East Midlands Ambulance Service (EMAS) audit of the Trust's Chemical, Biological, Radiological and Nuclear (CBRN) arrangements with no concerns raised. Matt Overton also referred to new updates to national guidance and the EPRR Workplan 2023/24 at Appendix B of the report.

Kate Truscott referred to the actions around winter planning and its status of 'to do' in the action plan despite the fact that it was now late November. Matt Overton clarified that the annual report was written in August 2023 and winter

planning had started at that point and was now in place having received the national updates, confirming that it was simply a timing issue with the production and submission of the annual report and that the actions were complete.

Gill Ponder referred to page 22 and queried whether the actions for winter planning were all complete, adding that it had been discussed at the Finance and Performance Committee the previous day where it was felt that the annual report being received in November was too late, but acknowledging there were a whole host of issues as to why this was. Gill Ponder also referred to the lock down test on page 24 and queried whether a date was set yet.

Matt Overton reiterated that the report was written in August 2023 and that all the winter planning actions had been getting updated via the workplan, with none not being achieved. In terms of the lockdown policy, Matt Overton advised that they had linked in with the Trust's Local Security Management Specialist (LSMS) Phil Young and assurance received that it would be done by the end of March 2024 on at least one site.

Sue Meakin joined the meeting.

The Committee discussed the timing of the EPRR annual report and agreed it needed to be earlier in the year. Sally Stevenson advised that it normally came to the July meeting of the Committee, but with Matt Overton's involvement in strike planning, etc. this year it had been delayed. Simon Parkes agreed that it should return to the July timeframe next year. Wendy Booth reiterated Sally Stevenson's comment about it normally coming earlier in the year, and also the need to pick it up as part of the Board reporting framework in terms of timing and also duplication of reporting.

Matt Overton confirmed the EPRR annual report would be reported to the December 2023 Trust Board meeting.

Matt Overton and Ashley Leggott were thanked for attending and left the meeting.

12.2 IG Steering Group Highlight Report

Sue Meakin took the report as read and asked for any questions.

Kate Truscott thanked Sue Meakin for her very comprehensive report and noted that generally the number of Information Governance (IG) incidents appeared to have increased and queried if this was due to better reporting. Sue Meakin confirmed this to be the case, adding this was a good thing and Kate Truscott agreed. Sue Meakin stated the main area of reporting was associated with records management, misfiling, etc. but also the true IG incidents involving data breaches, disclosure of information, etc., so two distinct splits.

Sue Meakin advised that the new Fairwarning system was now live within NLAG, which would identify inappropriate access to electronic records, and data on this would be contained within the next report.

Kate Truscott asked what else could be done to emphasise the message about confidentiality and its impact on others, suggesting maybe a Trust wide bulletin from Sue Meakin occasionally. Sue Meakin confirmed they do put items in Lessons Learnt and gave examples of ones they were planning to highlight around using correct emails, filing and tracking notes and also inappropriate access of records.

Gill Ponder referred to the numbers on page seven of the report and asked for clarification of her interpretation of the data shown. Sue Meakin confirmed the data was running on a twelve month basis and being collated manually as they had lost their usual dashboard when the Trust moved to Ulysees, and they would therefore need to produce a year end report. Sue Meakin added that they are now dealing with a lot of figures and categories.

Gill Ponder noted that Family Services appeared to be an outlier in terms of the number of incidents and asked if any targeted work was being done to address this. Sue Meakin responded to say that the figures would be reviewed at the Clinical Record Keeping Committee chaired by Alistair Pickering, and they would be considering what staff need to do their job and ensure understanding to prevent incidents.

Lee Bond asked if having electronic patient records instead of paper records would improve the position and Sue Meakin stated yes, definitely. Lee Bond asked if an investment in electronic records would have a qualitative benefit as well as a financial one and Sue Meakin confirmed yes. Lee Bond said this was helpful to know having just received a business case for one.

Lee Bond asked Sue Meakin what, other than IG training which is always elusive, worried her most about the IG agenda. Sue Meakin stated that in addition to cyber related issues, it would be Artificial Intelligence (AI) as this is what most IG professionals are thinking about, coupled with the recent announcement about Federated Data Platform (FDP). Sue Meakin added that essentially for her it was about the sharing of and access to Trust data.

Sue Meakin advised that they were looking at providing training for Board members and also as a result of the changes to the Data Security and Protection Toolkit (DSPT) training requirements a training needs analysis has to be done to look at what levels of training staff have, and they want to develop the same training programme across both Trust's in the Group. Sue Meakin added this was a new assertion in this year's DSPT, and was a big piece of work, and it would be an interesting year ahead.

Simon Parkes commented about the issue of joining data up across the NHS and the huge benefits for patients through improvements to services, adding however that it was a fine line to be found between protecting patient's data and also being open with them about it. Sue Meakin confirmed she was in agreement with data sharing, however it needed to be done right.

Simon Parkes thanked Sue Meakin and she left the meeting.

The Committee agreed to add this to the highlight report to confirm the Committee had received good assurance in relation to Information Governance, with the view that it was well gripped.

12.5 Review of Salary Overpayments and Underpayments

Sally Stevenson advised that it was disappointing to report an increase in the level of overpayments when it had been going in the right direction, and as was illustrated at page four of the report it only took one large overpayment to negatively affect the figures. Sally Stevenson added that it was further disappointing that the largest overpayment related to someone who left and continued to be paid because the paperwork wasn't sent to the Payroll team, but assured the Committee that recovery was in hand.

Lee Bond noted some consistency with findings by External Audit as part of the audit of the annual accounts. Simon Parkes stated that it was frustrating that processes weren't followed properly and the impact it had on all concerned. It was agreed to highlight this matter to the Board.

Lee Bond asked if the report showed how much had been recovered, as he couldn't see it and Sally Stevenson confirmed that the report did not show an overall recovery figure as it fluctuated all the time as recoveries were coming in. Lee Bond commented that it would be useful to know what the real loss to the organisation for salary overpayments was and Sally Stevenson responded to say that the limited few not recovered were shown on the Losses and Compensations report, and that everything else was recovered. Lee Bond commented that the overpayments were essentially a waste of everyone's time to deal with and resolve, which Simon Parkes agreed with.

Kate Truscott asked if the Trust had a third party working on behalf of the Trust to recover debts, and Sally Stevenson confirmed that the Trust used a debt recovery agency where necessary.

Gill Ponder asked if there was any specific targeting of areas where issues were identified. Sally Stevenson advised that this was done and advised that on Monday at the Finance Directorate Management Team meeting all the Divisional Finance Managers had been asked to go back to their divisions and remind them of the importance of making sure termination forms, etc. were done to avoid overpayments. In terms of repeat offenders, Sally Stevenson reminded the Committee of the non-compliance process in place to address these with a three stage letter process, etc. which involved line managers and Directors at stages two and three respectively. Additionally, general awareness was issued Trust wide, as it had been again that week, to remind all managers that if they had had anyone leave their team to remember to notify the Payroll team through the normal process.

It was agreed to note in the Board highlight report that an increase in salary overpayments was reported, in contrast to the downward trend reported previously to the Committee.

12.6 Document Control Report

Wendy Booth reported that 94.4% of controlled documents were in date, however 102 documents were overdue for review with the report highlighting specific divisions / directorates. Wendy Booth added that it was a positive position but clearly there was more work to do.
Gill Ponder queried the documents marked as high risk, adding she would like to be assured that they were actually high risk and if so were they being dealt with, and Kate Truscott concurred with this. Wendy Booth responded to say that the maternity documents were of concern for her.

Lee Bond commented that this linked to Gill Ponder's earlier comments regarding Chairs of Board sub-committee's being aware of such issues, as although the ARG Committee has a responsibility to review at a high level the question was where was this impacting within the organisation. Wendy Booth agreed with Lee Bond and added that the Quality and Safety Committee would have a view on this from an assurance perspective, but ultimately it is managers responsibility to deal with their documents, adding that it used to be picked up at the PRIMs meetings to make sure there was traction. Lee Bond commented that he was sure that it would get picked up again as part of the revised performance management regime but acknowledged things were in limbo at present.

It was agreed to include this issue in the Highlight Report to the Board.

Simon Parkes also stated that he would write to the relevant Directors to ask them if they had reviewed their high (6) and moderate (22) risk overdue documents to obtain assurance they were dealing with them and report back to the January meeting. Sally Stevenson to extract the details of these documents to enable Simon Parkes to contact the relevant Directors.

Action: Sally Stevenson / Simon Parkes

12.7 Standards of Business Conduct Policy Declarations Report

Wendy Booth highlighted that a small number of Executive Directors and Non-Executive Directors were out of compliance with their annual declarations and she would be chasing these up directly with the individuals concerned.

Gill Ponder commented that the report indicated low compliance from the Consultants which was a concern. Wendy Booth responded to say that maybe it needed to be part of the annual appraisal and revalidation process to ensure that it happens consistently. Kate Truscott stated that she would support this approach suggested by Wendy Booth.

Simon Parkes suggested it should be referred to the Workforce Committee, however Danielle Hodson reminded the Committee that it was an internal audit recommendation and that she would forward the recommendations to Wendy Booth.

Item 13 11/23 Action Logs and Highlight Reports from other Sub-Committees

The following action logs and Highlight reports were provided and noted without questions:

13.1 Finance & Performance Committee
13.2 Quality & Safety Committee
13.3 Workforce Committee
13.4 Health Tree Foundation Committee

Item 14 11/23 Private Agenda Items

There were no private agenda items.

Item 15 11/23 Any Other Business

15.1 CIC Update and Schedule of Audit, Risk and Governance Committee-in-Common Meetings 2024 /25

Simon Parkes provided an update in relation to the development of the new Committees-in-Common (CIC), and specifically the ARG CIC which he stated was unusual in that it had a statutory set of responsibilities which slightly restricts what it can do 'in common', in terms of having separate responsibilities for the financial statements, external audits which inform the financial statements, etc. Simon Parkes advised therefore that although the Group's two Audit Committee's would meet in common there would still be items of business which would not be common e.g. different internal audit programmes.

Simon Parkes advised that the HFMA NHS Audit Committee Handbook refers to there being three Non-Executive Directors members for each Trust, with two from each in attendance for quoracy. Simon Parkes explained that the intention is for the CIC meeting to be split into three sections – the first part being NLAG only business, the middle section being Group joint business and the third part being HUTH only business. The NED members would be invited to attend for the whole meeting, subject to any other pressing commitments they may have. The expectation is that the middle section containing joint business will expand over time whilst the two sections either side will gradually reduce. Simon Parkes advised that he and Jane Hawkard would ask for feedback as to whether or not the ARG CIC was working, acknowledging that it may not be right to start with but that on-going feedback would help develop it as necessary.

15.2 Review of SFIs and Standing Orders

Lee Bond advised that he believed the Trust was getting closer to understanding what the committee structure might look like going forward and once that was in place a Scheme of Delegation could start to be populated, with the SFIs and Standing Orders. Clarity around the structure is needed to undertake this work however.

Wendy Booth asked Lee Bond if the terms of reference for the Executive Cabinet and the Trust Management Group (TMG) had been finalised yet, adding that she had sent the draft versions to Jonathan Lofthouse but hadn't seen the final versions yet. Lee Bond stated that he had not seen them at all as yet, and nor had he seen an organisation structure showing where committees are and what feeds in where, other than to know that a Risk Committee is being set up and presumably a replacement for Trust Management Board (TMB).

Wendy Booth responded to advise that she had collated all of the known meetings and suggested that a brain storming session was needed with all of the Executives in terms of what was needed as management groups and which of those groups would report into TMG, agreeing any dotted lines of assurance to Board sub-committees, etc. Wendy Booth commented that the conversation was needed with all Executives to agree these matters, and Lee Bond suggested that Wendy Booth discuss it with Jonathan Lofthouse who may want to put it on a Tuesday afternoon cabinet meeting for discussion.

Action: Wendy Booth

Item 16 11/23 **Matters for Escalation to the Trust Board**

The following items were agreed to be included in the Highlight Report to the Board:

- Internal Audit Theatre Data Quality Report – limited assurance rating;
- Internal Audit Recommendations – positive position;
- Counter Fraud Update – high eLearning compliance and working elsewhere whilst off sick;
- Losses and Compensations Report – lost patient's dentures and hearing aids;
- IG Steering Group Highlight Report – positive assurance received;
- Salary overpayments – increase;
- Document Control – 102 overdue documents.

Item 17 11/23 **Matters to Highlight to other Trust Board Assurance Committees**

Simon Parkes to refer the Long Term Locums internal audit report to the Workforce Committee and the Nutrition and Hydration report and Learning from Complaints report to the Quality and Safety Committee.

Item 18 11/23 **ARG Committee Workplan – For Information**

Noted by the Committee, acknowledging the move to a CIC approach from January 2024.

Item 19 11/23 **Review of the Meeting**

Simon Parkes asked if there was any feedback on the meeting. Lee Bond advised that it had worked well for him and was in agreement with the proposed future construct of the CIC meetings. Kate Truscott commented that there were good reports once again which made the meeting much easier and thanked everyone for their contributions during the meeting. Gill Ponder agreed with Kate Truscott, saying that it was very clear why reports were there and it was clear what the Committee was being asked to do which was very helpful, with good discussions. Brian Clerkin commented that it had been a good meeting and he particularly liked section twelve of the agenda with a good suite of management reports in terms of management assurance.

Robert Pickersgill observed that there had been some very interesting items, not least the development of the Procurement collaborative, and advised Simon Parkes that he would be chairing the next Governor Assurance Group (GAG) in the absence of Ian Reekie and requested a discussion with him about what might get discussed at the GAG.

Wendy Booth informed the Committee that a meeting had taken place recently with Ian Reekie and others to review the Council of Governors (CoG) and GAG meetings as there was a view that some items of assurance were feeding into the GAG rather than the main CoG meetings. Wendy Booth added that the intention was to map this out further in January 2024 with the proposal that Highlight Reports from sub-committees will revert back to being submitted to the CoG rather than the GAG.

Simon Parkes thanked everyone for their feedback on the meeting which was helpful.

Item 20 1/23 **Date and Time of the next meeting**

5 December 2023
9am to 10am
Boardroom, DPoWH (*Audited annual accounts meeting prior to Trust Board sign off same day*)

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**5 December 2023**	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
	Kate Truscott	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Group Chief Financial Officer
	Jonathan Lofthouse	Group Chief Executive
	Wendy Booth	Interim Governance Advisor
	Sally Stevenson	Assistant DoF – Compliance & Counter Fraud
	Brian Clerkin	Managing Director (ASM) - External Auditor
	Chris Boyne	Deputy Director of Internal Audit (Audit Yorkshire)
	Nicola Parker	Assistant DoF – Planning and Control
	Adrian Beddow	Associate Director of Communications
	Robert Pickersgill	Deputy Lead Governor (Observer)

The meeting took place in the Boardroom at Diana, Princess of Wales Hospital (DPoWH), Grimsby with Simon Parkes and Robert Pickersgill in attendance virtually via MS Teams.

Item 1 12/23 **Welcome**

Simon Parkes welcomed Jonathan Lofthouse, Chief Executive, to the meeting, which was to receive the audited accounts and other year-end related audit matters.

Item 2 12/23 **Apologies for Absence:**

Apologies were noted from Helen Higgs (Audit Yorkshire).

Item 3 12/23 **Declarations of Interests**

Simon Parkes asked if there were any declarations of interest and none were advised.

Item 4 12/23 **Public Disclosure Statements**

4.1 Audited Annual Accounts 2022/23

Lee Bond advised that Nicola Parker would take the Committee through the changes made since the Committee received the draft annual accounts in April 2023. Nicola Parker referred the Committee to the summary at the beginning of the paper and the limited number of items listed were discussed.

In relation to the issue of Reinforced Autoclaved Aerated Concrete (RAAC) it was noted that these costs were anticipated as being covered by Public

Dividend Capital (PDC) and Lee Bond advised the Committee that they were awaiting confirmation of this.

Lee Bond stated that the changes made to the audited accounts were almost inconsequential and it was really pleasing to note so few amendments required as a result of the audit by the Trust's External Auditor.

Simon Parkes thanked Nicola Parker for the helpful summary setting out the changes made since the draft annual accounts were produced.

The Committee confirmed they were content with the audited accounts and thanked the Finance team and the External Auditor for their work in bringing the 2022/23 financial statements to a conclusion.

4.2 Audit Completion Report 2022/23

Brian Clerkin (ASM) advised the Committee that he would take the paper as read and just draw out the key points but began by thanking the Finance team for their assistance during their audit work.

Brian Clerkin advised the Committee that there were no unadjusted misstatements, no matters misreported, no issues with the matter of going concern and no fraud issues, adding that ASM would be emailing Lee Bond that day to ask him to confirm that there were no subsequent events for them to be made aware of (*Post meeting note: Lee Bond received this email on 5.12.23 and responded to confirm there were no subsequent events that would affect the audit opinion*).

Brian Clerkin confirmed that the draft report had been seen by the Finance management team and that management responses for the limited number of recommendations made had been incorporated into the document received by the Committee. The report made a limited number of recommendations to strengthen controls around the new area of IFRS16 – Leases, with Brian Clerkin advising that this was in common with many NHS organisations right across the system.

Brian Clerkin also highlighted that the draft Letter of Representation was contained within the report for information, and again this was standard.

4.3 Audit Certificate and Opinion 2022/23

Brian Clerkin informed the Committee that this paper certified that ASM had completed the 2022/23 audit of the Trust's financial statements but was in draft form until that day. Brian Clerkin confirmed that the audit had resulted in a clean opinion and there were no issues to draw to the attention of the Committee.

The Audit Completion Certificate is included within their opinion, and Brian Clerkin confirmed that he was content that this could now be signed.

4.4 Consistency Opinion 2022/23

Brian Clerkin explained that the document provided their opinion on the consistency of the figures between the audited financial statements and the Trust Accounts Consolidation (TAC) schedules for 2022/23. An unqualified opinion was concluded, with no differences identified.

4.5 Auditors Annual Report 2022/23

Brian Clerkin advised that this paper summarised the key issues arising from their audit of the Trust year end accounts and reports for 2022/23 and is a publicly available document, adding that it remained in draft form until the accounts were signed that day.

The audit resulted in an unqualified opinion on the Trust's financial statements, meaning that the statements gave a true and fair view of the Trust's financial position. Brian Clerkin also confirmed that the Health Tree Foundation accounts had also been certified in the last week.

The auditors annual report deals with the opinion on the financial statements, their commentary on the value for money (VFM) work which encompasses financial sustainability, governance and improving economy, efficiency and effectiveness, whether the Annual Governance Statement complies with guidance issued, etc. Brian Clerkin stated that there were no new significant weaknesses identified during their VFM work, however two prior year findings were considered noting that the Trust was still in the Recovery Support Programme (RSP) (formerly referred to as Special Measures) at 31 March 2023, but removed from RSP by NHS England post year end (17 May 2023). Brian Clerkin advised the Committee that these two brought forward issues relating to the RSP would be formally closed out during their 2023/24 audit.

Gill Ponder responded to say that everything was very straightforward and that once again the accounts had been prepared in excellent fashion by Nicola Parker and her team.

Lee Bond advised that his only comment was on the matter of forward planning and business planning and the challenges that would bring, adding however that this was a system wide issue not just a Trust one.

Kate Truscott thanked Brian Clerkin and his team and all those involved in closing down the audit of the 2022/23 financial statements. Simon Parkes echoed this, adding that he was grateful to ASM, and to the Trust's Finance team who had maintained momentum with producing the draft accounts, etc. under unique circumstances, and placed on record the Committee's thanks for this.

4.6 Annual Governance Statement (AGS) 2022/23 (Final)

Wendy Booth informed the Committee that there had been no changes to the AGS since the version received by the Committee at its meeting on 23 November 2023.

The Committee accepted the final version of the AGS for 2022/23.

4.7 Internal Audit Annual Report and Head of Internal Audit Opinion 2022/23

Simon Parkes advised that this was for completeness and noting only, as part of the full suite of public disclosure documents for 2022/23, having been received by the Committee at its July 2023 meeting.

4.8 Trust Annual Report 2022/23

Adrian Beddow advised the Committee that the Trust's Annual Report is uploaded as a PDF document to the Trust's external website, and in line with Government accessibility rules he has had to adjust the format of the document in places to ensure compliance with these rules. Adrian Beddow assured the Committee however, that none of the information contained within the report had been changed. He also placed on record his thanks to all involved in producing the report.

The Committee accepted the Trust's Annual Report, commenting that it had good commentary in it and a balance of things the Trust had done well and also things that are still a challenge for the Trust.

Item 5 12/23 Any Other Business

There were no other items of business.

Item 6 12/23 Matters for Escalation to the Trust Board (Public / Private)

Following review of all the papers in section 4 of the agenda, the Chair asked if members were content to recommend the adoption and formal signing of the 2022/23 financial statements to the Trust Board (at the Board meeting take place immediately following the Audit, Risk and Governance Committee meeting) and this was duly confirmed.

Item 5 12/23 Matters to Highlight to other Trust Board Assurance Committees

There were no matters to highlight to other Trust Board Assurance Committees.

Item 20 12/23 Date and Time of the next meeting

Thursday 25 January 2024
9am – 12.30pm
Microsoft Teams

The Chair noted that this would be the inaugural meeting of the Audit, Risk and Governance Committees-in-Common (CIC).

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)029

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Jane Hawkard, Non-Executive Director / Chair of HUTH Audit Committee
Contact Officer/Author	Jane Hawkard, Non-Executive Director
Title of the Report	**HUTH Audit Committee Minutes – October 2023**
Executive Summary	Minutes of the Hull University Teaching Hospitals NHS Trust (HUTH) Audit Committee held on 26 October 2023 and approved at the meeting of the Audit, Risk and Governance Committees-in-Common on 25 January 2024.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 25 January 2024
Prior Approval Process	-
Financial implication(s) (if applicable)	-
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

Hull University Teaching Hospital NHS Trust
Minutes of the Audit Committee
Held on 26 October 2023 via MS Teams

Present:	Mrs J Hawkard	Non-Executive Director / Chair
	Mr M Robson	Non-Executive Director / Vice Chair
	Mr L Bond	Group Chief Financial Officer
	Mrs R Thompson	Head of Corporate Affairs
	Ms S Stevenson	Assistant DoF – Compliance & Counter Fraud
	Mr J Collins	External Audit (Mazars)
	Mr A Hussain	Internal Audit (RSM)
	Mrs N Foley	Local Counter Fraud Specialist (CFP)
In Attendance:	Mrs H Knowles	Head of HR Services (Item 6.1)
	Mr E James	Director of Procurement (Item 8.1)
	Mrs S Meakin	Data Protection Officer / IG Lead (Item 8.5)

No **Item**

1 **Apologies:**
Apologies were received from Tony Curry and Suzanne Rostron. Mrs Hawkard welcomed everyone to her first meeting as Chair of the Audit Committee. It was advised that Lee Bond would be a few minutes late joining the meeting.

2 **Declarations of Interest**
There were no declarations of interest made.

3 **Minutes of the Previous Meeting – July 2023**
The public and private minutes were agreed as an accurate record of the meeting.

4 **Matters Arising / Review of Action Tracker**
There were no matters arising. The Committee reviewed the action tracker showing three items, with one action closed, one not yet due and one to be picked up with Mr Bond on his arrival in the meeting.

5 **External Audit (Mazars)**

5.1 Auditors Annual Report
Mr Collins advised that the report is a public facing document, published with the Annual Report and Accounts. The main difference is the value for money (VFM) commentary contained within it. Mr Collins stated that they had considered the CQC report on the Trust's maternity services and therefore included this in the actions.

Mr Bond joined the meeting.

Mr Collins referred to the additional fees from this year's audit work, adding that this was the subject of a separate paper to the Committee, but highlighting the two reasons for these including internal discussions and consistency checks. Mr Bond expressed disappointment at the additional fees and advised that he had spoken to Mr Collins about them following which he had agreed to pay them. Mr Bond confirmed that he was happy with the service from Mazars. Mr Collins confirmed that the fees were not recurrent fees and would ensure early dialogue next year if any additional fees were considered likely.

A discussion took place around External Audit's role in following up the CQC action plan and Mr Collins stated that they would track progress but would not specifically test anything as not within their scope, and they would rely on the judgement of the CQC as to whether or not it removed the inadequate rating from the Trust. Mr Hussain advised the Committee however that an internal audit was planned on the CQC action plan commencing early November 2023 and he would report back to the next meeting. Lee Bond also advised that Mike Wright, an external consultant in nursing issues and a former Chief Nurse had been engaged to review a raft of governance mechanisms and the Quality Committee would ultimately oversee this. The question was posed as to whether Mr Wright would be involved in reviewing ED not just Maternity services and this was subsequently confirmed by Mrs Thompson during the meeting.

Mrs Hawkard asked if Mr Collins was happy with the unadjusted misstatements and he confirmed that he was, adding that they were not unusual and not material in the context of the Trusts materiality values.

The Committee accepted the Auditors Annual Report.

5.2 Routine Progress Report and Sector Updates
Mr Collins had nothing further to add under this item.

5.3 Annual Review of External Auditor Performance / Additional Fees
The Committee noted the formal evaluation of the performance of the Trust's External Auditor, Mazars. The subject of additional fees arising from this year's audit work (2022/23) was discussed at item 5.1.

6 Internal Audit (RSM)

6.1 Internal Audit Progress Report & Associated Review Reports
Mr Hussain introduced the item and outlined progress since the previous meeting, informing the Committee that delivery of the 2023/24 internal audit plan was going smoothly. There were three reports which had been finalised since the last progress report to the Committee, of which one related to 2022/23.

Mrs Hawkard advised that Mrs Knowles, Head of HR Services, was in attendance to respond to the E-Rostering and Medical Bank review which had received a 'Partial Assurance' rating. Mr Hussain outlined the headlines from the report, also referring to the outstanding actions from the previous report and outlined the high priority recommendation. Mr Hussain understood that work was in train to address the issues identified but was not yet complete.

Mrs Hawkard asked Mrs Knowles to take the Committee through the actions starting on page 6 of the report and this was duly done, with Mrs Knowles outlining where actions were now complete or in progress. It was highlighted to the Committee that there were a couple of management actions that Mrs Knowles was not aware of as she was not the responsible owner on the RSM action tracker system and the Committee discussed this and where there were multiple stakeholders for actions who had overall responsibility. It was agreed that every report should have a responsible 'owner' to ensure all actions were followed up and that this role should be assisted by Mrs Thompson and Ms Stevenson were necessary.

Mr Robson highlighted that this was the second report on Doctors with concerns raised and queried who was generally responsible for the management of Doctors (not just implementing management actions from internal audit reports). Mrs Knowles responded to advise that the Medical Staffing team was not there to line

manage junior doctors and referred to introducing a line management model for them through the Employee Services Centre (ESC) for sickness but added that the ESC do not undertake return to work interviews. Mr Bond commented that it was not the responsibility of the Medical Staffing team to manage doctors on a daily basis, adding that hopefully in the coming weeks as the Health Group structure is devised, the clinical managers job descriptions should be very clear on their management responsibilities. Mrs Knowles stated that the Health Groups need to consider who will take on the management of Doctors. The Committee to be updated further by Mrs Knowles following the restructure, around April 2024.

Action: Helen Knowles

Mr Hussain commented that the roll out of E-Rostering to Doctors should help maintain discipline and asked how many areas it had been rolled out to already. Mrs Knowles responded to say that progress had been made but the ability for time input due to industrial action had been problematic and there was some way to go, adding that there had also been a turnover of staff in the Medical Staffing team.

It was agreed that this issue would be escalated to the Trust Board but with assurance received that it was progressing. Mrs Knowles stated that she was proud of her team but stated there was more to do. The Committee to be updated further on progress in due course.

Action: Helen Knowles

Mrs Knowles was thanked for attending and left the meeting.

Mr Hussain outlined the key findings from the Learning from Serious Incidents review, which they had been asked to undertake as a critical friend, receiving a 'Reasonable Assurance' rating. Mr Hussain stated that work was in train during the transition process to the new Patient Safety Incident Response Framework (PSIRF).

Mrs Hawkard noted that some actions should have been completed in line with the timescales agreed in the report and Mrs Thompson advised that she would check with the Head of Patient Safety and report back to the Audit Committee members. Mr Robson reiterated the importance of ensuring actions are completed.

Action: Rebecca Thompson

Mr Hussain referred to the third audit report in his progress report, the review of Emergency Preparedness, Resilience and Response (EPRR) which received 'Substantial Assurance'. Mr Hussain commented that this was a positive review overall and that the Trust demonstrated meeting 32 of the 35 core standards, hence the assurance rating applied.

It was noted that the overall EPRR plan would go to the Performance and Finance Committee in November 2023.

6.2 Follow Up of Internal Audit Management Actions

Mrs Hawkard commented that there were still a lot of management actions outstanding on the report received. Mr Bond stated that he had hoped to see fewer but that through working with Mr Hussain and his team, Mrs Thompson and Ms Stevenson that managers would be aware they needed to be cleared by the end of the calendar year.

It was noted that a number of actions were assigned to staff who had left the Trust and it was queried if the Chief Nurse was aware she had these to review. The question was also posed as to whether or not all those remaining were still relevant.

Mr Bond advised that he would pick up the issue of the six high recommendations and stated that he did not expect to see the same number of overdue recommendations at the next Audit Committee meeting in January 2024. All overdue management actions were being actively followed up.

Mr Hussain advised that a further twelve actions had been closed off since producing the report for the Audit Committee papers. Mrs Hawkard expressed concern at the level of overdue actions relating to the Data Security and Protection Toolkit (DSPT) review and Mr Bond suggested that these could be picked up later in the agenda when the Trust's Information Governance Lead was in attendance.

6.3 Fit and Proper Persons Test (FPPT) Framework – Audit Requirements
Mrs Hawkard advised that the paper was here for the Committee to consider the timing of the internal audit required under the new FPPT Framework. Mrs Thompson informed the Committee that the new requirements would commence with all new Board appointments and confirmed that the annual declaration was due to be submitted to NHS England (NHSE) by 31 March 2024.

Mr Bond questioned whether or not External Audit would want to see this for their 2023/24 audit, but Mr Collins confirmed that they would not be doing any additional work in relation to this.

After discussion it was agreed that Mrs Thompson would do the necessary internal work on the FPPT Framework requirements and then Internal Audit would schedule in a review for April 2024 as part of the 2024/25 Internal Audit Plan, and this would be the first of the required three yearly reviews. The audit report would then provide the required independent assessment for the Board.

Action: Mr Hussain

7 Counter Fraud (Counter Fraud Plus (CFP))

7.1 LCFS Progress Report
The Committee received a routine progress report from the Trust's Local Counter Fraud Specialist (LCFS) outlining proactive and reactive work performed since the previous meeting in July 2023. Mrs Foley highlighted some key points for the Committee including a national intelligence bulletin relating to secondary employment; three fraud prevention notices (FPN's) issued by the NHS Counter Fraud Authority, the latest national headline figure on fraud vulnerability to the NHS (£1.264billion) and three new fraud referrals received.

Mrs Hawkard queried how checks were done for ward staff in relation to one of the FPN's involving impersonating a medical professional and Mrs Foley responded to explain the process.

Mrs Hawkard commented that it was a really good report, adding that the Committee's lack of questions was not because of lack of interest but that everything was contained within the report.

7.2 Local Counter Fraud, Bribery and Corruption Policy and Response Plan
Mrs Foley informed the Committee that the policy was at the meeting for approval. Mrs Hawkard commented that it was a very comprehensive document and suggested inclusion of the Local Security Management Specialist (LSMS) in the FAQ section and also some examples in the dissemination section.

Mr Bond queried about how to get the message across to staff, etc. noting the importance of the awareness message and Mrs Foley responded to outline all the

different ways of raising awareness including, but not limited to, using the valuable support of the Communications team for awareness articles, through intensified awareness activity during the dedicated Fraud Awareness Month (FAM) and measuring awareness through the staff survey.

Mr Robson raised the issue of corruption being much harder to identify due to culture issues within departments and suggested it needed a higher profile in awareness material. The issue of making fraud awareness eLearning mandatory, as it is at Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and with a high compliance rate achieved (over 90%), was discussed and the need for consistency across the two organisations in the Group.
Mrs Hawkard thanked Mrs Foley for her comprehensive reports and for being so enthusiastic in her role.

Decision: The Committee approved the policy subject to the inclusion of the two minor additions proposed by the Chair.

8 Management Reports for Assurance

8.1 Single Source Waivers and Contract Renewals

Mr James advised that the report was the half yearly update showing the numbers against each of the eight different types of waiver, although highlighting that category E was the most used. Mrs Hawkard queried the waiver under CEO approval and why this would be, and Mr Bond asked Mr James to circulate the details to the Committee members. The Committee also discussed the non-compliant waivers.

Mr James was intent on reducing the number of waivers particularly for computer equipment.

Post meeting note: Mr James supplied the details of CEO waiver and further information on the non-compliant waiver extensions to Ms Stevenson via email after the meeting and this information was duly circulated to the Audit Committee members.

Mr James updated the Committee on the new light touch regime and the waivers by Care Group, before turning to the summary which showed that the number and value of waivers was down this year compared to 2022/23.

The Committee agreed with the recommendations at the end of the report, with Mr Robson querying whether items referred to in the second recommendation would have been through the procurement processes first and Mr James confirmed this to be correct, items would still follow the procurement process.

Mr Robson commented that it was a very good report and useful for the Committee to have.

The Committee then took item 8.5 next given that Mrs Meakin had arrived in the meeting.

8.5 IG Committee Highlight Report

Mrs Meakin advised the Committee that the report was in a different format with a view to moving towards the Committees-in-Common (CIC) approach and aligning with NLAG. She added that there was lots going on and acknowledged the number of audit management actions that needed following through which she was working with Tony Deal on to ensure all were reviewed and actioned accordingly. Mrs Meakin referred to the IT consultation and the fact that action owners may change in

the next couple of months as a result. Mrs Meakin also advised there is now a dedicated IT group with oversight of all audit actions.

Mr Bond commented that it was good to know that a dedicated group was overseeing the actions and referred to the concerns raised by Mrs Hawkard earlier in the meeting in relation to the DSPT overdue actions. Mr Bond went on to add that Shauna McMahon was due to leave the organisation very soon and that the Group CEO had asked him to resume his SIRO role until further notice. Mr Bond asked who the IG Committee Chair was as present and Mrs Meakin advised that it was Alistair Pickering.

Mr Bond stated that he wanted the Audit Committee members to take assurance from the work going on but also commented that access to records still concerned him and asked Mrs Meakin if the Trust was on the right lines regarding IG awareness with staff. Mrs Meakin responded to say that the new FairWarning system was being implemented (as it is at NLAG) which will flag, not stop, when systems are accessed potentially inappropriately and gave examples of the types of monitoring reports that can be built. Mrs Meakin stated that they would need to exercise some caution with the building of reports so as not to overload the alert monitoring process as they could need more staff for monitoring purposes if too many alerts are built in.

Mr Robson stated that it was a very good report which he took a lot of assurance from. However, he referred to the topic of Subject Access Requests (SARs) on page 7 of the report and noted the poor compliance rates with the response deadlines. Mrs Meakin advised that they were looking at how they work at both HUTH and NLAG to see if the two teams are working differently and that she would be talking to the SARs team to try and understand why deadlines were not being achieved.

Mr Robson asked a question relating to back-ups and Mrs Meakin clarified that they were being done, it was that they were missing the documentation that the Auditors expect to see.

Mrs Hawkard commented that the report comes to each meeting of the Committee and therefore they would be able to see progress being made.

Mrs Meakin was thanked for her attendance and left the meeting.

The Committee returned to the sequence of the agenda.

8.2 Review of Losses, Special Payments and Write Offs – Q2 2023/24
Mr Bond advised that dentures and hearing aids continued to be a problem. It was noted that as hearing aids also become smaller they are easier to lose and more expensive to replace. Work continues with ward teams to try to minimise all such losses.

The Committee noted the report.

8.3 Review of Credit Card Expenditure
Mr Bond advised that the routine report was here for historical reasons, and that there were no issues generally but asked Ms Stevenson to provide an update on the position with the IT credit card usage.

Ms Stevenson advised that Procurement and IT colleagues had met to agree a process for transferring IT suppliers over to purchase orders to negate the need for large volumes of credit card transactions, and this new process would involve the setting up of catalogues for IT equipment for goods frequently ordered to make the

process as quick and easy as possible. The extent of credit card purchases by the IT team should therefore be considerably reduced going forward once the new process was up and running. Ms Stevenson advised that Tony Deal would be at the next meeting in January 2024 for an update on cyber security arrangements and would be able to update more fully on the position with this.

Mrs Hawkard raised a query around oversight of visa's for international staff and Mr Bond responded to explain the process.

8.4 Review of Debts >£50k and over 3 months old
Mr Bond informed the Committee that he had no issues with the two items shown on the report, explaining that the Financial Accounting team monitor such items throughout the year and will periodically write off those that have been through a robust process.

There were no questions from the Committee and the report was noted.

8.6 Annual Review of SFI's and Standing Orders
Mr Bond advised the Committee that the Group CEO had requested he bring together a consistent set of SFI's and Standing Orders for the Group. Mr Bond went on to say that this was slightly tricky still at this stage as there was a need to understand the reporting hierarchy in terms of posts and committees/groups, etc. He added that the role of Board sub-committees requires discussion to ensure clarity as at NLAG they are assurance committees only whilst at HUTH for example the Finance and Performance Committee can authorise changes to the capital programme. Mr Bond advised of the expectation that the number of Health Groups would be finalised by the end of the week, and that there would hopefully be something different to update on at the next meeting.

9 Minutes from other Board Sub-Committees

Items 9.1 to 9.4
The Committee reviewed the minutes from the Performance and Finance Committee (Item 9.1), Quality Committee (Item 9.2) and the Workforce, Education and Culture Committee (Item 9.3). There was no meeting of the Charitable Funds Committee (Item 9.4). Mrs Thompson explained that the minutes were provided for assurance that the other Board sub-committees were operating as they should, not for going through in detail during the meeting.

A discussion took place as to who was covering the Quality Committee in light of Directors absences, and Mr Bond advised that there needed to be clarity to ensure items including audit actions did not get missed in the interim and to ensure accountability is maintained. Mr Robson advised that he would raise it at the Quality Committee meeting.

Action: Mike Robson

9.5 Quality and Remuneration Committee's Half Yearly Update
Mrs Thompson advised that this was the routine six monthly update and there were no issues to report.

The Committee noted the update.

9.6 Board Assurance Framework (BAF) and Corporate Risk Register (TB item)
Mrs Thompson explained that the BAF goes to all Board sub-committees and a report goes to every meeting of the Trust Board now (previously a quarterly report). Mrs Thompson advised it would all be changing significantly and the new Risk and

Assurance Committee (an operational committee made up of Executive Directors) would have oversight of the BAF.

Mr Bond suggested that there should be a review of the management arrangements at a future meeting of the Committee to ensure that the Committee was content there were no gaps. To be added to the workplan for the April 2024 meeting.

Action: Sally Stevenson

Mrs Hawkard commented that the BAF was full of information but was difficult to get a grip of as it lacked metrics which could show progress or deterioration, adding that she was pleased to hear that Executive Directors would make up the Risk and Assurance Committee. Mrs Hawkard stated that change and transition does create risk and things can often get missed.

The Committee noted the report and update from Mrs Thompson.

10 Private Agenda Items

None.

11 Any Other Business

11.1 CIC Update and Schedule of Audit, Risk and Governance Committee CIC Meetings 2024/25

Mrs Hawkard advised there was a meeting scheduled for 7 November 2023 to discuss the Audit Committee becoming a Committee-in-Common (CIC) and further details would be known and understood following this, including the issue of who chairs CIC's and potential legalities around this. Ms Stevenson advised that she had queried the issue of an Audit Committee being a CIC initially and that Wendy Booth, Interim Governance Advisor at NLAG, had checked and confirmed that it could be one.

The schedule of meeting dates for the Audit, Risk and Governance Committee (as it will be known from January 2024) was provided for information. Meeting invites have been issued to all members/regular attendees from a new central email address.

12 Matters for Escalation to the Trust Board

Items for the report to the Board, identified during the course of the meeting, were of a routine nature.

13 Matters for Escalation to other Board Committees

Mr Robson took an action to establish who was covering the Quality Committee in the absence of the existing Executive Lead (Item 9).

14 Audit Committee Workplan – For Information

Information only item.

At this point the Internal and External Audit representatives withdrew from the meeting to allow for a private discussion around the future provision of the External Audit service.

15 External Audit Contract – Future Provision

Mr Bond advised the Committee that the existing contract with Mazars was in its extension year and their audit of the Trust's 2023/24 financial statements would be their last audit under the existing contract. A tendering exercise would therefore

commence in November 2023 using a procurement framework and this would be a two year contract with the option to extend for a further two years to align with the NLAG External Audit service contract.

Mr Robson asked if the tender was for the Group or just HUTH and Mr Bond confirmed it would be just for HUTH. Mrs Hawkard asked for information about the Group structure to be included in the tender specification. *Post meeting note: Information regarding the Group structure between HUTH and NLAG was duly included in the tender specification.*

Decision: *The Committee approved the tendering process and acknowledged that members would be part of the process in the new year.*

16 Date and time of the next meeting:

Thursday 25 January 2024, 9am – 12.30pm via MS Teams
Inaugural meeting of the Audit, Risk and Governance Committees-in-Common.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)030

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Simon Parkes, Non-Executive Director / Chair of NLAG Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Results of NLAG Audit, Risk and Governance Committee Annual Self-Assessment Exercise**
Executive Summary	The annual self-assessment exercise has been conducted by the Northern Lincolnshire and Goole NHS Foundation Trust Audit, Risk and Governance (ARG) Committee. The updated draft self-assessment document for 2024 was reviewed by the following, with comments/suggestions duly incorporated as necessary: 1. Simon Parkes – NED / ARG Chair 2. Gill Ponder – NED / ARG Member 3. Kate Truscott – NED / ARG Member 4. Lee Bond – Group Chief Financial Officer 5. Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud 6. Wendy Booth – Interim Governance Advisor 7. Chris Boyne – Deputy Director, Audit Yorkshire (Internal Audit) 8. Brian Clerkin – Managing Director, ASM (External Audit) The results of the latest exercise, approved for submission to the Board by the ARG Committees-in-Common at its meeting on 25 January 2024, are recorded on the attached checklist. No deficiencies were identified in the review of the Committee's processes. The Committee use the Healthcare Financial Management Associated (HFMA) NHS Audit Committee Handbook (2018) self-assessment checklist for this annual exercise. The HFMA have advised that a full updated Handbook is scheduled to be published in February 2024. **The Trust Boards-in-Common are asked to note the results of the latest self-assessment exercise performed by the NLAG Audit, Risk and Governance Committee in January 2024.**
Background Information and/or Supporting Document(s) (if applicable)	HFMA NHS Audit Committee Handbook (2018)
Prior Approval Process	Audit, Risk and Governance Committees-in-Common – 25 January 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:

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Audit, Risk and Governance Committee

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

25 January 2024

Area/ Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?	√		Latest version available on the Trust intranet. Last approved by the Audit, Risk and Governance Committee (ARGC) in February 2023 and ratified by the Trust Board in April 2023. New Terms of Reference (ToR) produced for the introduction of Committees-in-Common in January 2024, signed off by the Board in December 2023.
Are the terms of reference reviewed annually?	√		Part of the Committee's annual work plan, and also adjusted as necessary in the intervening period. See above details also.
Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The Committee's ToR specifically refers to how it integrates with other Board sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of action logs and highlight reports at each meeting of the Committee, and identifying any issues that the Committee feel further assurance is required on. Additionally, there is formal ARGC member representation on each of the Board sub-committees.
Are committee members independent of the management team?	√		The Committee's membership comprises three Non-Executive Directors.
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Minutes and highlight reports submitted to the Trust Board. Chair of ARGC presents highlight report at TB (as do all other sub-committee Chairs). Highlight reports also submitted to the Governor Assurance Group (GAG) for oversight and assurance and the Lead Governor prepares a Highlight

Area/ Question	Yes	No	Comments/Action
			Report from the GAG to the Council of Governors (CoG).
Does the committee prepare an annual report on its work and performance for the governing body?	√		Annual report submitted to the Trust Board and CoG for information.
Has the committee established a plan of matters to be dealt with across the year?	√		Formal ARGC work plan first adopted in 2012, reviewed annually thereafter and any ad-hoc changes made as necessary in between. Rolling twelve month work plan adopted in July 2020. Last annual review conducted at February 2023 ARGC meeting. New workplan developed for the introduction of Committees-in-Common in January 2024, signed off by the Board in December 2023.
Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with ARGC ToR – 7 calendar days before each meeting.
Has the committee been quorate for each meeting this year?	√		Five scheduled ARGC meetings during 2023 (Feb/Apr/Jul/Nov/Dec) and all were quorate.
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through Internal Audit annual review. The Committee also routinely receives and reviews the BAF and Strategic Risk Register report at each meeting. The BAF is to be revised in light of organisational change and the move to a Group structure, and the Committee will be briefed on progress.
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other Board sub-committees. As from April 2017 the Committee has received a regular report on the BAF and Strategic Risk Register for oversight and scrutiny purposes.
Has the committee reviewed the accuracy of the draft annual governance statement?	√		ARGC minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
Has the committee reviewed key data against the data quality dimensions?	√		***New question in 2018*** - The Trust's Data Quality Strategy was refreshed and submitted to the July 2019 meeting of the ARGC for review/comment. The Committee receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan. Specific data quality audits have been added to the Internal Audit work plan since 2022/23 and these will continue to be included each year on a cyclical basis.
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Report and Accounts. The Committee received the draft accounts for review prior to submission to the External Auditor and NHSE. The Committee also received the audited accounts for review prior to formal approval by the Trust Board in December 2023 (issues with appointing an External Audit delayed the audit of the Trust's financial statements and the December deadline was agreed with NHSE).
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor and discussion at Committee meetings.
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Normally in June, prior to submission to NHSE, but in 2023 it was in December due to the delayed appointment of an External Auditor.

Area/ Question	Yes	No	Comments/Action
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. The Audit Completion Report includes explanations for any areas of non-adjustment. None identified in the 22/23 audit.
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Formal Internal Audit Charter and Internal Audit Working Protocol with Internal Audit Provider (currently Audit Yorkshire).
Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual plans are approved prior to the beginning of each financial year. Any changes to the plan are documented and approved through IA progress reports to each ARGC meeting as necessary.
Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		2023/24 plan derived from Internal Audit's individual discussions with Trust Executive Directors, followed by discussion of the draft plan at an Executive Team meeting(s) and then submission to the ARG Committee for review and final approval. Additionally, the Committee may suggest items of concern for consideration of inclusion in the annual internal audit plan.
Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting.
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting.
Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in ARGC ToR.
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Could be raised at the annual private meeting (November 2023) between the auditors and the Committee, or by calling an ad-hoc private meeting at any time or during Committee meetings if such an issue arose.

Area/ Question	Yes	No	Comments/Action
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		Audit Yorkshire's work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual which ensures a consistent approach and compliance with all relevant regulatory standards. In addition, they use an Internal Audit Quality Assessment Framework biennially and an external review every five years to objectively assess the quality of their service. Audit Yorkshire agreed with their Board to perform a self-assessment in 2019/20 to confirm compliance for the organisation and this external review was duly undertaken by CIPFA in February 2020 with the following outcome: *'It is our opinion that Audit Yorkshire's self-assessment is accurate and, as such, we conclude that Audit Yorkshire FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards.'*
Does the committee receive and review the head of internal audit's annual opinion?	√		ARGC minutes will evidence this.
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	√		ARGC minutes will evidence this. Due to the issues with appointing an External Auditor this document was circulated to Committee members via email in October 2023 and submitted for noting at the November 2023 ARGC meeting.
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		ARGC minutes will evidence this.
Does the committee review the external auditor's value for money conclusion?	√		ARGC minutes will evidence this.
Does the committee review the external auditor's opinion on the quality account when necessary?		√	No longer a requirement for external audit independent review. However, the Trust's Quality

Area/ Question	Yes	No	Comments/Action
[Note: this question is not relevant for CCGs]			Account was subject to review by Internal Audit and the findings (significant assurance) reported to the Committee in July 2023.
Does the committee hold periodic private discussions with the external auditors?	√		Once a year (normally June before the Audited Accounts meeting – but most recently in November 2023 due to the delayed appointment of the External Auditor) or at any other meeting if requested in advance by the auditors.
Does the committee assess the performance of external audit?	√		Formalised approach adopted in July 2020 with a paper to the ARGC providing a formal annual evaluation of External Audit performance. Last undertaken in July 2022 with the former External Auditor. Issues in the intervening period would be addressed as necessary. Not performed in 2023 due to the delayed appointment of an External Auditor and the completion of their first audit at the Trust in December 2023.
Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit planning/fee documentation.
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work devised and approved in February 2015 and subject to annual review. Revised January 2019 to reflect new NAO guidance on this area and reviewed annually thereafter. Next scheduled review at January 2024 meeting. Details of non-audit work included in the annual ISA260 report from the External Auditor. Value of non-audit work also identified separately in the annual accounts.
Clinical audit [Note: this section is only relevant for providers]			
If the committee is NOT responsible for monitoring clinical audit, does it receive	√		The Quality & Safety (Q&S) Committee are responsible for monitoring delivery of clinical audit

Area/ Question	Yes	No	Comments/Action
appropriate assurance from the relevant committee?			activity. Q&S Committee minutes received by ARGC. 2023/24 Clinical audit annual plan received by ARGC in July 2023 for information.
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A	See above.
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Plan agreed with Group Chief Financial Officer and received by the ARGC for review.
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Counter fraud work plan informed by register of fraud risks, internal audit, Cabinet Office's National Fraud Initiative (NFI), NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA / Cabinet Office.
Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written counter fraud progress reports from the Local Counter Fraud Specialist (LCFS) at each ARGC meeting. LCFS in attendance at each meeting.
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		ARGC minutes will evidence this where appropriate.
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ARGC ToR in relation to the LCFS. The LCFS also meets with the ARGC Chair annually.
Does the committee receive and review an annual report on counter fraud activity?	√		This has always been the case in relation to counter fraud work since 2000.

Area/ Question	Yes	No	Comments/Action
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		ARG Committee minutes will evidence this where appropriate.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)031

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Jane Hawkard, Non-Executive Director / Chair of HUTH Audit Committee
Contact Officer/Author	Jane Hawkard
Title of the Report	**Results of HUTH Audit Committee Annual Self-Assessment Exercise**
Executive Summary	The annual self-assessment exercise has been conducted by the Hull University Teaching Hospitals NHS Trust (HUTH) Audit Committee. The updated draft self-assessment document for 2024 was reviewed by the following, with comments/suggestions duly incorporated as necessary: 1. Jane Hawkard – NED / Audit Committee Chair 2. Mike Robson – NED / AC Member 3. Tony Curry – NED / AC Member 4. Lee Bond – Group Chief Financial Officer 5. Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud 6. Rebecca Thompson – Head of Corporate Affairs 7. Asam Hussain – Director, RSM (Internal Audit) 8. James Collins – Director, Mazars (External Audit) The results of the latest exercise, approved for submission to the Board by the Audit, Risk and Governance Committees-in-Common at its meeting on 25 January 2024, are recorded on the attached checklist. No deficiencies were identified in the review of the Committee's processes. The Committee use the Healthcare Financial Management Associated (HFMA) NHS Audit Committee Handbook (2018) self-assessment checklist for this annual exercise. The HFMA have advised that a full updated Handbook is scheduled to be published in February 2024. **The Trust Boards-in-Common are asked to note the results of the latest self-assessment exercise performed by the HUTH Audit Committee in January 2024.**
Background Information and/or Supporting Document(s) (if applicable)	HFMA NHS Audit Committee Handbook (2018)
Prior Approval Process	Audit, Risk and Governance Committees-in-Common – 25 January 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:

Audit Committee

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

25 January 2024

Area/ Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?	√		Last approved by the Audit Committee in April 2023 and ratified by the Trust Board in July 2023. New Terms of Reference (ToR) produced for the introduction of Committees-in-Common in January 2024, signed off by the Board in December 2023.
Are the terms of reference reviewed annually?	√		Part of the Committee's annual work plan. See above details also.
Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The Committee's ToR specifically refers to how it integrates with other Board sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of minutes at each meeting of the Committee, and identifying any issues that the Committee feel further assurance is required on. Additionally, there is formal Audit Committee member representation on each of the Board sub-committees. The Committee received all risk and control related disclosures through the Annual Governance Statement (AGS) and receives an annual Risk Management update.
Are committee members independent of the management team?	√		The Committee's membership comprises three Non-Executive Directors.
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Summary reports submitted to the Trust Board.
Does the committee prepare an annual report on its work and performance for the governing body?	√		The Trust Annual report (which includes the Audit Committee

Area/ Question	Yes	No	Comments/Action
			annual report) is submitted to the Trust Board.
Has the committee established a plan of matters to be dealt with across the year?	√		Formal AC work plan is agreed annually in April. New workplan developed for the introduction of Committees-in-Common in January 2024, signed off by the Board in December 2023.
Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with the Committee's ToR – 7 calendar days before each meeting.
Has the committee been quorate for each meeting this year?	√		Five scheduled AC meetings during 2023 (Feb/Apr/Jun/Jul/Oct) and all were quorate.
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through periodic Internal Audit review. The Committee also receives the BAF Governance Review annually. The BAF is to be revised in light of organisational change and the move to a Group structure, and the Committee will be briefed on progress.
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other Board sub-committees.
Has the committee reviewed the accuracy of the draft annual governance statement?	√		The Committee endorses the AGS before it is presented to the Board in June each year. AC minutes will evidence this.
Has the committee reviewed key data against the data quality dimensions?	√		The Committee receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan.
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Report and Accounts. The Committee received the draft accounts for review prior to submission to the External Auditor and NHSE. The Committee also

Area/ Question	Yes	No	Comments/Action
			received the audited accounts for review prior to formal approval by the Trust Board in June 2023. Audit Committee minutes will evidence this.
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor and discussion at Committee meetings.
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Part of the Annual Accounts discussions at the June Audit Committee meeting prior to submission to NHSE.
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. Letter of Representation includes explanations for areas of non-adjustment.
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		The Charter is included as an appendix to the annual internal audit plan presented to the Committee in April each year.
Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual and strategic plans are approved prior to the beginning of each financial year.
Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		2023/24 plan derived from Internal Audit's individual discussions with Trust Executive Directors, followed by discussion of the draft plan at an Executive Team meeting and then submission to the AC for review and final approval.
Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting.

Area/ Question	Yes	No	Comments/Action
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		Routine report at each meeting since July 2023.
Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in AC ToR.
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Could be raised at the annual private meeting (October 2023) between the auditors and the Committee, or by calling an ad-hoc private meeting at any time or during Committee meeting if such an issue arose.
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		RSM's UK work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual to ensure continuous improvement, and compliance with all relevant regulatory standards. In addition, the Standards require internal audit providers to have an external review every five years to objectively assess the quality of their service. The RSM UK Risk Assurance service line commissioned an external independent review of their services in 2021, to provide assurance that their approach continued to meet the required Standards, with the following outcome: *'RSM IA 'generally conforms' (highest rating that can be achieved) to the requirements of the IIA Standards…and there were no instances of non-conformance with any of the Professional Standards'.*
Does the committee receive and review the head of internal audit's annual opinion?	√		Audit Committee minutes will evidence this.
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	√		Audit Committee minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		Audit Committee minutes will evidence this. The Audit Completion Report at the end of the financial statements covers the requirements of ISA 260.
Does the committee review the external auditor's value for money conclusion?	√		Audit Committee minutes will evidence this.
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**		√	No longer a requirement for external audit independent review.
Does the committee hold periodic private discussions with the external auditors?	√		Once a year (most recently in October 2023) or at any other meeting if requested in advance by the auditors.
Does the committee assess the performance of external audit?	√		Formalised approach adopted in October 2023 with a paper to the Committee providing a formal annual evaluation of External Audit performance. Issues in the intervening period would be addressed as necessary.
Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit strategy/fee documentation.
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work devised and approved by the Audit Committee in April 2023 and now subject to annual review. Details of non-audit work included in the annual ISA260 report from the External Auditor. Value of non-audit work also identified separately in the annual accounts.
Area/ Question	**Yes**	**No**	**Comments/Action**
Clinical audit [Note: this section is only relevant for providers]			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The Quality Committee is responsible for monitoring delivery of clinical audit activity. Quality Committee minutes are received by the AC. The Clinical Audit Annual

Area/ Question	Yes	No	Comments/Action
			Report was also received by the Audit Committee for assurance (July 2023).
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A	See above.
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Plan agreed with Group Chief Financial Officer and received by the Audit Committee for review.
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Counter fraud work plan informed by register of fraud risks, internal audit, Cabinet Office's National Fraud Initiative (NFI), NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA / Cabinet Office.
Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written counter fraud progress reports from the Local Counter Fraud Specialist (LCFS) at each ARGC meeting. LCFS in attendance at each meeting.
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		Audit Committee minutes will evidence this where appropriate.
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ARGC ToR in relation to the LCFS. The LCFS also meets with the ARGC Chair annually.
Does the committee receive and review an annual report on counter fraud activity?	√		Audit Committee minutes will evidence this where appropriate.
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		Audit Committee minutes will evidence this where appropriate.

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)032

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8th February 2024
Director Lead	Gill Ponder, NED/Chair of Finance and Performance Committee
Contact Officer/Author	Gill Ponder, NED/Chair of Finance and Performance Committee
Title of the Report	Finance and Performance Committee Minutes – December 2023
Executive Summary	The Finance and Performance Committee Minutes from the meetings held in September and October 2023 and subsequently approved at the following months meetings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Performance, Estates and Finance Committees-in-Common - January 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:

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

Finance & Performance Committee

Meeting held on Wednesday, 20 December 2023 from 13:30 to 16:30
Via MS Teams

Present:	Gill Ponder	Non-Executive Director (Chair)
	Ashy Shanker	Deputy Director of Planning and Performance/Interim MD South Bank and Acting COO
	Lee Bond	Group Director of Finance
	Simon Parkes	Non-Executive Director
	Fiona Osborne	Non-Executive Director
In attendance:	Ian Reekie	Lead Governor
	Annabelle Baron-Medlam	Acting Head of Compliance & Assurance (section 5.1)
	Bill Parkinson	Associate Director of Safety & Statutory Compliance
	Richard Peasgood	Executive Assistant to COO
	Georgina Birley	Executive Personal Assistant to COO (for the minutes)

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1. Welcome and Apologies for Absence

Gill Ponder welcomed everyone to the December Committee meeting.

Apologies were received from Shaun Stacey, Group Chief Delivery Officer, Brian Shipley, Deputy Director of Finance, Ab Abdi, Interim Site MD/Deputy COO, Edd James, Director of Procurement, Dr Gavin Anderson, HUTH and NLaG Cancer Lead and James Lewis, Associate Director of Engineering & Estates.

It was noted that the Committee was quorate.

2. Declaration of Interests

There were no Declarations of Interest declared.

3. To Approve the Minutes of the Previous Meeting held on 22 November 2023

The minutes of the meeting held on the 22nd November 2023 were approved with the following changes:

Page 3, last paragraph, change from “Fiona Osborne stated that under section four, risks to deliver CQC improvements plan, the statement not able to evidence progress due to unreliable data appeared multiple times”. The question raised wasn’t reflected so it should read “Fiona Osborne asked if section 4 should now include a risk on the lack of reliable data given this is cited as a risk to delivery against multiple CQC improvement plans.”.

Page 5, 2nd to last paragraph, changed from “Fiona Osborne stated on slide 12 on Same Day Emergency Care (SDEC) the data referred to May and it had improved in June”, should read “Fiona Osborne stated on slide 12 on Same Day Emergency Care (SDEC) the data is stated as May and June however the results differ to the same data presented to the Committee in June. In addition it indicates an improvement, contrary to the presentation.”.

Page 7, 6.4, changed from “Fiona Osborne stated that the Cancer waiting times 104 day backlog continued to be a lowlight month on month with the same action against it”. It missed the question that was asked which was “Fiona Osborne stated that the Cancer waiting times 104 day backlog continued to be a lowlight month on month with the same action against it. She asked if it was time for the Committee to reintroduce Deep Dives with the services.”.

4. Matters Arising

4.1 Action Log

24 05 2023

5.3 – Lee Bond stated there had been a process for evaluation and timetable agreed at Capital Investment Board on 17 October 2023 as part of a regional process for capital investments. For revenue investments, there was a process in place which would be completed in January 2024 and brought back to the Committee then. Action carried forward to January 2024.

23 08 2023

7.1 – Ashy Shanker stated she had spoken with the Emergency Department (ED) team and they could not evidence the role human factors played with ED performance, but actions and best practice models had been put in place. ECIST and GIRFT had visited and not identified areas of concern. It was agreed that the action would be carried forward and the Flash Board Reports would be cross referenced with the ED medical staffing rotas.

20 09 2023

8.3 – To be covered in the main meeting, action closed.

8.5 – The paper had been circulated, action closed.

18 10 2023

6.1 – Gill Ponder stated there had been no Audit, Risk and Governance (ARG) Committee meeting since the last Finance and Performance (F&P) meeting.Action to be carried forward.

6.4 – Gill Ponder stated that the feedback from the Workforce Committee had been presented at the Board Meeting on 5-12-23 and was that there was a strategy in place for the Community Diagnositc Centres (CDC's) staffing and that plans would be monitored by the Workforce Committee. Action closed.

8.5 – Gill Ponder said from the Terms of Reference of the Capital and Major Projects Committee that the Business Planning Timetable was now part of that Committee's Terms of Reference. Lee Bond stated that he would confirm which Committee would be responsible for Business Planning in future with Wendy Booth. Action reassigned to Lee Bond and carried forward.

22 11 2023

5.1.1 – Fiona Osborne stated this action had been discussed at the Quality and Safety (Q&S) Committee and had been assigned to the Quality Improvement (QI) team. Action closed.

5.1.2 – The information was not provided to Annabelle Baron-Medlam prior to the meeting. Action carried forward to January 2024.

6.2 – This action was a duplicate of action 7.1, so was closed.

6.3 – Completed and action closed.

6.4 – To be covered in the main meeting. Action closed.

6.5 – Gill Ponder confirmed that the paper had been amended before being discussed at Trust Board. Action closed.

4.2 Terms of Reference (ToR)

The Committee noted the Terms of Reference and that they were being rewritten due to the new Group Committees in Common.

4.3 2023-24 F&P Committee Workplan V4

A new Workplan would be produced to align with the revised Terms of Reference for the new Group Committees in Common.

4.4 Action Plan

Gill Ponder confirmed most items on the action plan had been completed and anything that had not would be overtaken by the new arrangements for the Committees in Common structure from January 2024.

5. Presentations for Assurance

5.1 CQC Progress Report

Annabelle Baron-Medlam stated that there had been an increase in actions rated with full compliance, with zero actions rated no assurance, 22 with limited assurance but no changes to actions linked to this Committee. She stated that the Goole Midwifery Led Unit had been visited by the Care Quality Commission (CQC) and it had been a positive visit.

Gill Ponder observed there had been no updates on actions linked to this Committee for some time. Annabelle Baron-Medlam stated she would work with her team and the divisions to review those actions and assurance ratings and how they could be amended to show the improvements made.

Action: Annabelle Baron-Medlam to report on revised updated actions linked to this Committee at the next meeting.

6. Estates & Facilities (SO1.4)

6.1 LV/HV

Bill Parkinson stated the generator site wide tests had identified gaps in the Uninterrupted Power Supplies (UPS) and the Trust was undertaking feasibility studies to assess how they could be replaced. There were issues with the back up diesel generator, CSSD1, with a plan to replace it but to mitigate the risk a generator had been hired at a high monthly cost. The UPS in the IT main server room at Scunthorpe General Hospital (SGH) needed to be replaced, at a cost of £88k, due to it being on the verge of failing. Black starts were required to be carried out on the generators at SGH which would require a major shutdown. Due to uncertainty of power restoring after the shutdown, the feasibility was being assessed by an external contractor. In the meantime, black starts were being simulated.

Simon Parkes asked how confident they were that the generators would work if a black start test was carried out. Bill Parkinson confirmed that the concerns were if the main power was shut off, it might not turn on again, not that the generators would not work.

Fiona Osborne asked in regard to the UPS if the risk was being developed by the estates and clinical teams and why it was not on the risk register before as it had been discussed at previous F&P meetings. Bill Parkinson confirmed it was on the action log, but the entry would be updated to make it clearer.

Action: Bill Parkinson to update the risk register with the UPS issues.

Fiona Osborne stated that she was frustrated with the number of actions that were marked as completed and closed, but the narrative stated differently, with an example of 285198 stating staff were aware of the fault and it had been closed but

no action had been taken to repair the fault. Bill Parkinson stated the action should state the work was linked to the roof repairs that were needed and that it was closed due to pressures on them to close Ulysees items. Gill Ponder added that patient and staff safety concerns should be addressed and updating the issues log by closing the Ulysees action or closing it by stating that there was not enough money available to do the work was not the right thing to do. Those issues should remain open and visible until the work had been completed.

Gill Ponder asked about the issues with Nurse call bells, as there were a number of entries that stated that they had not worked in emergency situations. The call bell risk remained open and Lee Bond confirmed it needed to be resolved if was an ongoing risk. Bill Parkinson confirmed the IT UPS had been ordered and was awaiting delivery.

Action: Lee Bond and Estates and Facilities team to review the clinical risks arising from items on the action log.

Gill Ponder asked if the Trust had applied for more funding to complete the borehole drilling that had been started at SGH to improve the heating by using natural resources. Lee Bond stated that a funding bid had been submitted but had been unsuccessful.

Action: Lee Bond to find out if the Trust had applied for further funding to access the heat sources identified by the previous work drilling the boreholes.

6.2 Assurance Confirmation & Board Highlights

Gill Ponder summarised the highlights to Board to be the UPS gaps , along with the generator replacement plans. The server room major issue and inability to do a black start, along with the mitigations, would also be highlighted. Also, concerns about patient and staff safety issues and clinical risks arising from the action log that came to the Committee, as risks were presented but recorded responses to logged issues were not reducing the risk significantly. The clinical risks of logged issues would also be reviewed to see if any items needed to be prioritised for funding allocation.

7. Review of NLaG Monthly Performance and Activity Delivery (IPR) (SO1.2 / SO1.6)

7.1 Unplanned Care

Ashy Shanker stated that ambulance handovers over 60 minutes had seen a positive decrease to 318 for November, but missed the target and handovers of 30-60 minutes decreased to 416. ED four hour performance had improved to 76% but missed target, Urgent Care Service (UCS) waiting time hit target with 99.2%, which was a small decrease, ED attendance decreased to 14,469 and UCS attendance also decreased to 5,624. Patients that waited over 12 hours without a decision to admit or discharge decreased to 352 but missed target and patients waiting over 12 hours from decision to admit to ward admission decreased to 687 but missed target. Patients discharged on the same day decreased to 43.8%, inpatient length of stay remained on target at 2.0, with patients on an extended stay all decreased and hitting target. Bed occupancy figures stated it had

decreased however there had been issues with the accuracy of bed reporting, but those had been resolved the day before the meeting and the data was being checked to confirm accuracy. Once confirmed, that would allow escalation beds and bed occupancy numbers to be monitored more closely.

Fiona Osborne stated that the 30-60 minute handover figure had reduced but it was still above the mean range and asked if the latest information showed it coming down further, given the current focus on ambulance handover times. Ashy Shanker stated with the Integrated Acute Assessment Unit (IAAU) and the frailty pathway going live at SGH, that would create space to move patients out of ED, improve congestion and create improved flow.

There was a focus on discharging patients before 12:00 and having daily consultant led ward rounds. Junior doctor industrial action (IA) did not affect performance significantly due to the Trust already being highly dependent on senior staff. Lee Bond stated that the IPR referred to ED waiting times and not the new targets the Trust had signed up to. Gill Ponder added she would like to see the trajectories requested previously to show how the Trust was set to perform in the coming months against the recent reset targets that the Trust had accepted.

Action: Lee Bond to discuss with the relevant directors to improve the IPR to base it on current targets and add in trajectories for the next meeting.

7.2 Planned Care

Ashy Shanker stated advice and guidance (A&G) had increased to 10%, Cancer Two Week Waits (2WW) had increased to hit target at 96.3%, Cancer 28 day performance had increased to hit target at 75% and Cancer request to test 14 days had missed target at 86.5%. The Cancer 62 day GP referrals had missed target and decreased to 41.9%. Due to national reporting changes, the Cancer backlog of 62 days had decreased to 104 patients and the backlog of over 104 days had increased to 34 patients.

The 18 week complete Referral to Treatment (RTT) had decreased to 60.9%, incomplete RTT pathways had positively decreased to 40,380 and incomplete RTT pathways of 52 weeks had decreased to 792. A priority was to decrease the number of incomplete RTT pathways over 65 weeks. Outpatient overdue follow ups not RTT had positively decreased to 37,294. Virtual outpatient follow up appointments had decreased to 22.2% but overall the Trust was seeing less follow ups and outpatient appointment did not attend (DNA) rates had decreased to 6%. PIFU follow ups had improved to 4.4%.

There was an issue withtheatre utilisation data as internally the data suggested that it was around 80% but when the data was sent to the national team the way they interpreted it adjusted it to circa 50%. The Get It Right First Time (GIFRT) team confirmed they agreed with the Trust's data and suggested improvements on how it was recorded, but it was not wrong. York and Scarborough Trust also had the same problem. Lee Bond stated that it was due to a data quality issue on how the Trust adjusted the theatre list times and when it was sent externally they removed the whole list.

Fiona Osborne stated it was frustrating to only just hear about the theatre utilisation data issue when it was known about before the IPR was created. Ashy Shanker stated the issue was known but the reasoning was not, hence why it was not included.

Action: Ashy Shanker to ensure that further information on the theatre utilisation data issue was included in the next IPR.

Gill Ponder stated that the end of life equipment being shared between sites was affecting theatre productivity and resulting in cancelled lists according to the IPR narrative and asked what the equipment was, the costs of moving it between sites, if moving it was shortening its life span, the cost of the lost sessions and what could be done to improve the situation.

Action: Ashy Shanker to find out what end of life equipment was being shared between sites, the cost of moving it and lost theatre sessions and the cost to purchase additional equipment to have it at each site.

7.3 PCIP – to include a deep dive into Cancer standards

Fiona Osborne stated on page 9 and 10, under Elective Recovery Funding (ERF), it showed that Surgery and Critical Care (SCC) were propping up the Trust total. Ashy Shanker agreed due to the fact that the majority of income generating activity came from that Division. In Medicine, there were a mixture of issues with vacancies and lack of referrals.

The backlog of Cancer patients had plateaued but the Trust was working on reducing them by putting on additional sessions and looking at what support was needed from HUTH and making sure the Inter Patient Transfers (IPTs) were done in a timely manner. To reduce the backlog of patients waiting for urology prostate biopsies, input from E&F was needed to create clean rooms to free up theatres. A fortnightly meeting was taking place with HUTH to reduce the cohort. Gill Ponder stated that if clean rooms were the only thing needed to reduce that cohort of patients and the funding was available, it should be prioritised by E&F. Lee Bond stated that he was not aware of the issue.

Action: Ashy Shanker and Lee Bond to discuss the benefits of the clean rooms, the funding available and whether the work could be prioritised by E&F to improve the service to patients.

Fiona Osborne pointed out the variation of the Cancer backlog of 104 day waiters data. Ashy Shanker stated it was due to reporting changes and that she was aware of the need for it to improve so the Trust could identify if it was a trend.

Fiona Osborne stated on slide 6, by Cancer site, lung percentage of patients over 104 days was a significant percentage of the overall total number of patients. Denise Gale stated that this was due to the lack of Consultants and that the Trust had tried to recruit additional Consultants and had successfully recruited one, but they were now leaving. Also contributing was the difference in how the patients were managed at SGH and Diana, Princess of Wales Hospital (DPoW), the change with the lung health check programme and the large amount of Consultant upgrades. There were also issues with workforce shortages at Hull University

Teaching Hospitals (HUTH) resulting in a high risk, but there had been £371k of Cancer Alliance slippage which had been used to agree locum cover in lung from January to March 2024.

Simon Parkes stated that there was only a small number of Cancer backlog patients waiting over 104 days and that he did not understand why they could not be seen. Ashy Shanker replied that it was due to capacity issues and IA, but Cancer patients were the last to be cancelled as a result of IA. Denise Gale added that the urology longest waiting patients were due to waiting to see an oncologist, but additional sessions were being created and booked for January 2024, using the Cancer Alliance slippage.

Gill Ponder stated that slides 15 and 16 suggested that Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) patients were not being treated equally to HUTH patients. Ashy Shanker confirmed that was not true and, by having the fortnightly meeting, it was helping attendees to understand each Trusts' challenges. Gill Ponder stated in slide 12 that it referred to transferring IPTs to HUTH faster but asked if that helped patients, rather than just making the Trust's performance figures look better. Ashy Shanker stated it was better for the patients as they were not waiting a long time before being transferred to HUTH for review.

Gill Ponder asked, referring to slide 16, what additional equipment was needed to increase capacity for TRUS biopsies and reduce the waiting time from 30 days to 7 days. Denise Gale responded that she had spoken to the division regarding the equipment but no capital was available to make the purchase. They had approached the Health Tree Foundation, but a response had not been received. Gill Ponder stated that she was on the Trustee Committee for the Health Tree Foundation, but had not seen a request for this equipment come to the Committee.

Action: Denise Gale to check if the application to the Health Tree Foundation had been submitted and, if it had, the response received.

7.4 Assurance Confirmation & Board Highlights

The Committee agreed to raise to the Board that there were continued concerns with ambulance handovers, that there were actions in place but they were not improving performance to hit targets, but it was hoped that performance would improve when the frailty pathway had come online, the UCS was 24/7 and IAAU was open in January. The Committee had asked for performance figures against trajectory in addition to the IPR. The Committee would also highlight thatheatre equipment was being shared by sites affecting theatre productivity, the request for a trajectory for the reduction in Cancer patients waiting over 104 days and the possibility of prioritising E&F capacity for clean rooms for prostate biopsies.

8. Review of NLaG monthly Financial position (Finance Report) (SO3.1 / SO3.2b)

8.1 Finance Report M8

Lee Bond stated the Trust's position was slightly better than plan in month and Year to Date (YTD), with a £15.8m deficit, which would become £24.9m on a straightline projection before management action., Technical savings and forecast

ERF over-performance would bring the position to the £13.4m planned deficit. The system had a deficit of £63m, which should be £30m by the end of 2023/24. The Trust's underlying deficit position was £51.1m.

Capital expenditure was behind on the YTD plan due to slippage of the IAAU developments, but once the invoices were paid that would improve the position. There were concerns about the amount of cash required for the two CDC's and Digital plans and the Trust were in the process of collating revised cash flows and agreeing a revised capital programme for the year. The Trust would likely need cash support in M1 of 2024/25 so would start the request process once the month 9 figures were confirmed.

The waiting lists remained almost static in month with long waits still being a challenge. Temporary staffing remained a problem having spent £40.7m in the first 8 months of the year. The newly announced IA by junior doctors would have a negative effect due to the cost of covering those staff and the reduction in activity. The other significant risk was bed pressures over Winter.

Gill Ponder observed that vacancies had reduced slightly but there had been no significant reduction in bank and agency staffing spend. Fiona Osborne stated that the amount of bank spend had reduced but the agency spend had not on medical staffing. She asked about the unidentified SIP stretch target and how much of the £10m was due to be identified and delivered by year end. Lee Bond stated it was non-recurrent balance sheet flexibility.

Gill Ponder asked if the long term locum medical staff had been asked to come on payroll. Lee Bond stated that he was not aware but that a lot would not want to due to having to then pay tax via PAYE.

Action: Lee Bond to confirm if locum medical staff had been invited to join the Trust payroll and feedback the response to the Committee.

Lee Bond stated that Jonathan Lofthouse had tasked Dr Kate Wood with ensuring all medical staff did 12 PA's.

Action: Lee Bond to quantify how the reduction of medical staffing PA's would affect the Trust's financial position.

8.2 Business Care Assurance

None discussed.

8.3 Procurement

Lee Bond presented the paper written by Edd James, Procurement Director. There were six workstreams, with four on track and two delayed. All jobs that were advertised had been appointed to. The Trust was visited by the National Supply Chain Chief Executive and he was likely to recormend both York Trust and NLaG for the early adoption of the nationally funded inventory management system. Gill

Ponder stated that she was assured by the report and asked what the value vouchers referred to in the report were and how they could be spent.

Action: Lee Bond to confirm what value vouchers were and how the Trust could spend them.

8.4 Corporate Benchmarking Report

Lee Bond stated the key points were that most areas were not hugely challenged but HR and recruitment were very expensive relative to other organisations, but there were no immediate plans to reduce spend in those areas due to the workforce challenges facing the Trust. Legal costs had also increased. .

Gill Ponder asked if the Trust carried out more clinical audits than it needed to due to the Trust apprearing to be spending more than others.

Action: Lee Bond to confirm the resources involved in the clinical audit team and whether all the audits carried out were mandatory.

Gill Ponder stated that for printers the Trust had gone from being in the top quartile to the bottom and remarked that the Trust should be trying to go paperless. Lee Bond replied that the Trust should be aiming to be paperless, but he was not aware of progress of other Trusts on that.

Action: Lee Bond to confirm with the digital team the number of printers and the plan to go paperless.

Gill Ponder stated that the recruitment cost per Full Time Equivalent (FTE) was high in comparison to others and observed that the apprenticeship levy was not being fully utilised. She asked when the unfilled vacancy review would come back to the Committee. Lee Bond stated the paper had not been to the Group Exec Meeting yet. Gill Ponder also asked if the Payroll FTE costs were high, whether consideration had been given to outsourcing it. Lee Bond confirmed that Simon Nearney, Group People Officer, managed payroll and the costs of the Group payroll production needed to be reviewed to see if outsourcing was a viable option.

Action: Lee Bond to speak with Simon Nearney about attending the next Committee meeting and presenting a combined payroll and HR report addressing the issues from the benchmarking data.

8.5 Assurance Confirmation & Board Highlights

Gill Ponder summarised that the Committee would highlight to the Board the position on Finances for month 8 and the YTD performance, the risks to the financial plan from more industrial action and bed pressures over Winter, the likely request for cash support in Month 1 of 2024/25 and the medical temporary staffing issues. It would also raise the assurance on Procurement and that the benchmarking report had raised a number of areas where there appeared to be opportunities to reduce costs.

9. BAF

9.1 SO3-3.1 Deep Dive

This was covered in agenda items 8.1-8.4.

10. Items for Information (Not For Printing)

11.1 Performance Letters to Divisions following PRIMS Meetings

The Committee noted the PRIMs letters from November 2023.

11.2 Capital Investment Board (CIB) Minutes

The Committee noted the CIB minutes from October 2023.

11. Any Other Urgent Business

Lee Bond stated that the HOLT agency contract was due to be renewed and a paper was due to be presented at Trust Board, but due to the paper not being presented at this Committee first it was removed from the agenda. A temporary contract extension was agreed. The master vendor contract paper would be reviewed at the next Committee meeting in January.

Action: Lee Bond to ensure that the HOLD Master Vendor Contract paper was included on the agenda for January's Committees in Common meeting.

Matters to Highlight to Other Trust Board Assurance Committees

There were no items to highlight to other Committees raised during the meeting.

12. Matters for Escalation to The Trust Board (Public/Private)

Items to be included in the Board Highlight Report were captured at the end of each section of the agenda.

Review of Meeting

Gill Ponder stated that it was Fiona Osborne's last Committee meeting before leaving the Trust and thanked her for her support and valuable contribution to the Committee. Gill Ponder confirmed the new Committees in Common from January would include two NED's from each Trust. .

Fiona Osborne responded that the meeting had been good and challenging. Although some of the areas discussed highlighted some lack of assurance, the problems were recognised and actions were being taken to improve performance.

Simon Parkes stated that it would be a long time before the data issues would be resolved but overall it was a good meeting. He thanked Gill Ponder for chairing the Committee and hoped that the new Committees in Common would give more opportunity to discuss the issues that needed addressing across the Group.

13. Date and Time of the Next Meeting

The next meeting would take place as follows:

Name: **Performance, Estates & Finance Committees in Common**
Date: 24 January 2024
Time: 09:00-12:30
Venue: Main Boardroom, DPoW

Annual Attendance Details:

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Gill Ponder	√	√	√	√	√	x	√	√	√	√	√	√
Fiona Osborne	√	√	√	√	√	√	X	√	√	X	√	√
Lee Bond	√	√	√	x	√	x	√	√	√	X	√	√
Jug Johal	√	√	√	√	√	x	X	√	√	√	√	X
Shaun Stacey	√	√	√	√	√	√	√	√	√	X	X	X
Ian Reekie	x	√	√	√	x	√	√	√	√	X	√	√
Richard Peasgood	√	√	√	√	√	√	√	√	√	√	√	√
Simon Parkes	x	x	√	√	√	√	√	√	√	√	√	√
Brian Shipley	√	√	x	√	x	√	√	√	√	√	√	X
Annabelle Baron-Medlam	√	√	√	√	√	√	√	√	√	√	√	√
Abdi Abolfazl	√	x	x	√	x	x	√	X	√	√	X	X
Ashy Shanker	x	√	√	x	x	√	√	√	√	X	√	√
Shiv Nand	√	x	x	x	x	x	X	X	X	X	X	X
Dr Peter Reading	x	√	√	x	x	x	X	X	X	X	X	X
Linda Jackson	x	x	x	x	x	√	x	X	X	X	X	X
Craig Hodgson	x	x	x	x	x	√	√	X	X	X	X	X
Kate Truscott	x	x	x	x	x	x	√	X	X	X	X	X
Sue Liburd	X	X	X	X	X	X	X	X	X	√	X	X
Georgina Birley	X	X	X	X	X	√	√	√	√	√	√	√
Matt Overton	X	X	X	X	X	X	X	X	X	√	√	X
Adam Creegan	X	X	X	X	X	X	X	X	X	X	√	X
Bill Parkinson	X	X	X	X	X	X	X	X	X	X	X	√
Denise Gale	X	X	X	X	X	X	X	X	X	X	X	√

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)033

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Mike Robson, Non-Executive Director
Contact Officer/Author	Rebecca Thompson, Head of Corporate Affairs
Title of the Report	Minutes of the HUTH Performance and Finance Committee held 18 December 2023
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 are attached for review
Prior Approval Process	Performance, Estates & Finance Commitees-in-Common - January 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:

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 18 December 2023

Present:	Mr M Robson	Chair
	Mr T Curry	Non-Executive Director
	Mrs J Hawkard	Non-Executive Director
	Mr L Bond	Group Chief Finance Officer
	Mr G Briggs	Interim Managing Director North
	Mrs A Drury	Deputy Director of Finance
	Mr A Creegan	Interim Director of Performance
In Attendance:	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies for absence** Apologies were received from Mr S Stacey, Group Chief Deliver Officer, Mrs J Hawkard, Non-Executive Director and Mr S Evans, Operational Director of Finance. Mr Robson thanked the members of the Committee for their contributions throughout the years as the meeting was the last HUTH only Committee. He also thanked Mr Curry as he would be transferring from the new Performance, Estates and Finance Committees in Common to the Quality and Safety Committees in Common.	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held 27 November 2023** The minutes were approved as an accurate record of the meeting.	
4	**Action tracking list** Mr Bond advised that Grant Thornton had been commissioned to review the ICB financial situation and the outcome would be available from February 2024, and it was hoped that the National Planning Guidance might have been published too. Mr Bond agreed to provide a generic planning update in January for 2024/25 which would bring together the two Trusts. Mr Robson thanked Mr Bond but did not want to lose sight of the actual plan for managing the financial deficit. Mr Creegan advised that the 4 hour performance for HUTH included Type 1 and Type 3 figures, so the 60% reported was not just ED performance but included the UTC performance. Mr Robson stated that although this would make the performance look better this did not negate the need for the improvement work. Mr Briggs advised that the Trust would now be monitored on its Opel Levels and Opel 4 would mean daily scrutiny. Mr Bond agreed to provide a paper to the January Committees in Common regarding vacant posts over 6 months.	

5 Work Plan 2023/24

The Committee received the workplan and agreed that the outstanding items would transfer to the new Committees in Common workplan.

6 6.1 Performance Report

Mr Briggs updated the Committee regarding ED performance and reported that the Trust was being held to account for Ambulance turnarounds. He added that patients with no criteria to reside was still high at 190.

Cancer performance was starting to improve due to the initiatives in place. The trajectory was to get to 140 people waiting 63 days by the end of March 2024 and this would place the Trust in a much better position nationally.

The elective recovery activity was at 107% for new patients, 105% for follow ups, but there was more work to do regarding Day Cases. Mr Briggs added that the industrial action would impact on the current position. The teams were reviewing the cancellations line by line and patients were being re-booked quickly to lessen the impact on the targets.

Work was ongoing to ensure the Trust had no 65 week breaches by the end of March 2024.

Mr Curry asked about ED performance reporting and the importance of clear actions, the impact of the actions and the timings the actions would be closed and embedded. Mr Creegan stated that a fully integrated IPR would capture the improvements and their impacts.

Mr Robson asked about the Emergency Summit and Mr Briggs advised that it went well. The Non-Elective Recovery Plan and Ground Floor reconfigurations were presented to system partners including GPs. Mr Briggs added that the UTC would be operational from 14 January 2024 which would ease some of the pressure on ED and there were sensible discussions around the patients with no criteria to reside.

Mr Curry asked if there were any firm commitments following the summit and Mr Briggs advised that it was clear that partners wanted to work with the Trust and help, and joint meetings to discuss GP referrals were being established. Mr Creegan advised that a new PTL tool was being used to re-profile booked patients to release capacity. He added that 5% of patients decline appointments and some do not even realise they are on a list. There were opportunities to be gained by using the new tool as it would swap out any unwanted appointments.

The Committee discussed the 13th Floor and ward 1 with the view to closing them. Mr Bond advised that this would help the finances, particularly ward 1 which was not part of the plan.

Mr Robson asked about the UTC and asked for details around how it will work. Mr Creegan advised that effort, manpower and good partners were required to make it work. The Committee discussed flows and how patients would be triaged. Mr Bond stated that triaging patients from one area, in particular the UTC would be advantageous and the pathway needed to be very clear to all. Mr Curry added that the staffing model was key.

Resolved: The Committee agreed limited assurance for the Trust's performance although greater confidence had been gained due to the ongoing improvement work.

6.2 Screening Programme Update

Mr Briggs advised that the Breast Screening Service assurance visit during October 2023 did not identify any immediate concerns.

The lack of an NHSBSP qualified consultant at Grimsby is a concern – partially mitigated by extra appointments (Monday to Friday) at Castle Hill. Management teams from both north and south bank have developed a working group and continue to manage issues relating to workforce and improve resilience across the Humber.

On-going integration/interface issues related to Windows 10 continue to be a concern.

Pathology turnaround times which are outside of national guidance and a risk for cancer performance delivery due to workforce are a cause for concern.

The Bowel Screening Service had a QA visit in March 2023, the final report includes 30 recommendations. Workforce capacity and a succession plan for the clinical director are areas of concern. Good progress was made in closing the 3-month actions and the evidence submission for the 6-month actions is complete with a review planned for January 2024.

On-going current capacity constraints, leading to delays in diagnostics for both screening and 2WW cancer pathways, as well as pathology delays are both areas for escalation.

The AAA Screening Programme was delayed in commencing the screening of the 2023/24 cohort due to completion of the 2022/23 cohort. The programme remains behind trajectory and workforce continues to be a risk for the 2023/24 programme, which is being mitigated to some degree by a number of actions.

The Targeted Lung Health Check (LHC) data submission regarding the re-invited patient cohort did not fit with the mandated national requirements. A review and resubmission on 23 October 2023 has resolved this issue. This is a new programme and the 1st time that patients had been re-invited.

The Humber Diabetic Eye Screening Programme (DESP) continues to reduce screening backlogs, there continues to be workforce constraints particularly on the South Bank. Recruitment and on-going training seek to mitigate the risk.

Increased accommodation costs in a number of rural areas has limited the programmes ability to take on leases which will impact on inequalities. Additionally, the costs of electric vehicles in line with the Trust NetZero strategy are not affordable within current budgets.

Action: Mr Bond asked Mr Briggs for more information regarding the increased accommodation costs.

The Screening Programme Update is provided to PAF on a quarterly basis with the next report due in March 2024.

Resolved: The Screening update was given limited assurance due to constraints on resources, but it was noted that this is covered by the Cancer Programme.

7 7.1 Month 8 Finance Report

Mr Bond presented the Month 8 finance report and advised that the Trust was ahead of plan (£3.1m deficit) and was still forecasting achievement of the year-end target. The key risks were winter, high cost drugs and maternity CNST. The cost of the winter ward and the UTC development were also risks but there had been no material adverse variances regarding the UTC yet.

Mr Bond reported that the CRES forecast was to deliver £48.3m against a plan of £53.9m (89%). The Trust has identified £29.6m CRES year to date.

High cost drugs within the ICB block contract showed an increase in Month 8 and non-pay costs had also increased in Surgery and Clinical Support.

Mr Bond updated the Committee regarding the capital expenditure position which was at £24m year to date. This was £2.8m behind plan. The main variances were due to the Day Surgery and the approval process of the Phase 2 Business Case.

The revised digital strategy was discussed and this would be a joint HUTH/NLAG strategy and would sit within the ICS digital strategy. A future EPR solution was being reviewed.

Mr Bond advised that the cash position had reduced significantly due to increased payments to suppliers. He added that there was a large element of PDC cash to be received over the next 4 months and any agreed additional income as part of the financial reset was still to be received.

The system position at month 7 was a deficit of £34m, but it was still expected that the planned year-end position would be achieved.

Mr Robson asked about financial planning for 2024/25 and Mr Bond advised that the planning process would start once the Care Groups were in place. He added that there was no National Guidance published yet. Mr Robson stated that CRES modelling would also be difficult without knowing the Care Group management structures.

Mrs Thompson asked about the in-year Finance BAF risk and whether this could be reviewed in light of the forecast to achieve the target. Mr Bond requested that this be reviewed in month 9.

Mr Curry asked about the temporary staffing costs and whether they were likely to deteriorate further. Mr Bond advised that the increased costs mainly related to the Industrial Action and the strikes in December and January could impact further.

Mr Robson expressed his concern regarding the underlying system position and Mr Bond advised that Grant Thornton were working with the ICS to review the position.

Resolved: The Committee agreed that the assurance levels would be as follows:

- ***In year finances – limited due to the industrial action and associated costs***
- ***Underlying position – limited***
- ***Capital – reasonable although more clarity regarding the EPR funding was required.***

8 8.1 Capital Resource Allocation Committee

Mrs Drury advised that the Committee discussed any plans likely to be brought forward which included the Robot replacement, CDC equipment and the MRI Scanner.

All Capital work was on track and there was a push to get invoices in and paid as timing in Q4 was key.

Mrs Drury advised that the Committee/Board may be asked to sign off the Paediatric Day Surgery business case in January 2024.

Mr Curry asked about the impact of the EPR withdrawal and Mrs Drury advised that it would be deferred rather than withdrawn. Mr Bond added that there was not a viable financial solution currently so the new Chief Information Officer would be tasked with reviewing this.

The Committee discussed the new Performance, Estates and Finance and Major Capital Projects Committees in Common and how the capital items would be split in the new Group model. Mrs Drury added that the operational meeting would continue to manage the Capital plan.

8.2 Board Assurance Framework

Mrs Thompson advised that she was working through the Q3 Board Assurance Framework and was not expecting any changes to BAF risks 4 (Performance), 7.2 (Underlying deficit) and 7.3 (Capital).

BAF 7.1 (in year finance target) would be reviewed in Month 9 with a view to reduce the risk rating.

8.3 Contract Approval

There were no contracts for approval.

9 Any other business

There was no other business discussed.

10 Date and time of the next meeting:

Wednesday 24 January 2024, 9am – 12.30pm
Main Board Room, Diana Princess of Wales Hospital, Grimsby

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)034

Name of the Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday, 8 February 2024
Director Lead	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee
Contact Officer/Author	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee
Title of the Report	Workforce Committee Minutes – November 2023 - NLaG
Executive Summary	Workforce Committee Minutes from the meeting held on Tuesday, 21 November 2023, and approved at the Workforce, Education and Culture Committee-in-Common meeting held on Tuesday, 30 January 2024. The minutes are for information.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Workforce, Education and Culture Committee-in-Common meeting held on Tuesday, 30 January 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:

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday, 21 November 2023 at 14:00 hours via Microsoft Teams

Present:

Susan Liburd	Non-Executive Director (Chair)
Linda Jackson	Vice Chair and Non-Executive Director
Kate Truscott	Associate Non-Executive Director

In Attendance:

Abolfazl Abdi	Deputy Chief Operating Officer
Paul Bunyan	Interim Deputy Director of People
Jenny Hinchliffe	Deputy Chief Nurse
Simon Nearney	Group Chief People Officer
Robert Pickersgill	Governor, Membership Office
Lyn Duffy	Human Resources Governance and Policy Lead (item 6)
Annabelle Baron-Medlam	Inspection Compliance and Assurance Manager (item 10)
Mr Ajay Chawla	Clinical Dean and Consultant in Accident and Emergency (item 11)
Kathryn Hallam	Undergraduate Education Manager, HYMS (item 11)
Jane Heaton	Associate Director of Strategic Medical Workforce (item 11)
Valerie Almira Smith	Head of Organisational Development, Wellbeing, and Inclusion (items 12 and 13)
David Sprawka	Head of Recruitment and Employment Services (item 17)
Wendy Stokes	Executive Personal Assistant to Group Chief People Officer (taking minutes)

1. Welcome and apologies for absence

Apologies received from Shaun Stacey.

2. Declarations of Interest

The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

3. Minutes of the previous meeting held on Tuesday, 19 September 2023

Page two, item five, last line should read: around interview skills.

Page nine, item twelve, paragraph two, line three should read: The new bed-based establishment.

With the above amendments the minutes from the previous meeting held on Tuesday, 19 September 2023 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

Page seven, item nine:
The Chair highlighted that the Group Chief Medical Officer is the accountable lead officer for the Annual Doctors in Difficulty (DID) Report and that the report was also taken to Trust Board.

4.1 Review of Action Log

Action 13 – CQC Progress Report – Mandatory Training Compliance
The Chair stated this was a good news story about staff going above and beyond to provide training to increase compliance. Shaun Stacey and Anabelle Baron-Medlam are picking this up and the committee will be updated.

Action 14 – CQC Progress Report – Mandatory Training Compliance – To agenda the need for an increased uptake in mandatory training at Operational Management Group
Shaun Stacey to provide an update in January 2024

5 People Strategy Annual Delivery Plan 2023-24 – Quarter 2 Update

Paul Bunyan presented the People Strategy Annual Delivery Plan 2023-24, Quarter 2 Update available on SharePoint and taken as read.

Kate Truscott stated it was good news about the development of a Certificate of Eligibility for Specialist Registration (CESR) programme and Fellowship programme. Given the challenges in medical staffing and the slight deterioration in position, Kate was concerned about the capacity to deliver the programmes and she asked if the trust can be assured that people will get a good training experience. Paul Bunyan confirmed programmes are being piloted in areas where the trust feels it can get success and where there is a college representative, clinical lead, and service lead. The trust is mindful of the support required and pilots are taking place in anaesthetics, ophthalmology, and urgent and emergency care. The trust would not launch CESR where the required support is not guaranteed because it would not work.

Regarding recruitment from Kerala in India, the Chair asked in terms of the team that went out to Kerala and the trust commitment to equality and diversity did people in that team have relevant lived experience or was the trust colonial in its approach. Paul Bunyan confirmed eight people travelled, six were Indian and two were white British, David Sprawka and Ruth Kent. The Chair went on to ask how advanced future recruitment plans were with Dubai. Paul Bunyan reported the trust has links with a private hospital in India whose flagship is in Dubai. This is a central hub for professions from all over the world and they have a rich skill mix. From a Community Diagnostic Centre (CDC) perspective the Indians do not have radiographers the same as at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), but they do have sonographers that are already doing what is expected in the UK.

Regarding the Health Education Alliance Kate Truscott asked what is happening with Grimsby. Paul Bunyan reported Grimsby is included in the alliance and would partner with other educational solutions like the Grimsby Institute.

6 People Strategy Focus/ Deep Dive – Employment Tribunals and Potential Learning from Last Year

Lyn Duffy presented the People Strategy Focus/Deep Dive on Employment Tribunals and Potential Learning from Last Year available on SharePoint and taken as read.

Kate Truscott thanked Lyn for supporting people going through a recent employment tribunal. Kate highlighted the importance of documentation and its content. Emails could be reproduced at a tribunal, so it is important to use professional language. Lyn Duffy added that the Human Resources (HR) team do try to give guidance and this topic is covered as part of the People Monthly Manager Update.

Linda Jackson supports the work being done to expand disability awareness into neurodiverse areas and she thanked Lyn Duffy and the HR team for what they had achieved. Linda supports Liz Houchin, Freedom to Speak Up (FTSU) Guardian and a national issue is that you often cannot see a disability and that does not always mean a person does not have a disability.

In terms of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) the Chair asked what changes HR had seen with the introduction of the Just and Learning Culture. The Chair felt that should show a positive impact in terms of tribunals and the Chair asked if there was any data around whether individuals were taking the trust to tribunal on the grounds of disability and if so, had they previously declared their disability. Lyn Duffy stated there is a variety of reasons for non-disability declaration and more recently individuals have maintained they have a disability, and this was something they raised with their manager. In other cases, it was more around managers should have realised individuals had a disability. Lyn added she can probably get that data if required. The Chair felt the data would be really helpful as well as reminding staff about the importance of declaring disabilities. Simon Nearney stated it was really good to see actions being taken around reasonable adjustments and embedding that more in NLaG. Simon felt that mistakes will be made, and the most important thing is that individuals learn from them, and they will be able to improve and get better. The number of tribunals has decreased, but will the trust be able to sustain that over the next two years with all the planned changes in the organisation. The Chair felt there may be more challenging conversations around productivity and performance and that may well change the profile of claims moving forward.

Paul Bunyan added that on multiple occasions individuals say they have disclosed a disability and the manager has not seen that in a formal sense. The HR team are trying to work through that vocabulary, if not within a formal system managers may still know.

Regarding presentation slides two and three, outlining the number of employment tribunals and NLaG spending on legal costs over the past five years, Abolfazl Abdi asked if there was any correlation for slide three. Lyn Duffy reported that the correlation between slide two and three is that in the last ten years, although slide three is only looking at the previous five years costs, these included solicitor and barrister fees when claims have been defended as well as the legal costs of settlement. Lyn added that the advice given might be at the very beginning of the process and sometimes part way through a tribunal hearing where the barrister had already instructed, and a lot of work had been undertaken. The hearing in 2020/21 went to an employment tribunal and was quite costly.

Jenny Hinchcliffe highlighted that some hidden costs are not considered such as the time taken for staff involved. Jenny recently spent days going through 2,000 pages of information for a tribunal and when you consider the number of people involved in staff time only, the real costs must be astronomical and that cannot be lost.

7 Freedom to Speak Up (FTSU) Strategy 2020-24 – Annual Progress Report

Simon Nearney presented highlights from the FTSU Strategy 2020-24 Annual Progress Report available on SharePoint and taken as read.

Regarding people using the FTSU service Kate Truscott asked if Liz Houchin prepares a breakdown of issues and concerns and whether she correlates information raised by BAME staff and matters of concern in the NHS Staff Survey. Simon Nearney stated the breakdown is not in the report and he asked the committee if that should be included. Linda Jackson agreed that Liz does have that information. Kate Truscott felt that information would be useful to show who is accessing the FTSU service and whether the issues and concerns are matters of concern in the NHS Staff Survey. Simon Nearney agreed to speak to Liz regarding putting that information in the report going forward.
Action: Simon Nearney

NHS Staff Survey questions have changed, and some have been removed. Linda Jackson referred to page 4 of the report, questions numbered 19a and 19b and she questioned what the trust is doing to make people feel secure. Simon Nearney referred to the fallout from the Lucy Letby case in Chester and the need for staff to feel safe and comfortable and for managers to listen to their staff. Liz Houchin is leading on a promotional campaign and has arranged several open door and drop-in sessions. A total of seventy-six staff had spoken up this quarter compared to fifty in the same quarter of the previous year and that was not focused in one area. Liz Houchin felt quite assured by that and is talking about resources to respond to staff. Linda Jackson added that staff are mainly talking about behaviours and relationships and the trust needs to be mindful about people feeling comfortable to raise clinical concerns. Linda felt it is about how the trust promotes that more. Abolfazl Abdi stated that in Operations the number of people approaching Liz has increased, they do feel more comfortable on that journey. At a recent NHS Providers conference one of the professors said that people must feel 110% comfortable even if it is not their job.

Jenny Hinchcliffe stated that in corporate nursing they put clinical contact time in their calendar to give them the opportunity to walk around areas and have those conversations and to encourage staff to report concerns. Jenny felt it needed a multifaceted approach. Linda Jackson agreed that informal contacts bring out so much, and when she has visited areas with Liz some people do say that they have a concern.

The Chair confirmed the committee approved the FTSU Strategy 2020-24 Annual Progress Report.

8 Freedom to Speak Up (FTSU) Guardian – Quarter 2 Report

Simon Nearney presented highlights from the FTSU Guardian Quarter 2 Report available on SharePoint and taken as read.

The Chair asked if there was any correlation between FTSU data and exit interviews.
Paul Bunyan confirmed not directly, the connection is with FTSU information and ongoing HR issues, concerns, and cases. Simon Nearney added that going forward there will be a dashboard with the normal workforce indicators populated with complaints, FTSU data, staff survey results and health indicators, around falls and quality issues, which will give a richness of data showing the trust where to focus its attention.

9 Board Assurance Framework (BAF) – Quarter 2 Report

Simon Nearney presented the BAF Quarter 2 Report available on SharePoint and taken as read. Simon highlighted there are two main risks for the committee.

Regarding Strategic Objective 2 (SO2), Simon suggested the risk remains at twenty. Simon was hopeful that can be reduced to fifteen in the new year once international and national recruitment plans deliver. The focus this year has been on nursing recruitment and that is changing to focus on medics.

Regarding Strategic Objective 5 (SO5), Simon suggested the risk remains at twelve. This is a gigantic challenge, and the single group executive currently has six vacancies which are out to advert. Simon was hopeful that appointments can be made in December 2023 and January 2024 and staff should be in post for April 2024. The Care Group Consultation goes live today for thirty days, and this is the right thing to do in terms of patients and pathways. This will destabilize the organisation and that is why Simon feels the risk should remain at twelve for now.

Linda Jackson stated regarding leadership, she felt the score should go up because it will take a long time to get everyone settled into Care Groups and there is also the next level of leadership to consider. This is a risk to morale, and some people are already leaving the trust which is more of a risk than previously. Linda felt this should also be highlighted to Trust Board. The Chair agreed with Linda about increasing the risk. Simon Nearney added that as an organisation the trust must focus on an improvement programme and its delivery. There are contentious issues in Accident and Emergency (A&E) and leaders must manage national standards. Linda Jackson added it is really hard to communicate effectively with that amount of people and get that right. Once people know where they sit and are part of the future they will reenergize. Simon Nearney agreed to review the risk.

Action: Simon Nearney

Robert Pickersgill asked what the two trusts believe is a successful process and is the Board thinking in those terms taking the opportunity to rethink the focus and vision. Robert went on to ask what the vision is and what does success look like. Linda Jackson stated the case for change is to break down barriers to provide a seamless service across the Humber. There is only so much the two trusts can do separately. There is more work to do and regarding what does success look like, that is pathways working better to ensure patients are seen by the right person in a timely manner. Robert Pickersgill added that quantification was needed. Abolfazl Abdi felt it is about access to services and inequalities. A single pathway across the Humber will help and that work has already started with cardiology and haematology. The quality of workforce planning in terms of consistency of numbers, clinical training and supervision are all a big part of sharing lessons. Simon Nearney stated that Jonathan Lofthouse has only been at the trust for three months and this is part of the whole development of a new long-term vision and to work out what the purpose is, know the benefits and develop joint values. The financial situation for both trusts is not good, and they have started to plan on a wider footprint. There are five hospitals, and both trusts need to think differently about getting waiting lists down. HUTH also offers tertiary services.

10 Care Quality Commission (CQC) Progress Report

Annabelle Baron-Medlam presented highlights from the CQC Progress Report available on SharePoint and taken as read.

Regarding safeguarding and mental capacity training Kate Truscott asked what the trust is doing to improve that position. Jenny Hinchliffe reported that additional training has been scheduled but

there are some issues with staff not attending and cancelling at the last minute. They are reviewing capacity and the vulnerability teams are active on wards making sure patients have been assessed. Staff know what they are doing and have support if they need that. Kate Truscott went on to ask can the committee be assured that the vulnerability team are doing a good job and is there any way the committee can help to support access to training.

The Chair reported this is being prioritised in other meetings and she asked if activity is being captured and tracked in a meaningful way, or is it anecdotal, and can the trust provide that evidence to CQC. The Chair added there is limited assurance in terms of progress, and she asked committee members to ask colleagues in respective forums to keep this high on the agenda and continue to look at this because she would like to see progress in the next quarter.
Action: All

11 Undergraduate Medical Education – Annual Report

Kathryn Hallam presented highlights from the Undergraduate Medical Education Annual Report available on SharePoint and taken as read.

Kate Truscott congratulated Kathryn Hallam and Ajay Chawla for achieving HYMS Tutor Excellence Awards and she asked how HYMS can incorporate that into what they do and into future reports. That would be of interest to the committee because the trust wants trainees to come back and work for them. Kathryn Hallam stated that they do try and meet every group at the end of their placement. They set a proforma and can undertake quality improvement to look at the scores. They act on things and do have difficult conversations. Kathryn agreed to put a summary into future reports. Ajay Chawla added the trust takes feedback and there is also central feedback collated by HYMS, although that usually arrives a few months later, that can also be included in the report going forward.

The Chair reported that the trust is moving to Committees in Common and is currently looking at which papers will be submitted to the new Committees. That will include providing some specific asks when looking for assurance. The Chair asked what the Board and Executives need to do to make sure the service is running effectively, and whether capacity in the education centre had been resolved. Kathryn Hallam reported that the Postgraduate Medical Education Centre has a separate business case. Regarding HYMS, they cannot do more with the existing space, they must do the best they can with what they have. They plan well ahead and do use some rooms in the Postgraduate Medical Education Centre. Ajay Chawla added that if numbers increase, they may have to share services.

12 Staff Lottery Committee – Annual Report

Valerie Almira-Smith presented highlights from the Staff Lottery Committee Annual Report available on SharePoint and taken as read.

The promotor is Simon Nearney, and Valerie Almira-Smith chairs the Staff Lottery Committee. The committee includes a range of people from Organisational Development (OD), Finance, Communications, IT, and staff representatives when decisions are discussed and made around funding. The committee would fund painting walls, carpeting, furniture, and chairs.

Kate Truscott asked Valerie to talk her through administration costs and development costs of £153.7k. Valerie stated that every staff lottery member pays £5 each month with 25% of that being for Lottery administration, Lottery system development and portal server hosting costs. Every month there is an excess of £15k and that has accumulated due to the pandemic. Administration

costs are for a part-time band 3 person totaling £14k each year. The Lottery provider changed from Keyzo to Sterling Lotteries in 2022-23 and they apply a small administration fee and payroll administer membership through the salary sacrifice scheme.

Linda Jackson stated the Staff Lottery Committee is similar to the Charitable Funds Committee in that they do not want to accumulate funds. Linda asked Valerie if they are starting to use the funds because that does concern her. Valerie confirmed the committee is talking to the Yorkshire Wildlife Park and looking at family outings including Xmas shopping outlets and using funds to pay for tickets and buses. Some funds have already been used to pay for Our Stars tickets and they have a moustache competition for Men's Health Awareness and International Men's Day.

The Chair highlighted the annual report is for information only. Linda Jackson added that will need to be looked at next year as part of the Committees in Common (CiC) meetings.

13 National Staff Survey – Latest response rate

Valerie Almira-Smith reported the response rate today is at 44.3% and the survey closes at the end of the week. This is an improvement from last year at 35% and the trust is hoping for at least a 50% response rate. To reach 60% the trust will need a miracle and although controversial, paper copies have achieved a response rate of 59%.

14 Quality and Safety Actions

No outstanding quality and safety actions.

15 Finance and Performance Action

15.1 Community Diagnostic Centres (CDCs) – Workforce Plan

Paul Bunyan presented the CDCs Workforce Plan available on SharePoint and taken as read.

The Chair highlighted that the CDCs Workforce Plan and recruitment of staff agenda item was from a concern raised by the Finance and Performance Committee.

Kate Truscott was concerned about radiology and current staffing level challenges and the possible impact of them on the organisation. Kate also wondered about the knock-on effect of more people being diagnosed sooner, and she questioned what the next stage in the pathway is and what the capacity modelling and potential increase of patients will be coming into the five hospitals. Abolfazl Abdi felt that was a valid point and to some extent it will help looking at patients earlier in the pathway and would give a smoother journey later on. Regarding impact and time period the pathway will quicken step by step and this may also help the trust more in terms of their management because some patients may not even need to be referred to the trust.

The Chair stated that a similar discussion took place at Finance and Performance Committee and regarding pathway prioritisation and earlier intelligence that gives a better level of service.

16. Workforce Integrated Performance Report (IPR) – Trust and Directorate

Paul Bunyan presented highlights from the Workforce Integrated Performance Report (IPR) available on SharePoint and taken as read.

Kate Truscott commented on the average length of 20 weeks for disciplinary cases, and she asked if there are any improvements that can be made. Paul Bunyan stated that they have changed the way they report cases, and you will see what has closed in month. All current disciplinary cases are under police investigation. Linda Jackson suggested reporting cases under police investigation separately because those cases will skew the averages. Regarding the CESR programme and implementation of that the Chair asked for that to be included in the Workforce Deep Dive.

17. Recruitment KPI Dashboard – October 2023

David Sprawka presented highlights from the Recruitment KPI Dashboard available on SharePoint and taken as read. David reported the main concern for the trust is around consultant recruitment.

Regarding the twelve-month trajectory for medical staff, Linda Jackson stated numbers at the end of the year are going to be slightly less than at the beginning and she would like to see more information regarding that to get a level of assurance. Linda went on to request a Workforce Deep Dive to be presented at the next meeting to give assurance. Linda highlighted there are lots of positives that are worth noting on the escalation report. The Chair added that a lot of focus had been put onto nursing and midwifery. Paul Bunyan confirmed he will include data for HUTH as well.
Action: Paul Bunyan

18. Workforce Profile – Annual Report

Paul Bunyan agreed to present the Workforce Profile Annual Report at the January 2024 meeting and that will include HUTH data.
Action: Paul Bunyan

19. Industrial Action

Paul Bunyan reported no industrial action is currently planned.

20. Equality, Diversity, and Inclusion (EDI) Letter from Steve Barclay

The Chair stated that Steve Barclay has now moved on. Linda Jackson highlighted he was saying that if trusts had massive EDI teams would it be better to spend that money on a consultant. Linda felt that he did have a point that perhaps some trusts should consider. The chair did not permit wider discussion of the item, due to the change in Secretary for State for Health and committee agenda time constraints.

21. Annual Workplan

The Chair reported the committee is working to the existing workplan, changes will be made moving to the Group structure and Committees in Common (CiC) from January 2024.

22. Trust Board Highlight Report

The Chair agreed the following items to be highlighted in the Escalation Report:

- The committee considered and approved the FTSU Guardian Quarter Two Report and the FTSU Strategy 2023/2024 Annual Progress Report
- Limited assurance given on the CQC Progress Report

- BAF SO5 - reviewed the risk in terms of leadership and the organisation going through significant change
- Overseas recruitment – Middle East (Dubai) and India
- No industrial action planned at present
- IPR – medical staff

23. Items for Information

Items listed in Appendix A shared with the committee and available on SharePoint.

24. Any other urgent business

No urgent business discussed. The Chair gave a huge thank you to everyone for covering a range of topics in depth.

25. Date, time, and venue of next meeting:

Workforce, Education and Culture Committee in Common (CIC)
Date: Tuesday, 30 January 2024
Time: 09:00 hours
Venue: Boardroom, Hull Royal Infirmary

The meeting closed at 16:28 hours

Cumulative Record of Workforce Committee Attendance (2023/2024)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Sue Liburd	4	4	Jenny Hinchcliffe *	4	4
Kate Truscott	4	3	John Awuah *	1	1
Linda Jackson	4	2	Gillian Ponder *	1	1
Simon Nearney	4	3	Paul Bunyan *	1	1
Shaun Stacey	4	2	Simon Parkes *	1	1
Ellie Monkhouse	4	0	Abolfazl Abdi *	1	1

* Deputy or representative

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)035

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Tony Curry, Non-Executive Director
Contact Officer/Author	Rebecca Thompson, Head of Corporate Affairs
Title of the Report	Minutes of the HUTH Workforce, Education and Culture Committee held 11 December 2023
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 are attached for review
Prior Approval Process	Workforce, Education & Culture Committees-in-Common - January 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:

Hull University Teaching Hospitals NHS Trust
Minutes of the Workforce, Education and Culture Committee
Held on 11th December 2023

Present:	Tony Curry (TC)	Chair
	Rebecca Thompson (RT)	Head of Corporate Affairs
	Simon Nearney (SN)	Director of Workforce and OD
	Ashok Pathak (AP)	Associate Non-Executive Director
	Helen Knowles (HK)	Head of HR Services
	Myles Howell (MH)	Director of Communications
	Wajiha Arshad (WA)	Guardian of Safe Working
	Mike Robson (MR)	Non-Executive Director
	Fran Moverley (FM)	Freedom to Speak Up Guardian
	Jo Ledger (JL)	Interim Chief Nurse
	Rachel Waters (RW)	Staff Side Chair
	Jack Kastelik (JK)	Director of Medical Education
	Kate Wood (KW)	Group Chief Medical Officer
In attendance:	Amy Slaughter (AS)	Personal Assistant (Minutes)
	Karen Mechen (KM)	Practice Development Matron
	Michio Schuck (MS)	Pastoral Lead for International Nurses

No **Item**

1 **Apologies:**

Una Macleod (UM) Non-Executive Director
Javed Salim (JS) Staff Side Representative
Rob Chidlow (RC) Interim Director of Governance

The agenda was taken out of order after this point.

6 **International Nurses Pastoral Support**

KM and MS delivered a presentation on the pastoral support provided to international nurses. The programme for international recruitment has been developed by the Trust since 2017 in which time the Trust has recruited 528 international nurses. The presentation demonstrated several challenges facing international nurses when they join the Trust including lack of cultural awareness, inability to voice concerns, lack of career progression support, communication barriers, loneliness, and homesickness.

The pastoral team planned to create a new programme of support to international nurse and used an internal survey from previous international nurses to gather information. Actions the pastoral team made include changing the interview process, talent spotting, implementing pre-arrival sessions, providing eLearning to support OSCE assessments, helping to build a sense of belonging, meet and greets at the airport, 2-day orientation around the city of Hull, 2-day bespoke induction, setting up a WhatsApp group, providing professional development support for career progression and conducting wellbeing checks every 3 months.

International recruitment has now ended, the focus is now on retention. It was highlighted that the indefinite leave to remain visa amount has increased by over £400 per person. MS asked for support from the committee to a send letter to local MPs asking for NHS staff to be exempt from the visa fees. The committee discussed the fees of recruitment and training to replace staff lost due to the increased fees. The committee agreed to support the letter to MPs.

Action: SN will work with MS to draft letter to send to the MPs regarding exemption from visa fees for NHS staff.

It was highlighted that the first 6 months is a crucial part of the transition period for international nurses to be provided with support. Further actions include implementing career progression pathways, providing support through the application and interview process and rolling out cultural competency awareness training for managers.

The video, My Story, was shared with the committee. SN asked for the video to be played at the next Board meeting, KW will request for the abridged version to be included as the Patient Story.

9 Recruitment and Retention

9.1 Nursing and Midwifery Staffing Report

The Interim Chief Nurse presented the Nursing and Midwifery Staffing Report. The number of Care Hours Per Patient Day (CHPPD) has increased. The Trust currently has 35.67 WTE registered nurse vacancies. Appendix 3 shows the workforce model and the different initiatives in place, which shows the Trust will be over-established. The non-registered nurse vacancy rate is currently 49.10 WTE, mass recruitment campaigns continue.

The first cohort of RNDAS have now qualified as registered nurses. The Trust has now welcomed its' University new registrants, with 85 Adult students (out of a total of 125), 12 Paediatric (all) and 14 Midwifery students (out of 16) having already acquired their NMC personal identification numbers.

The turnover rate for nursing and midwifery staffing has reduced to 8.1%, which is an improved position. The workforce model includes 40 additional recruits to cover maternity leave.

AP asked about the reasons for high turnover in ICU and ED, JL advised that they are high stress environments however more support is now provided for ED staff from the nurse educators team and bespoke work on ICU leadership is being undertaken.

The assurance for the Nursing and Midwifery Staffing report was agreed as substantial.

2 Declarations of Interest

No declarations of interest.

3 Minutes of the meeting held 9th October 2023

The minutes of the meeting held 9th October 2023 were approved.

3.1 Matters Arising

No matters arising.

4 Action Tracker

The action tracker was reviewed and updated.

RW shared the common themes facing staff currently are an increasing uncertainty relation to organisational change including the group structure, psychological impact of the possibility of job roles changing, stress and anxiety and the use of the formal policy for managing attendance. MR asked what more can be done for staff, RW stated that communication regarding changes is crucial. SN discussed the pacing of organisational change and the impacts. RW mentioned that the Chief Executive

bulletins do not always answer questions raised by staff and can spread more uncertainty. MR asked if there is a mechanism for staff to ask questions and be provided with answers, MH advised there is an email account which responds daily to queries and FAQs are included on Pattie. RW noted that staff cannot ask questions anonymously which can discourage staff from seeking answers, MH highlighted that there has been issues with anonymous posts in the past.

Action: MH and RW to meet to discuss what else is needed to support staff during the Group organisational change.

5 Work Plan 2023

The Work Plan for 2023 was noted.

7 Employee Engagement, Communication and Recognition

7.1 Freedom to Speak Up Guardian Report

The Freedom to Speak Up Guardian presented the Q2 Freedom to Speak Up Guardian report. The number of individual concerns received in Q2 was 38, the overall number of concerns has already exceeded the total for 2022/23. The overriding subject of concerns was inappropriate behaviours. FM and JL commenced drop-in sessions, which have been successful however some issues that were raised should have been resolved by managers. The Trust have adopted the new national Freedom to Speak Up policy, FM is currently reviewing the Trust whistleblowing policy with the HR team. It was noted that one of the new international nurses has completed the training to be a Freedom to Speak Up champion.

MR asked if any concerns had been raised regarding organisational change, FM advised that currently no issues have been raised. KW asked if there will there be a point where FM cannot take on any more concerns due to the increasing amount, FM advised this is likely as the role is not full-time. FM is working with the communications team to develop a feedback survey. The assurance for the Freedom to Speak Up Guardian Report was agreed as substantial.

7.2 Guardian of Safe Working Report

The Guardian of Safe Working presented the Q2 Guardian of Safe Working report. In Q2, 159 exception reports were recorded. The main reason for the increase in exception reports is the use of eRoster, which has increased visibility for junior doctors. Over 80% of rotas are now live on eRoster. The issue with foundation doctors been asked to perform ECGs has improved, a plan is in place in case this issue resurfaces. The nursing staff have completed competency training to ensure all staff can now perform ECGs. The exception reports for ECGs were usually performed overnight due to nursing staff shortages. DME received a high number of exception reports due to lack of Self-Development Time (SDT), the difference between SDT and study leave has been communicated and the number of trainees taking SDT has increased. The assurance for the Guardian of Safe Working Report was agreed as reasonable.

11 Modernising the Way We Work

11.2 Junior Doctor eRoster Roll-Out (Project Update)

The Head of HR Services presented the Junior Doctor eRoster Roll-Out Project Update. The challenges that have faced the project are commitment from medical services and reluctance from services who want to continue using spreadsheets. Other challenges include recording of junior doctor absence due to the lack of a clearly identified line management model for junior doctors. The project is also aiming to strengthen the rota change process, ensuring the contractual requirement to give at least six weeks' notice of rota pattern changes is upheld. As at the end of

November 2023, 83.1% of junior doctor rotas were live on the eRoster system. 11 rotas are currently not on eRoster. By March 2024, all rotas need to be on the system, this requires engagement from the clinical teams. KW commended the achievements of the project. KW noted that the issue of line management and absence management for junior doctor sickness is an important group-wide issue. The assurance for the Junior Doctor eRoster Roll-Out Project Update was agreed as reasonable.

11.1 E-Rostering Report

The Head of HR Services presented the E-Rostering Report. The achievements and support of the nursing eRoster team have been recognised. As of August 2023, 80% of staff in scope are on eRoster. A considerable piece of the implementation project is the integration of rosters to payroll, circa 500 staff have been linked to payroll in 2022/23 including the Pharmacy department. The Trust is predicted to be at level 4 against the national levels of attainment, a submission will be made in 2024. The team continue to support staff rotations between departments. It was acknowledged that there is an unknown impact on eRostering due to organisational changes including management and reporting. The assurance for the eRostering report was agreed as substantial.

8 Equality, Inclusion and Diversity

8.1 LGBTQ+ Network Objectives (Update Report)

The Head of HR Services presented an update on the LGBTQ+ Network Objectives. The LGBTQ+ Network developed their own set of objectives for 2022/23 as there is no national framework. There have been several achievements against the 2022/23 LQBTQ+ objectives: over 800 colleagues have made a Rainbow Badge Pledge, the Trust has been accredited at the initial stage on the national assessment for the Rainbow Badge, the Trust declaration rate has increased to 3.2%, the Zero Tolerance to LGBTQ+ Framework will be launched during LGBTQ+ history month, the LGBTQ+ conference was a success and the Trust had a stall at the 2023 Pride event in Hull.

The proposed objectives for 2023/24 include: establishing an Ally network, producing workforce specific transgender inclusion guidance, re-assessment of the Trust against the Rainbow Badge, lighting up Trust buildings with the Pride flag during LGBTQ+ history month.

MR asked if there are nominated LGBTQ+ champions in the Trust, HK advised that the network do not have champions and utilise the Allies network instead. It was noted that Tom Rust is very visible as the chair of the LGBTQ+ network. Allies are identifiable by the wearing of the rainbow lanyards. The assurance for the LGBTQ+ Network Objectives Update was agreed as reasonable.

10 Health and Wellbeing

10.1 Covid and Flu Vaccination Progress Report

The Group Chief People Officer delivered a verbal update on the Covid and Flu Vaccination progress. 45% of staff have had both the flu and covid vaccination. Vaccination clinics will close at the end of December 2023. The 75% target will not be reached for staff to receive the additional leave day.

MR asked how data is recorded for staff who have vaccinations outside the Trust, SN advised that staff need to inform the Trust and provide evidence from GP. KW asked what the challenges have been, SN explained that staff have vaccine fatigue, some staff only want the flu job and not the Covid and some staff have expressed they do not want the vaccines without the guarantee of an additional days' leave. A

discussion took place about the comparison of vaccine uptake to previous years when the incentive was offered, it was noted that prior to Covid the Trust reached an 85% flu vaccine uptake. RW asked if the Trust would reconsider providing the incentive, this is an issue that will be discussed by the Group Executive Team. The assurance update on the Covid and Flu Vaccination progress was agreed as limited.

12 Governance

12.1 People Strategy Performance Report

The Group Chief People Officer presented the People Strategy Performance Report. The Trust vacancy rate remains low at 1.4%, nursing vacancy rate 0.3% and consultant vacancy rate 4.8%. Turnover remains high at 10.7% compared to the target of 9.3%, the first-year rate turnover remains an issue. Job planning is currently at 74%, sickness is at 4%, appraisals are at 83.9%, mandatory training is over the 85% target. The staff survey completion rate was 49.9%, which is above the national average of 44%. The assurance for the People Strategy Performance Report was agreed as reasonable.

13 Any Other Business

13.1 Group Values Report

The Director of Communications presented the Group Values report. 50 sessions with staff across the Group have been planned to determine a new set of values, these sessions are led by members of the Group Executive Team. The values are to be agreed by 1st April 2024. The Barrett Values model will be used to pull together the data and themes for the agreed values. RW asked if there will there be a staff side specific session, MH advised there will be no sessions for specific groups and the sessions will be for all members of staff.

Date and time of the next meeting:

Tuesday 30th January 2024, 9am – 12.30pm, Boardroom, Alderson House

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)036

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 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 Minutes – November 2023 - NLaG
Executive Summary	Minutes of the Health Tree Foundation Trustees' Committee (HTF) held November 2023 and approved at the following meeting January 2024
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Health Tree Foundation Trustees' Committee – January 2024
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **9 November 2023 – Via Teams Meeting**

Present:		
	Neil Gammon	Independent Chair of HTF Trustees
	Susan Liburd	Non-Executive Director
	Gill Ponder	Non-Executive Director
	Kate Wood	Group Chief Medical Officer
	Lee Bond	Group Chief Finance Officer
	Simon Leonard	Communications Assistant
	Clare Woodard	Head of Smile Health
	Lucy Skipworth	HTF Charity Manager
	Jug Johal	Director of Estates and Facilities
	Paul Marchant	Finance Accountant
	Melanie Sharp	Deputy Chief Nurse

Item 1 11/23 **Apologies for Absence**

Apologies for absence were received from: Ivan McConnell, Jonathan Lofthouse, Jamie Lewis and Ellie Monkhouse.

Item 2 11/23 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 11/23 **Minutes of Meeting held on 7 July 2023**

The minutes from the meeting held on 7 September 2023 were approved.

Item 4 11/23 **Matters Arising**

4.1 Community Diagnostic Centres – Grimsby & Scunthorpe

Neil Gammon/Lucy Skipworth/Clare Woodward attended the Council of Governors meeting to brief them on how the charity would like to be involved. Jonathan Lofthouse raised a concern that money from the Health Tree Foundation should be spent on our patients at hospitals and in the community. Neil Gammon responded that due to an expected significant footfall at both locations it was felt the Health Tree Foundation image would be better seen with this way.

Lucy Skipworth updated the wish in depth was for skylights, a charge box in A&E, wall vinyls, small toys and some coloured chairs.

Gill Ponder sees this more as a fund-raising opportunity rather than an expenditure which will raise the charity profile. It is hoped there will be the opportunity to donate in the CDCs as they have a large footfall. It was noted

there is a donation box in A&E and is hoped something similar could be done in the CDCs. Jug Johal does not see this as an issue. Clare Woodward noted this needs to be part of the CDC build and not at an additional cost to the charity. Trustees were in support of this.

Action: Lucy Skipworth to look at CDC donation opportunities.

Clare Woodward noted that the donations kit is quite expensive. There would need to be market research to check return on investment to ensure the best products are used for fundraising. Gill Ponder noted there are free standing contactless machines on the market at modest prices.

Action: Lucy to put together information on how the donations are working in current locations.

Action: Clare Woodward to research available donation kit.

Item 5 11/23 **Review of Action Log**

The action log was reviewed and updated accordingly.

Pennies from Heaven costs have been explored.

Action: Lucy Skipworth to move on with the initiative. ALL agreed.

7.1 7/9/23 Kate Wood noted it would be better to buy more robust fans for longevity and robustness. Mel Sharp noted that the fans are well received. Gillian Ponder suggested when people are asking for fans it be queried where they will be stored during the winter as this may solve a re-order issue. Additionally, wall mounting may solve this storage issue along with reducing any damages.

Action: Lucy Skipworth to look into costs for more robust fans.

Item 6 11/23 **Items for Discussion / Approval**

6.1 Wish 252/23 – Wayfinding – Discussion

The report was taken as read. Lucy Skipworth met with Mel Sharp and Jo Loughborough regarding funding of a new wayfinding system. The quote was for £110k excluding VAT which would have 4 proposed phases. They are: Updating internal public areas, external signage around the hospital, all ward areas and moving into a digital phase. This would require a fundraising strategy to be drawn up with a public fundraising appeal and would likely need a dedicated project management team.

Jug Johal agreed this is an important piece of work, however, it was noted we are going through a consultation process. The concern is that part way through sites will be re-configured, and work will need to start again.

Kate Wood noted it is essential piece of work as a lot of time is spent supporting and directing patients and visitors on our sites. The consultation finishes in January and will go to the ICB in March for decision. Scoping of this can be done on a grander scale due to money needing to be raised. Being digital is where it becomes more expensive and must be done across the whole site.

Sue Liburd agreed regarding people asking for directions. Sue queried if this could be considered as part of the reconfiguration. Regarding digital, could a 'google map' style be done for sites? This should be a cost shared with Estates and Facilities.

Mel Sharp informed that a NLAG signage meeting has started. There is learning available from other hospitals that use digital.

Gillian Ponder noted fundraising will take time and suggested that outpatient letters include details of where to go type directions. An interim solution of coloured lines was suggested ie. Follow the blue line to where you need to go. Mel Sharp reassured that examples of how outpatient letters can include directions is already being looked at. Zoning would be simple but is an issue when departments then move. Mel Sharp to share details of what is currently being looked at with Gill Ponder.

Neil Gammon raised a concern that we are treading on policy work rather than Health Tree Foundation business and who would have responsibility to do it. This item to be included in the highlight report to the Trust Board. Guidance to be asked from the group. It was confirmed that a formal wish has already been submitted and that Health Tree Foundation don't work as part of the signage committee. There would need to be a formal acceptance that this will be a jointly funded activity.

Kate Wood noted when a wish is submitted the normal process is that the details need to be worked through. This has not happened yet. Once this is completed it can come back to the group to look at where part funding is needed.

Action: Lucy Skipworth to start the wish process with the Wayfinding Group.

Gillian Ponder noted that students are looking for projects to work on. It may be worth approaching a college/university to get students to develop a project and may save a considerable sum of money. Suggestion was to do a competition.

Action: Mel Sharp to approach colleges/universities regarding doing a project development.

Neil Gammon thanked Clare Woodard for her time supporting HTF, firstly as Charity Manager and then Head of Smile Health.

6.2 SDEC/AAU Skylight Panels

Thanks were given to Jug Johal and the team for their work on this project. A resolution has been reached and there is a revised price for the skylights.

Gillian Ponder noted at the last Trust Board highlight report there was a comment about reducing donations. This was attributed, in great part, to the cost of living crisis. This was contested by NED, Simon Parkes, who said that this is not true across the national landscape.

Item 7 11/23 Updates from Health Tree Foundation

7.1 HTF Manager Update Report

Gill Ponder noted there was an action raised at Trust Board regarding fundraising and donations. Apparently, Simon Parkes had challenged the HTF assertion that charities are getting less donations due to the cost of living crisis and further queried if this was due to industrial action. At the Trust Board, Ellie Monkhouse felt it would be useful for the charity to explore this in detail. More public awareness is needed of areas that may need charitable donations.

Lee Bond felt there is a danger of a wild goose chase and a challenge needs to be done with Simon Parkes as this is clearly apparent in other charity work. Concern should be the fund-raising activities.

Action: Neil Gammon to gather evidence from NHS charities in response to Simon Parkes comment.

The report was taken as read. Health Tree Foundation were successful in their £30k development grant bid. The Health Tree Foundation website is being redesigned which will include an appeals page where people can donate directly. This is still at the design stage. Hey Smile Foundation have been working with Humber Creative to create a circle of wishes digital system. This will be a fully automated, standalone system where fund guardians will be able to see their wishes and where they are in the process. Reports will be able to be pulled showing where funds are and aren't being sent. This to be rolled out in January 2024.

Clare Woodward updated that just over £16K is being spent on the website and circle of wishes.

Lucy Skipworth updated regarding Health Tree Foundation birthday celebrations. The 8th birthday was used to celebrate. New and old fundraisers and supporters were invited. Goole went very well. Scunthorpe did not work as well but may be due to the location of the HTF office. Grimsby was well attended. This worked well as a good drop in session. Thanks were given to Trustees as this worked very well.

It was suggested, following the continuing success of Cleethorpes Seaview Street Cancer shop something similar could be done in Scunthorpe and/or Goole.

Action: Lucy Skipworth to work on a Cancer shop for Scunthorpe and Goole. Updates to be given in the new year.

The team have hosted community days inviting fundraisers to the events. Upcoming events were showcased along with wishes submitted. These were also used as networking and will be done every 3 months in the community.

The grant funding applications have not been successful. 8 further applications have been submitted.

NELC Funding Information Fair was attended in October. This gave opportunity to speak with different local charities and gain advice about successful applications. One charity with a successful £2.3m bid said the

advice was to involve as many statistics as possible, however, they used the word count to make it matter with what was said and why it would make a difference.

Corporate partnerships have been successful, with Forester Boyd and Louth Golf Club having chosen HTF to be the charity of the year for 2023 and 2024. The charity is also working closely with Ashby Golf Club to be their chosen partner.

The NHS Charities Together Charity Leaders Engagement Day was attended. This was an excellent networking opportunity. It was helpful to see we are already well structured.

A presentation was given to the Rotary Pentagon Club in Scunthorpe. This was well received.

Caistor Lions are involved with the Keelby Santa run. They have donated £200 towards the funding of medals. 4 banners have been donated to advertise the event.

The first Fairchild Legacy Ward at Scunthorpe has now been completed. Jonathan Lofthouse has agreed to open the Dementia friendly bay on Ward 16. Gillian Ponder queried if there is an opportunity to encourage others to donate as this is a cause that could grow and enable something similar in Grimsby. It was queried if Look North could be approached. Mel Sharp noted there is a plan to do good promotion with this. Staff morale has improved. Ward 17 is next, and staff can't wait for it to start.

7.2 Risk Register

The report was taken as read. There were no points to note.

Item 8 11/23 Sparkle Programme

8.1 Sparkle Update

The report was taken as read. Lucy Skipworth updated work is being done on the backlog.

Item 9 11/23 Finance Update

9.1 Finance Report

Lee Bond noted there are about £145k of debtors and equally only £19k of cash. The annual plan shows we are £135k behind the income plan (28%). We are 36% behind on fundraising activities.

Paul Marchant updated that the £145k debtor includes £132k related to the Irene Woodcock legacy. Solicitors have phoned to confirm this to go in the bank this week. This to be spent on medical equipment at Goole. Paul Marchant/Lucy Skipworth are working on data to see where fund raising is

being made. The spend is behind by £300k. Income should come through heading towards the Christmas period.

Action: Lucy Skipworth/Paul Marchant to do some analysis of fund-raising income

.

Gillian Ponder queried page 6 income generation – income generated has fallen this year yet we are bringing in more if we exclude NHS charities. Paul Marchant responded the funding costs are the same but if the grant is removed we are not generating as much.

Action: Paul Marchant to look at income generation.

9.2 CCLA Investment update

The written update provided by Heather Lamont from CCLA was noted with no questions.

9.3 Draft Annual Report & Accounts 22/23

The report was taken as read. Paul Marchant updated the auditors report has been approved with 1 minor change. These to be filed with Charity Commission by the end of January. The audit fee to be changed reflecting a price increase of £9k. Minor format and typos to all be done. ALL approved to go to Jonathan Lofthouse and Neil Gammon for approval and sign off.

Thanks were given to Lucy Skipworth and the team for all their hard work on the report.

Gillian Ponder noted on page 5 there are too many ‘T’s’ in mascot on the contents grid.

Sue Liburd noted this is a well structured report but noted page 19 that some ‘i’s’ were in bold and the Rita machines ‘i’ is also in bold.

Lucy Skipworth noted this report will be available digitally, via post and email. ALL agreed this should also be sent to the Trust Board for information.

Action: Lucy Skipworth to do typo amendments.

Action: Neil Gammon to ensure the Annual Report goes to the Trust Board for information.

Item 10 11/23 Any Other Business

Terms of reference to be updated and presented at the January 2024 meeting.

Action: Lucy Skipworth

Meeting attendee list to be addressed prior to the January 2024 meeting.

Action: Neil Gammon

Item 11 Matters for Escalation to the Trust Board

11/23

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Signage and wayfinding.
- Advising the Trust Board about the skylight panels.
- Annual report to feature as an item for information for the Public Trust Board.

Action: Neil Gammon

Item 12 Date and Time of the next meeting:

11/23

Thursday 10 January 2024
9.00am – 12.00pm
Via MS Teams

Attendance Record:

Name	Nov 2022	March 2023	May 2023	July 2023	Sept 2023	Nov 2023
Neil Gammon	✓	✓	✓	✓	✓	✓
Jonathan Lofthouse					✓	Apols
Peter Reading	✓	✓	✓			
Shaun Stacey				✓		
Terry Moran						
Linda Jackson						
Gill Ponder	✓	✓	Apols	✓	✓	✓
Mike Proctor						
Maneesh Singh						
Lee Bond	Apols	✓	✓	Apols (Rep)	Apols	✓
Jug Johal	✓	✓	✓	✓	Apols (Rep)	✓
Kate Wood	Apols	Apols	Apols	✓	✓	✓
Ellie Monkhouse	Apols (Rep)	Apols (Rep)	Apols (Rep)	Apols (Rep)	✓	
Christine Brereton	-					
Paul Marchant	✓	✓	✓	Apols	✓	✓
Andy Barber	-	-				
Victoria Winterton						
Clare Woodard	✓	✓	✓	Apols	✓	✓
Adrian Beddow	-					
Ian Reekie (Governor)						
Tony Burndred	-	✓	✓	-	-	
Susan Liburd	✓	Apols	✓	✓	✓	✓
Simon Leonard	✓	✓	✓	✓	Apols	✓
Lucy Skipworth	✓	✓	✓	Apols (Rep)	Apols (Rep)	✓
Ivan McConnell						Apols
Total	**8**	**10**	**10**	**7**	**8**	**10**

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)037

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Tony Curry, Non-Executive Director
Contact Officer/Author	Rebecca Thompson, Head of Corporate Affairs
Title of the Report	Minutes of the HUTH Charitable Funds Committee held 16 November 2023
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 are attached for review
Prior Approval Process	The minutes have not been approved at any other meeting
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:

Hull University Teaching Hospitals NHS Trust
Minutes of the Charitable Funds Committee
Held on 16 November 2023

Present:	Mr T Curry	Chair
	Mr M Robson	Non-Executive Director
	Mrs J Hawkard	Non-Executive Director
	Mr D Haire	Project Director Fundraising
	Mr S Evans	Operational Director of Finance
In Attendance:	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr L Bond, Group Chief Financial Officer	
2	**Declarations of Interest** There were no declarations received.	
3	**Minutes of the previous meeting held in May 2023** The minutes of the meeting were approved as an accurate record.	
4	**Action Tracker** The Committee reviewed the Action Tracker. There were no actions outstanding. The Committee discussed Corporate Social Responsibility and the future role of the Committee.	
5	**Work Plan** The Workplan would be revised in 2024 to reflect the reduction in number of meetings per year now the Charitable Funds have transferred to the WISHH Charity. The Terms of Reference would also be reviewed and presented to the next meeting. The investors report will be closed down due to the funds transferring to WISHH.	
6	**Financial Report including Fund Balances** Mr Evans advised that income is not received by the HUTH Charity anymore and the residual balances are being reviewed with a view to closing them down. The Trust have written to the Charity Commission to gain formal approval to transfer the balances to the WISHH Charity. Mr Haire has been named as the contact point between the Trust and the Charity Commission. Mr Robson asked why the numbers in the report and the accounts differed slightly and Mr Evans advised that the report figure was the draft figure before the External Auditors audit and the accounts figure was the final figure. Mrs Hawkard asked about any future large donations and Mr Hair advised that they would all be received by the WISHH Charity.	

Legal guidance was being sought regarding the £4m Allam legacy that remained as this was the majority of money now held in the Trust Charity account.

7 2022/23 Draft Charitable Fund Accounts

Mr Evans presented the year-end accounts. The Auditors fee had been held and the 2023/24 audit would only be an independent evaluation.

The only income coming into the account was now investment and interest payments.

Mr Evans advised that the Trust Board had approved the transfer of the funds to WISHH and an Extra Ordinary Charitable Funds Committee should be added to mid-January to ensure the accounts were approved and signed by the Chair before the end of January 2024.

The Committee discussed keeping the account open for another year to ensure the Allam funds were cleared and all other funds were transferred with Charities Commission approval and subject to any advice by Capsticks.

Resolved: The Committee approved the approach set out in the report and agreed to an extra-ordinary committee in January 2024.

8 Project Director's Report

Mr Haire presented the report and advised that he was working with Capsticks to produce a Memorandum of Understanding to be in place when the balance of funds transferred fully to the WISHH Charity. The MOU sets out the principles on which the transaction is taking place and builds safeguards for the Trust should there be any issues.

Mr Robson was keen for the Charitable Funds Committee to have some influence on Charity spending and Mr Haire advised that the WISHH Charity were very proactive but there would be new paperwork for services putting in requests. He added that he and Mr Bond were Trustees with the WISHH Charity.

Mr Haire advised that the Space to Grow appeal had exceeded the £100k target and had also been successful in a £198k bid for a Health and Wellbeing suite at HRI.

The WISHH Charity had achieve £900k in the last 12 months against a target of £1m. The Charity was looking to fund another member of staff to give more bandwidth.

Benefactor developments such as the Diabetes Centre and the Digestive Centre were moving forward but the financial pressures were significant.

Mr Haire spoke about the robotic theatre and the fact that the first robot was almost 10 years old. It was being utilised well but the company it was purchased from would stop supporting it in 2024.

PET CT – The Daisy Charity have sourced a scanner at £2m and it was being shipped out of Israel.

Mr Haire updated the Committee regarding the Arts Strategy and commended the work relating to a comic style adult booklet for stroke patients. Also provided were professional speech notes for patients which was the first in the UK. Mr Robson stated that it was important to use Art in any therapeutic environment. Mr Haire agreed but advised that the pace of some projects sometimes mitigated that, but better results would be seen if Art was included.

9 General Purpose Fund Balance

Mr Haire presented the paper and highlighted 3 bids for funding already approved by the Chairman. These were: fees and support costs for tw part-time PhD students £40k, fees and support costs for a second year MSc student and funding for 8 reclining chairs for patients in the ED.

It was proposed that close down funds were used for: the provision of furniture and equipment in the Allam Diabetes centre (£325k) and contribution to the building costs of the Health and Wellbeing centre at HRI (£126,500).

Mr Haire also advised that action would be taken to realise the Trust's investments with CCLA.

Resolved: The Committee approved the 3 bids detailed above, approved the use of the close down funds and agreed to allow Mr Evans to review the investments and report back at the next meeting.

10 Chairman's Summary of the Meeting

Mr Curry summarised the meeting stating that there was still work to transfer the balances to the WISHH Charity as the Trust was still waiting for approval from the Charity Commission and the DoH.

This year' financial accounts were subject to completion of the audit and the final version would be presented to the Committee in January 2024 for sign off.

11 Any Other Business

Mr Curry agreed to review the Committees Terms of Reference and the role of the Committee in the future. He was keen to include the Art Strategy, Corporate Social Responsibility Strategy and liaison with the WISHH Charity.

Assurance that the WISHH Charity was acting on behalf of the Trust was required and this would be carried out through an annual meeting with the Trustees. Mr Haire added that it was important that the Trust knew how to identify to WISHH if there were particular funding priorities.

Mr Curry stated that substantial assurance should be given to all items discussed in this meeting.

12 Date and time of the next meeting:

Monday 15 January 2023, 10am – 11am
EO Meeting to approve the accounts

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)038

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Shaun Stacey, Chief Delivery Officer Ivan McConnell, Group Chief Strategy & Partnerships Officer
Contact Officer/Author	Adam Creeggan, Interim Group Director of Performance
Title of the Report	Integrated Performance Report
Executive Summary	This report provides details of performance achieved against key national performance, quality, and governance indicators defined in the NHSE Single Oversight Framework (SOF).
Background Information and/or Supporting Document(s) (if applicable)	The IPR currently reflects the sovereign report for both NLAG and HUTH. The report relates to performance against statutory requirements of the Trust license (NALG). A single format report is in development and will be presented for Month 1 positions 2024/25.
Prior Approval Process	Presented to Performance, Estates and Finance Committee in Common
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)	System plans to address equality in elective wait times via mutual aid (patient transfer between providers) are referenced within the report.
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

IPR EXECUTIVE SUMMARY **Date: January 2024**

1. ACCESS & FLOW – Shaun Stacey

Highlights: (share 3 positive areas of progress/achievement)

- DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)
- Cancer – 28 Day Faster Diagnosis
- % Discharge Letters Completed Within 24 Hours of Discharge

Lowlights: (share 3 areas of challenge/struggle)

- Ambulance Handover Delays 60+ Minutes
- Number of patients waiting over 12hours from decision to admit to ward admission
- Bed Occupancy Rate (General and Acute)

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Ambulance Handover Delays 60+ Minutes	Plan to increase contacts through community 2-hour urgent care response and integrate with social care, to further increase contacts, to help with admission & conveyance avoidance	Conveyance avoidance will decrease the volume of ambulances arriving at ED allowing timelier handover of patients.
Number of patients waiting over 12hours from decision to admit to ward admission	Reiteration of the criteria to admit to all grades of clinicians within ED as part of the MADE Event	Reiteration of the criteria to reside will reduce the number of admissions and thus reduce the number of trolley waits.
Bed Occupancy Rate (General and Acute)	Delivery of new IAAU/SDEC builds	The new build areas will aid with placing the right patient in the right place at the right time, increasing flow and reducing length of stay to improve the bed occupancy rate.

IPR EXECUTIVE SUMMARY	Date: January 2024

1. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

Highlights: (share 6 positive areas of progress/achievement)

- The number of acute pressure ulcer incidents reported has decreased. Al incidents of moderate harm continue to be reviewed at the weekly scrutiny meeting which is support by our ICB colleagues
- Our figures for C-Difficile infections have remained static for this month. We have currently reported 13 in total with a national Threshold of 20.
- There has been a significant increase in the Friends and Family Test response rates in Emergency Departments. The introduction of the new FFT provider service has contributed to the recent improvement in responses as well as the focus and steer from the Temporary Patient Experience Manager.
- The rolling 12 month SHMI remains within the 'as expected' banding with the latest value of 102.02 for the period September 2022 – August 2023.
- Adult sepsis screening completed within 15 minutes in response to elevated NEWS2 score continues to improve and there has been an improvement in the percentage of paediatric sepsis screening tools completed (56% in December 2023 compared to 45% in November 2023).
- We continue to manage patient safety alerts, meeting national deadlines for the past 10 months.
- Duty of candour rate is maintained at 100%.

Lowlights: (share 6 areas of challenge/struggle)

- There has been a slight increase in the total number of reported in-patient falls. One moderate harm (Ward 5) and one major harm (Ward 27) were reported and prompt multi-disciplinary huddles was completed with no new learning and all appropriate risk reduction interventions were in place.
- There has been a slight increase in the number of Community acquired Pressure Ulcers

- Formal complaints fell for a second consecutive month with 21 received for December, however complaints received do continue to be very complex in nature and require significant investment in time from the Lead Investigator(s) and Complaint Facilitator(s). Written responses provided appear to remain detailed and appropriate, as this is likely to attribute to the low levels of re-opened complaints as responses appear satisfactory to the complainants.
- Formal complaints performance declined to 71% -
- The percentage of SJRs sighting problems in care/negative learning associated with recognition of End Of Life (EOL) pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation has risen to 25% in October 2023.
- Compliance with MCA assessments and best interest recording that meet the legal requirements continued to be low with 4% and 0% in October, respectively
- Weight entry on ePMA remains challenged by dual systems.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Increase of 2 inpatient falls this month	The incidents of falls are reviewed at the monthly Nursing Metric meeting and triangulated with no themes identified.	Prompt falls huddles continue with a multi-disciplinary approach to identify any concerns immediately and actions in place to ensure safety
Increase of 2 community acquired Pressure Ulcers	Each Network has reviewed its caseloads and the numbers reported are reflective of this. Most reported are Category 2. On review at the weekly scrutiny meeting there were no consistent themes or new learning identified and all of the incidents occurred in separate care homes.	Will continue to review caseloads and identify any new themes
Reduction in formal complaints performance	The reduction can be attributed to 4 very long-standing complaints reaching conclusion. These complaints were complex in their nature.	Work continues with the Complaint Facilitators to ensure the sign-off process is timely. Weekly one-to-ones with the Complaints Manager & Facilitators, Support & Challenge meeting and Patient Experience Lead oversight will continue to enable focus remains on the 60 Day KPI.

The percentage of SJRs sighting problems in care/negative learning associated with recognition of End of Life (EOL) pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation has risen to 25% in October 2023.	ReSPECT training continues to be delivered and over 40 clinical staff have completed Abbreviated authorship/ReSPECT training during October's Medicine Divisions Quality Safety and Audit meeting. Work has been completed to help improve the level of communication in our discharge summaries around DNACPR decisions and ceiling of care recorded on ReSPECT forms.	Reduction in negative learning associated with recognition of EOL pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation.
Compliance with MCA assessments and best interest recording that meet the legal requirements.	QI projects are underway on Ward 23, Ward 24/IAAU and the Stroke ward at SGH. 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. The MCA working group continue to meet to share learning and change ideas.	Improved patient/carers experience due to compliance with MCA.

Weight entry on ePMA remains challenged by dual systems.	Presentations to raise awareness of the importance of weight recording on EPMA have been delivered. Monthly summary reports continue to be shared with ward leaders displaying compliance levels to encourage improvement. A working group is planned with links to QI resource.	Improve safety of weight related prescribing.

IPR EXECUTIVE SUMMARY	Date: January 2024

1. WORKFORCE – Simon Nearney

Highlights:

- The Turnover position has decreased again, this is now at 10.47% and the lowest it has been since recording via the IPR.
- The PADR combined AfC and Medical Staff PADR rates still remains above target at 86.7% with an increase this month of 1.9%
- Sickness rates remain above target, however, has reduced by 0.38% and is currently at 5.06%. The sickness rate continues to reduce and is the lowest it has been in the 'winter period' since recording of the IPR.

Lowlights:

- Role Specific Mandatory Training remains below target at 80.1% against a target of 85%
- The Vacancy release date has prevented from updating the vacancy date for December as it exceeds the production timeframe, this is mainly due to the bank holidays in December/January preventing the reports to be ready. Two months wot of vacancy data will be produced when we produce the IPR in February

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Role Specific Mandatory Training Role Specific Mandatory training remained stable this past month, and is sustaining its position just above 80%, 5% below the Trust target. **Vacancy Data** The vacancy release date has prevented us from updating the vacancy data for December as it exceeds the production timeframe, this is mainly due to the bank holidays in December/ January preventing the reports to be ready. Two months' worth of vacancy data will be produced when we produce the IPR in February.	**Role Specific Mandatory Training** Moving and Handling, Resus and Deteriorating Patient (ALERT) remain a clear focus for improving role specific compliance, all of which are classroom-based and significantly impacted by non-attendance. Overall Moving and Handling provision (all modules) reported 81% compliance @2.1.24, with 829 out of compliance. This provision has seen a sustained improvement in compliance over the past 6 months. Throughout 2023, 4559 staff enrolled on to Moving and Handling modules, with 1974 completing (43% completion). During this period, 656 staff did not attend (DNA) the session they had enrolled on to (14% DNA). Overall Resus provision (all modules) reported 70% compliance @2.1.24, with 1900 out of compliance. This provision has seen a slight improvement over the past 3 months but remains significantly below the Trust target. Throughout 2023, 6642 staff enrolled on to Resus modules, with 4642 completing (70% completion). During this period, 823 staff did not attend (DNA) the session they had enrolled on to (12% DNA).	**Role Specific Mandatory Training** Additional actions during January 2024 to address concerns identified: • Gather baseline data from all staff groups to assess the main barriers to attending classroom-based provision – via Mentimeter • Gather baseline data from all staff groups to assess main barriers to completing eLearning timely – via Mentimeter • Gather more detailed data from staff group – Medical and Dental to identify specific barriers to completing all required learning – via targeted MS Forms • Analyse data collected to review practices / processes and set plans for supporting improvement in attendance and compliance

	Deteriorating Patient (ALERT) provision reported 53% compliance @2.1.24, with 427 out of compliance. During 2023, 647 staff enrolled on to this provision, with 298 completing (46% completion). During this period, 111 staff did not attend (DNA) the session they had enrolled on to (17% DNA). Staff Group – Medical and Dental continue to report the lowest compliance for Role Specific Mandatory training @ 56.16% on 2.1.24, with 2784 out of compliance. Analysis of classroom-based provision for this staff group shows that, during 2023, 6623 staff enrolled on to face to face sessions, with 3916 completing (59%), 816 withdrawing (12%), and 1188 not attending (DNA) (18%).	

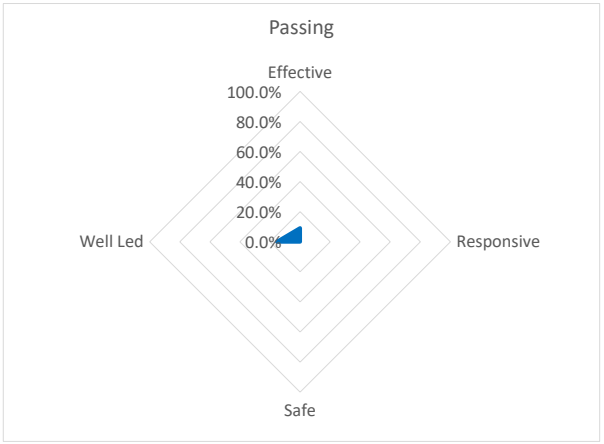
Radar

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

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

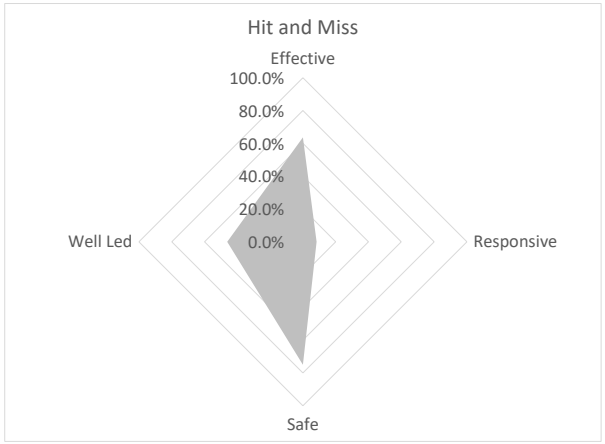
Total: 3



% Discharge Letters Completed Within 24 Hours of Discharge
Core Mandatory Training Compliance Rate
Medical Staff PADR Rate

Hit and Miss

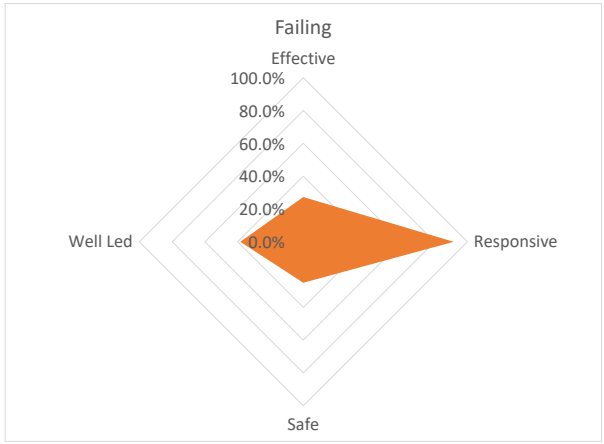
Total: 17



% Outpatient Non Face To Face Attendances
% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Mixed Sex Accommodation Breaches
Total Inpatient Waiting List Size
Venous Thromboembolism (VTE) Risk Assessment Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Complaints Responded to on time
Sickness Rate
Unregistered Nurse Vacancy Rate *
Registered Nurse Vacancy Rate *
Medical Vacancy Rate *
Medical Vacancy Rate - Consultants *
Medical Vacancy Rate - Other *

Consistently Failing

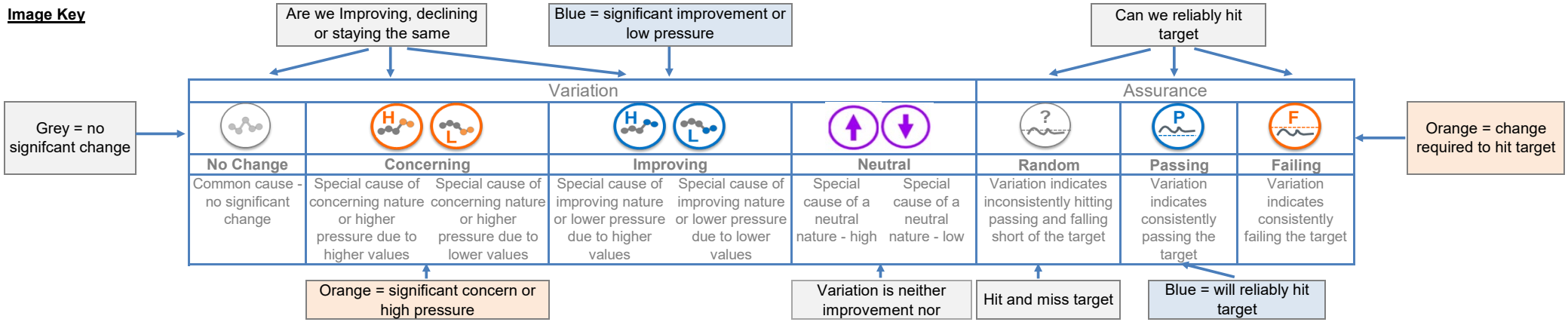
Total: 20



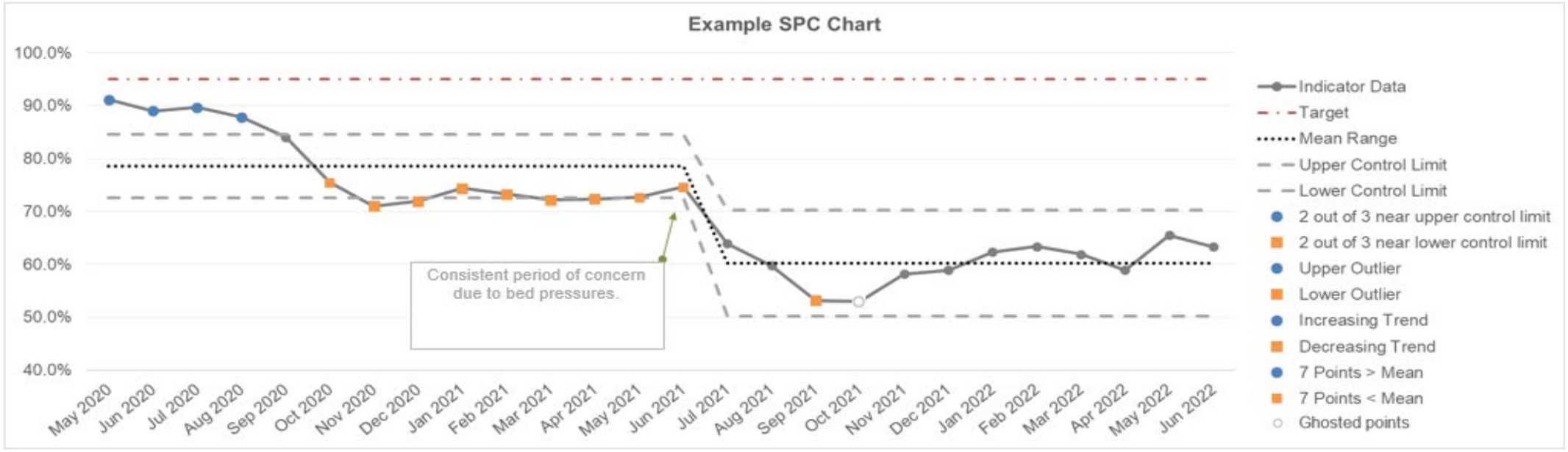
% Inpatient Discharges Before 12:00 (Golden Discharges)
Ambulance Handover Delays - Number 60+ Minutes
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Emergency Department Waiting Times (% 4 Hour Performance)
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
Outpatient Did Not Attend (DNA) Rate
PADR Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Role Specific Mandatory Training Compliance Rate
Turnover Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
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*
Community Acquired Pressure Ulcers (Number)
Trustwide Vacancy Rate *
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 / L	% Discharge Letters Completed Within 24 Hours of Discharge	% of Extended Stay Patients 21+ days Inpatient Non Elective Average Length Of Stay Duty of Candour Rate Mixed Sex Accommodation Breaches Sickness Rate Unregistered Nurse Vacancy Rate *	Turnover Rate PADR Rate Combined AfC and Medical Staff PADR Rate Role Specific Mandatory Training Compliance Rate
	Common Cause		Medical Staff PADR Rate Core Mandatory Training Compliance Rate	% Patients Discharged On The Same Day As Admission (excluding daycase) Inpatient Elective Average Length Of Stay Complaints Responded to on time Venous Thromboembolism (VTE) Risk Assessment Rate Registered Nurse Vacancy Rate * Medical Vacancy Rate * Medical Vacancy Rate - Other *	% Inpatient Discharges Before 12:00 (Golden Discharges) Outpatient Did Not Attend (DNA) Rate 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) Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* 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 Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Community Acquired Pressure Ulcers (Number) Trustwide Vacancy Rate *
	Special Cause Concern	H / L		% Outpatient Non Face To Face Attendances Bed Occupancy Rate (G&A) Total Inpatient Waiting List Size Medical Vacancy Rate - Consultants *	Number of Overdue Follow Up Appointments (Non RTT) Number of Incomplete RTT pathways 52 weeks* Percentage Under 18 Weeks Incomplete RTT Pathways*

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.

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.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Dec 2023	59.7%	92.0%	Alert		
	Number of Incomplete RTT pathways 52 weeks*	Dec 2023	751	353	Alert		
	Total Inpatient Waiting List Size	Dec 2023	12,438	11,563	Alert		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Dec 2023	26.4%	1.0%	Alert		
	Number of Incomplete RTT pathways 65 weeks	Dec 2023	99	0.0%	Alert		n/a
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Dec 2023	39,830	9,000	Alert		
	Outpatient Did Not Attend (DNA) Rate	Dec 2023	6.7%	5.00%	Alert		
	% Outpatient Non Face To Face Attendances	Dec 2023	19.4%	25.00%	Alert		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Dec 2023	47.3%	85.0%	Alert		
	Cancer Waiting Times - 104+ Days Backlog*	Dec 2023	25	0	Alert		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Dec 2023	13.3%	75.0%	Alert		
	Cancer - Request To Test In 7 Days*	Dec 2023	47.1%	100.0%	Alert		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2023	61.5%	76.0%	Alert		
	Number Of Emergency Department Attendances	Dec 2023	14,635	10,114	Alert		n/a
	Ambulance Handover Delays - Number 60+ Minutes	Dec 2023	639	0	Alert		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Dec 2023	705	0	Alert		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Dec 2023	453	0	Alert		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Dec 2023	40.7%	40.0%			
	% of Extended Stay Patients 21+ days	Dec 2023	10.5%	12.0%	Highlight		
	Inpatient Elective Average Length Of Stay	Dec 2023	1.6	2.5			
	Inpatient Non Elective Average Length Of Stay	Dec 2023	3.5	3.9			
	% Discharge Letters Completed Within 24 Hours of Discharge	Dec 2023	97.0%	90.0%			
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Dec 2023	18.3%	30.0%	Alert		
	Bed Occupancy Rate (G&A)	Dec 2023	95.1%	92.0%	Alert		

Scorecard - Quality and Safety

Northern Lincolnshire and Goole NHS Foundation Trust

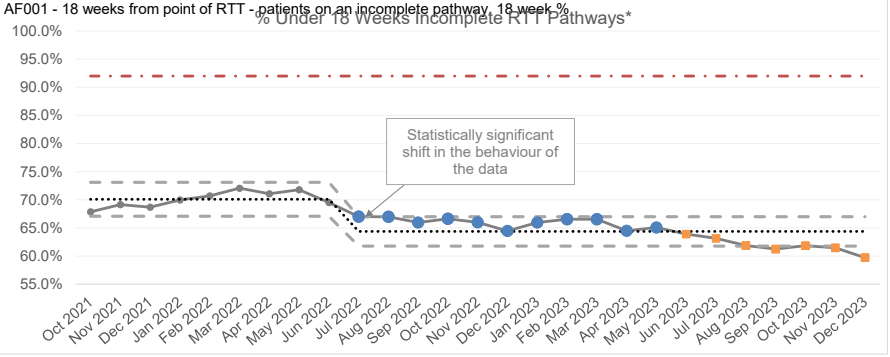
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when 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)*	Nov 2023	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Nov 2023	0.30	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Nov 2023	0.10	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Nov 2023	0.10	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Nov 2023	0.50	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Sep 2023	103.4	As expected	**Alert**		As expected
	Summary Hospital level Mortality Indicator (SHMI)	Jul 2023	102.2	As expected			As expected
	SHMI diagnosis groups outcome risk percentage (infections)	Jul 2023	91.6%	No target			n/a
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Oct 2023	25.0%	No target		n/a	n/a
Safe Care	Patient Safety Alerts actioned by specified deadlines	Nov 2023	100.0%	100%			n/a
	Number of Serious Incidents raised in month	Nov 2023	4	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Nov 2023	0	0		n/a	n/a
	Duty of Candour Rate	Nov 2023	100.0%	100%			
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2023	4.6	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2023	3.5	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Dec 2023	95.7%	95.0%			
	Care Hours Per Patient Day (CHPPD)	Nov 2023	8.6	No target			n/a
	Mixed Sex Accommodation Breaches	Nov 2023	2	0	**Highlight**		
	Community Acquired Pressure Ulcers (Number)	Nov 2023	51	0	**Alert**		
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Dec 2023	3.7	No target			n/a
	Complaints Responded to on time	Dec 2023	71.0%	85.0%			
	Friends & Family Test: Inpatient Score Percentage Positive	Oct 2023	98.1%	No target			n/a
	Friends & Family Test: A&E Score Percentage Positive	Oct 2023	84.6%	No target			n/a
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Nov 2023	6.0	No target			n/a
Mental Capacity	Number of contacts with the MCA/DoLS team	Dec 2023	0.0	No target		n/a	n/a
	Percentage of MCA assessments that meet the legal requirements	Oct 2023	4.0%	No target		n/a	n/a
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Oct 2023	0.0%	No target		n/a	n/a
Prescribing	Harm impact for weight related medication prescribing incidents	Dec 2023	0	No target			n/a
Maternity	Robson Scores - Group 1	Dec 2023	8.1%	No target			n/a
	Robson Scores - Group 2	Dec 2023	25.6%	No target			n/a
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Dec 2023	12	No target			n/a
	Still Birth Rate per 1000	Dec 2023	6.6	No target			n/a
	Spontaneous 3rd or 4th Degree Tear	Dec 2023	0.6%	No target			n/a
	Instrumental 3rd or 4th Degree Tear	Dec 2023	3.7%	No target			n/a

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.

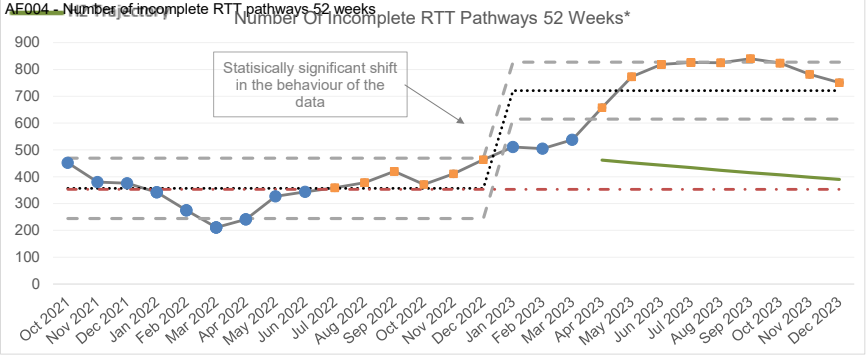
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate*	Nov 2023	11.4%	8.0%		L	?
	Registered Nurse Vacancy Rate*	Nov 2023	8.1%	8.0%			?
	Medical Vacancy Rate*	Nov 2023	12.6%	15.0%			?
	Trustwide Vacancy Rate*	Nov 2023	8.6%	8.0%	Alert		F
	Medical Vacancy Rate - Consultants*	Nov 2023	18.8%	15.0%	Alert	H	?
	Medical Vacancy Rate - Other*	Nov 2023	8.8%	15.0%			?
Staffing Levels	Turnover Rate	Dec 2023	10.4%	10.0%	Alert	L	F
	Sickness Rate	Nov 2023	5.1%	4.1%		L	?
Staff Development	PADR Rate	Dec 2023	86.2%	85.0%	Highlight	H	F
	Medical Staff PADR Rate	Dec 2023	93.0%	85.0%			P
	Combined AfC and Medical Staff PADR Rate	Dec 2023	86.7%	85.0%	Alert	H	F
	Core Mandatory Training Compliance Rate	Dec 2023	90.2%	85.0%			P
	Role Specific Mandatory Training Compliance Rate	Dec 2023	80.3%	85.0%	Alert	H	F

AF001 - 18 weeks from point of RTT - patients on an incomplete pathway, 18 week %



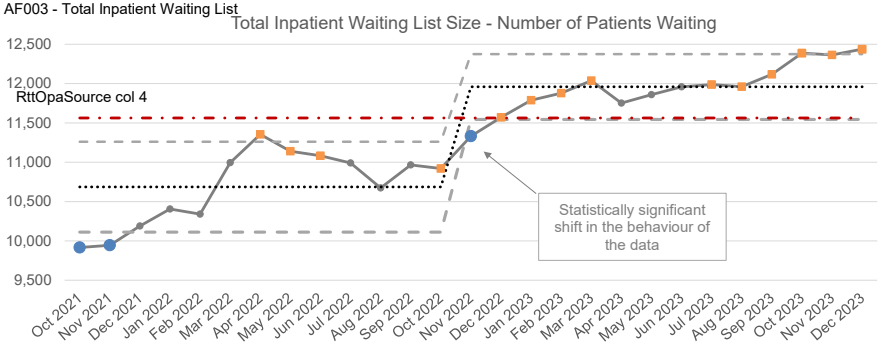
Dec 2023	Target	Variance	Assurance
59.7%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



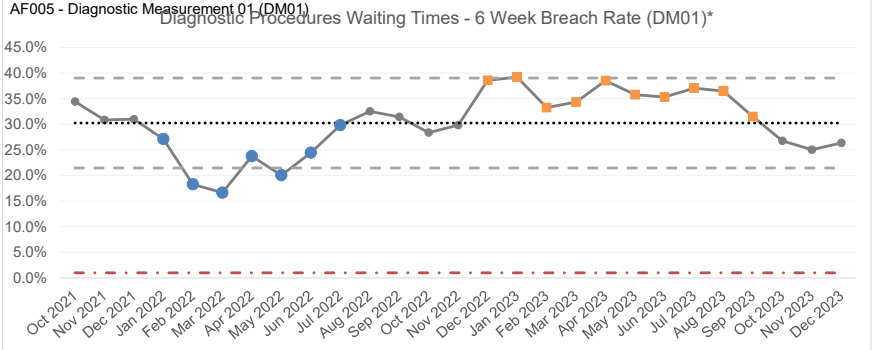
Dec 2023	Target	Variance	Assurance
751	353	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

AF003 - Total Inpatient Waiting List



Dec 2023	Target	Variance	Assurance
12,438	11,563	Special cause of concerning nature or higher pressure due to higher values	Inconsistently hitting passing and falling short of the target

AF005 - Diagnostic Measurement 01 (DM01)



Dec 2023	Target	Variance	Assurance
26.4%	1.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:
Continued growth in the size of waiting list, resulting in deterioration in RTT performance and the ability to deliver an improvement in the 52 week position and diagnostic services remain significantly adrift from target.

Challenges:
- Growth in the waiting list has been impacted by workforce vacancies, sickness and industrial action affecting outpatient and theatre delivery.
- Delays in commencing independant sector work has significantly reduced outpatient activity levels within Gastroenterology.
- The impact of increased acute activity over the period has meant that elective capacity has had to be stood down on occasion.
- Capacity shortages within some diagnostic modalities such as echocardiography and MRI have caused delays in the patient pathway and there have been some delays in reporting within CT and MRI.

Key Risks:
- Ageing diagnostic equipment across multiple modalities - loss of service provision may potentially cause clinical harm potential due to pathway delays.
- Diagnostic recruitment and retention / workforce skill mix.
- Impact on operational delivery due to ongoing industrial action.
- Inability to fill consultant vacancies in hard to fill specialties.

Actions:
- Recruitment of Radiographers /Radiologists nationally and internationally to support mobilisation of Community Diagnostic Centres.
- Additional sessions established to support delivery of Divisional activity plans both internally and within the independent sector (ongoing)
- Waiting list Initiatives to recover lost activity due to Industrial action (ongoing)
- Recruitment of 2 Respiratory Consultants (Nov '23 - commencement March 24)

Mitigations:
- Locum staff appointed were possible to maintain service delivery.
- Diagnostic equipment maintenance contracts in place, equipment risks on risk register.
- Weekly performance review in place, robust processes in place to regularly review waiting lists and focus on long waiting and high-risk patients.
- Clinical risk stratification to ensure allocation of all appointments is based on clinical priority of patients
- Mobilisation of Community Diagnostic Centre CT/MRI vans on alternative pad locations

	Dec 2023	
	99	
	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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Data Analysis:
RTT delivery of 65 weeks is on track to achieve zero in March

Challenges:
- Focussing primarily on 65 week waits and cancer cases has impacted on other waiting list cohorts such as 52 weeks, creating longer waits.
- Whilst 65 weeks may be achieved by March this may not be sustainable if workforce vacancies and capacity constraints are not addressed.

- **Key Risks:**
- Ageing diagnostic equipment across mulitple modalities - loss of service provision may potentially cause clinical harm potential due to pathway delays.
- Diagnostic recruitment and retention / workforce skill mix.
- Impact on operational delivery due to ongoing industrial action.
- Inability to fill consultant vacancies in hard to fill specialties.

Actions:
- Recruitment of Radiographers /Radiologists nationally and internationally to support mobilisation of Community Diagnostic Centres.
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Mitigations:
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- Diagnostic equipment maintainance contracts in place, equipment risks on risk register.
- Weekly performance review in place, robust processes in place to regularly review waiting lists and focus on long waiting and high-risk patients.
- Clinical risk stratification to ensure allocation of all appointments is based on clinical priority of patients.
- Mobilisation of Community Diagnostic Centre CT/MRI vans on alternative pad locations

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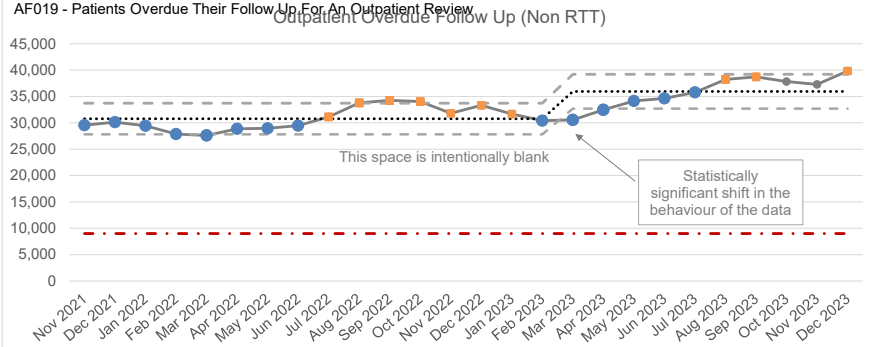
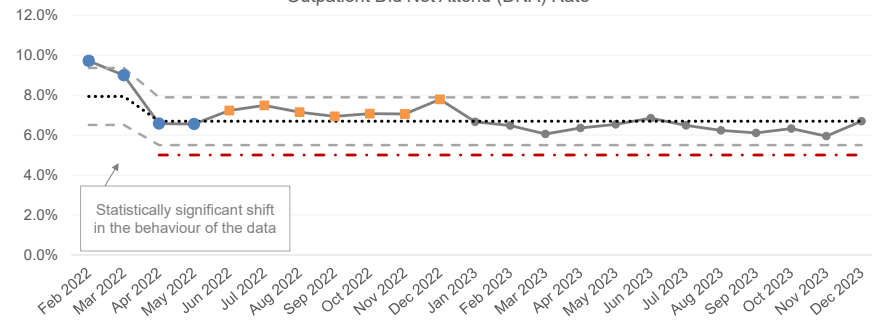
AF019 - Patients Overdue Their Follow Up For An Outpatient Review



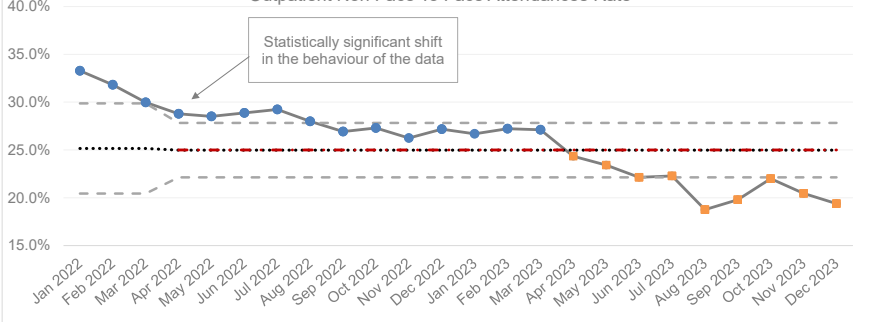
Dec 2023: 39,830
Target: 9,000
Variance: Special cause of concerning nature or higher pressure due to higher values
Assurance: Consistently falling short of the target

Outpatient New DNA Rate



Dec 2023: 6.7%
Target: 5.0%
Variance: Common cause - no significant change
Assurance: Consistently falling short of the target

Outpatient New Virtual Appointments



Dec 2023: 19.4%
Target: 25.0%
Variance: Special cause of concerning nature or higher pressure due to lower values
Assurance: Inconsistently hitting passing and falling short of the target

Data Analysis:
Outpatient DNA rate consistently adrift of target. The number of outpatient appointments delivered virtually continues to reduce and the number of patients overdue a follow-up appointment is on an upward trajectory.

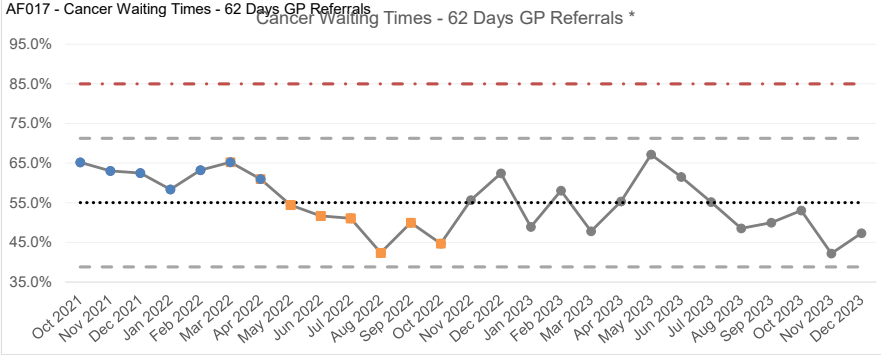
Challenges:
- Achieving the 25% reduction in follow-up activity continues to have a significant impact on the overdue follow-up waiting list, as we try to balance capacity. Despite the work todate, patients continue to be added to the follow-up list, and the number overdue remains high.
- Opportunities 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. ENT are our first pilot, and we hope to start this in January 2024.
- Management resource available to the Outpatient Programme is limited due to operational constraints.
- A lack of funding to continue roll-out of the Connected Health Network at pace is causing some frustration. Although there has been an agreement to finalise Cardiology roll-out to the last 3 Primary Care Networks.

Key Risks:
- Clinical buy-in across some specialities to deliver the 25% reduction. Radical change required, regarding validation and discharge.
- Delay in securing a long-term finance model for CHN as pump prime funding expired in March 2023.
- Impact on operational delivery due to ongoing industrial action.
- Continued increase in the overdue follow-up waiting list, as follow-up capacity is reduced.
- Non face to face attendance rates will fall due to the contract for video consulting ending in March with no further funding secured to extend.

Actions:
- Within the 'Getting it Right First Time' (GIRFT) action plans, a number of initiatives have been agreed including changes to pathways and consideration of 'Patient Initiated Follow-Up' (PIFU) pathways where clinically appropriate, this work will continue (Oct - Mar 24).
- Patient Knows Best (PKB) patient portal is being developed to support condition specific PIFU pathways, this will be developed throughout 2024.
- Divisional Medical Directors to explore options for delivering the 25% reduction in follow-ups Pilots agreed with ENT, Paediatrics and Gynaecology for direct communication with patients. To commence January, subject to supplier delivery (Jan 24)
- Focussed work has commenced within the Medicine specialties of Gastroenterology, Respiratory and Cardiology (ongoing)
- GIRFT for Outpatients is underway across 14 specialities. There are 78 actions in total, being monitored via the GIRFT Steering Group (ongoing).
- Discussions on CHN future finance model is progressing with NLAG and ICB finance leads, some TIF funding is being utilised as an interim arrangement to complete Cardiology roll-out across all the PCN's in Northern Lincolnshire (Mar 2024)
- Data Packs are being developed to support specialties in reducing follow-ups, showing inconsistencies across the specialty workforce. Gastroenterology is the first pilot area to use the pack. Gynaecology urology, respiratory and ENT are in development (ongoing)

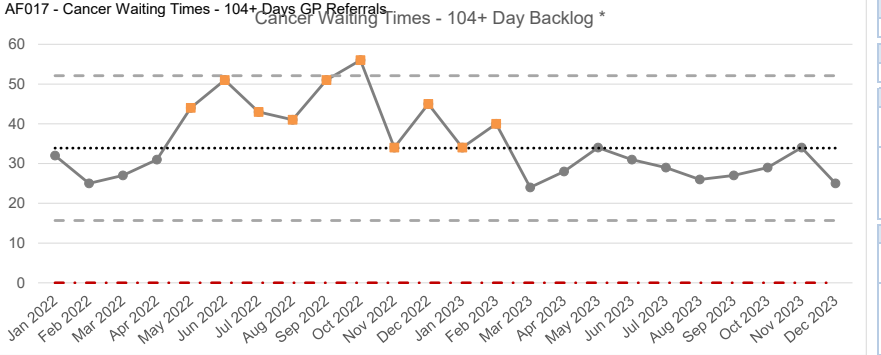
Mitigations:
- Clinicians engaged through GIRFT to support PIFU adoption, discharge and OP Follow-up Patient Validation.
- Divisional Medical Directors engaged in discussions and proposals to validate follow-up patients (via direct correspondence)
- Discussions continue on future finance options for Connected Health Network, interim arrangements in place to finalise Cardiology roll-out. CHN Evalution paper developed, final draft is being considered by COO.
- Specialty level trajectories in place within the activity plans for 2023-24 for follow-up activity reduction.

AF017 - Cancer Waiting Times - 62 Days GP Referrals



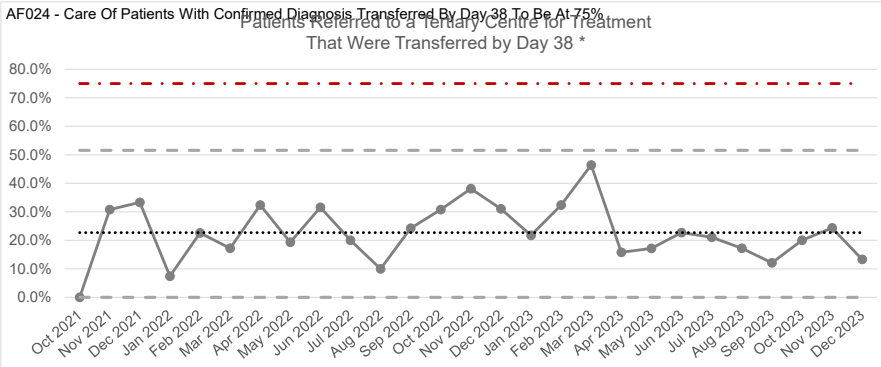
Dec 2023	Target	Variance	Assurance
47.3%	85.0%	Common cause - no significant change	Consistently falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



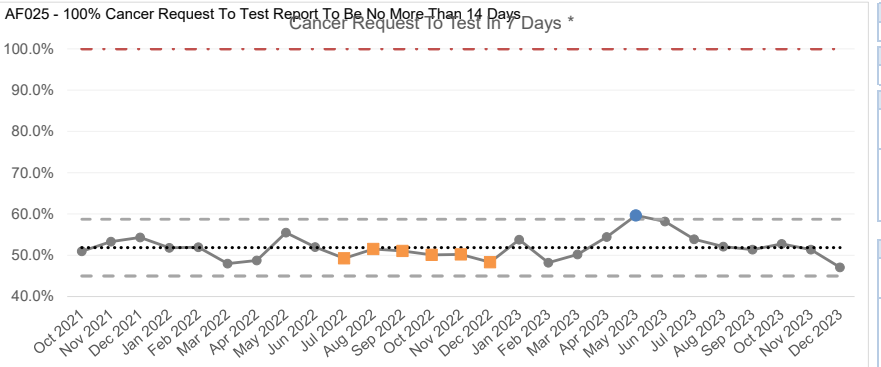
Dec 2023	Target	Variance	Assurance
25	0	Common cause - no significant change	Consistently falling short of the target

AF024 - Care Of Patients With Confirmed Diagnosis Transferred By Day 38 To Be At 75%



Dec 2023	Target	Variance	Assurance
13.3%	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



Dec 2023	Target	Variance	Assurance
47.1%	100.0%	Common cause - no significant change	Consistently falling short of the target

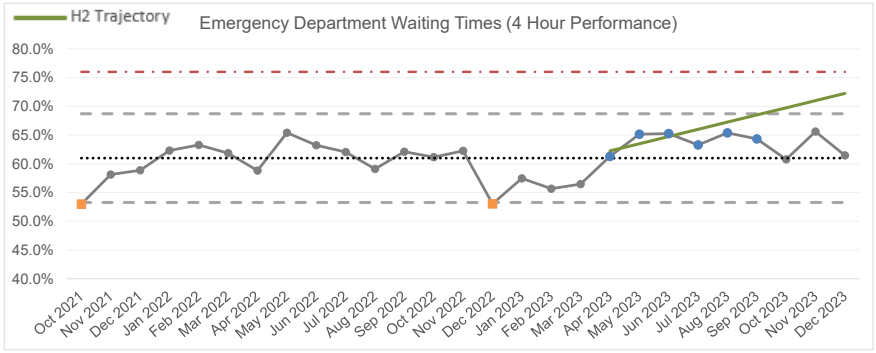
Data Analysis:
Failing to request diagnostic test within 7 days from referral has impacted upon the ability to transfer to the tertiary centre by day 38 which has contributed toward non-achievement of 62 days from referral to treatment target and impacted upon the +104 week waiters.

Challenges:
- All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62-day pathway).
- 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.
- 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 creates patient delays and impacts on delivery of national cancer stanndards.

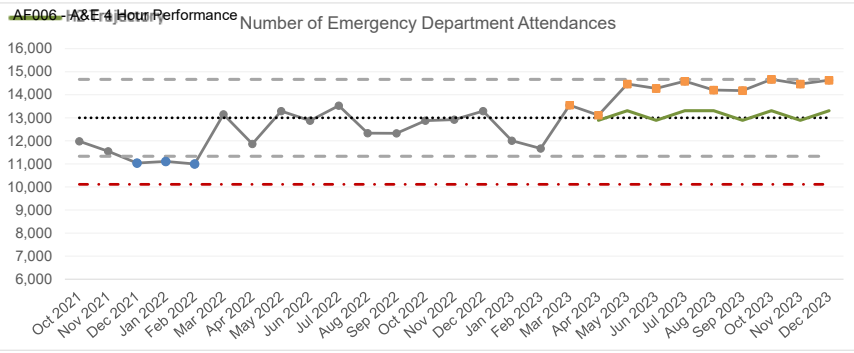
Key Risks:
- Request to Test (14 days) requires reduction to 7 calendar days to meet 28-day Faster Diagnosis Standard
- Upper GI pathway includes HUTH, currently significant delay due to demand on services.
- There are issues related to visiting consultant services for Oncology referrals for tertiary based staging scans (EUS, PET CT) and associated wait for results affect the ability to transfer for treatment by Day 38.

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.

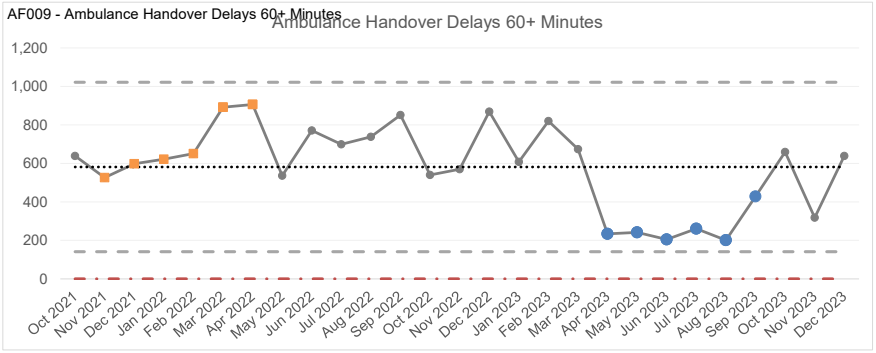
Mitigations:
- 62-day performance is being reviewed and managed weekly.
- Joint weekly PTL review between Medicine and Surgery Upper GI in place.
- Cancer Improvement Plans developed for each cancer tumour site - undergoing revision Jan-March 24, based on impact of improvements to date.
- Micro-management 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..



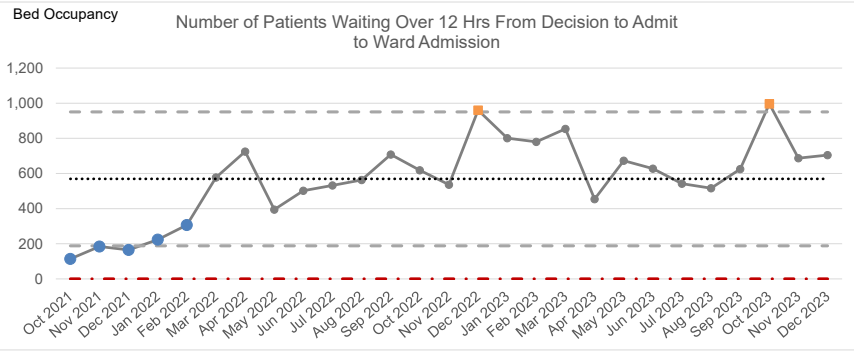
Dec 2023	Target	Variance	Assurance
61.5%	76%	Common cause - no significant change	Consistently falling short of the target



Dec 2023	Target	Variance	Assurance
14,635	10114	Special cause of concerning nature or higher pressure due to higher values	There is no target therefore target assurance is not relevant



Dec 2023	Target	Variance	Assurance
639	0	Common cause - no significant change	Consistently falling short of the target



Dec 2023	Target	Variance	Assurance
705	0	Common cause - no significant change	Consistently falling short of the target

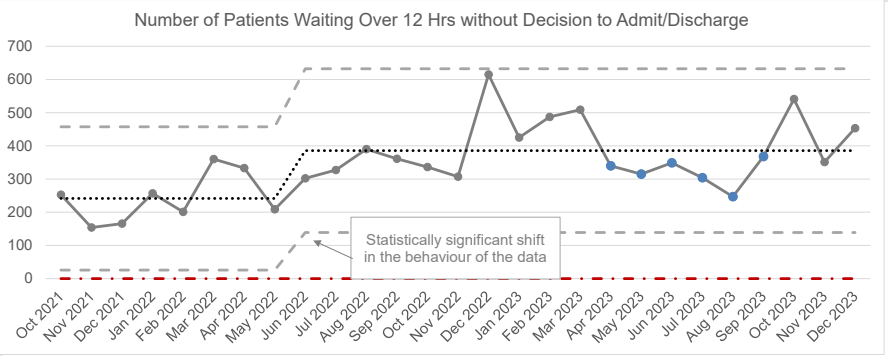
Data Analysis:
Attendances are significantly above trajectory which has impacted on delivery of 76% target. Delays in A&E resulting in protracted hand overs and waits for ward admission.

Challenges:
- Delays in hospital handover process creating issue within the community due to delays in access to ambulances.
- 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.
- Demand on services impacts on hospital flow and delays in admission resulting in regular escalation of OPEL status.
- Continued rise in attendances at ED.

Key Risks:
- Inability to meet the Royal College of Emergency Medicine staffing requirements in the Emergency Department.
- 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:
- QI projects have commenced in relation to 4 hour performance and improving flow, meetings taking place with key stakeholders an (ongoing).
- Process improvement has been carried out in relation to Ambulance Handover to ensure achievement of 30 minute (ongoing).
- Work being carried out in relation to system issues that are leading to 12 hour breaches (ongoing).
- Clinical specialties linked to 12hour breaches under review (ongoing).
- Front door frailty model implemented Dec 23 (ongoing)
- SDEC case mix audit being undertaken with regional CAP support to ensure correct patients are being referred to SDEC (Jan 24)
- Plan to increase contacts through community 2 hour urgent care response and integrate with Social care, to further increase contacts, to assist with admission and conveyance avoidance (Jan 24)

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 will be implemented from 08/01/24.
- New 1:14 junior doctor rota implemented from December.
- Escalation process in place for all ambulance handovers over 30 minutes
- Morning de-brief meeting is taking place to review reasons for delays the previous day.
- 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.
- Virtual ward, Outpatient Parenteral Antimicrobial Therapy (OPAT) and Home first now implemented.



Dec 2023	Target	Variance	Assurance
453	0	Common cause - no significant change	Consistently falling short of the target

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Data Analysis:
Significant delays in patients waiting in excess of 12 hours for a decision to admit.

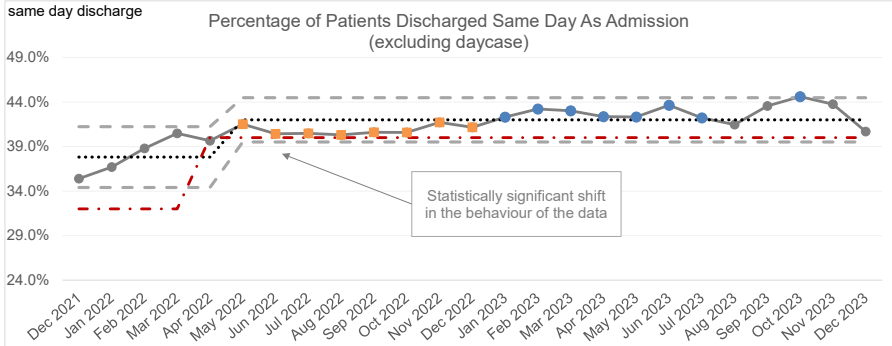
Challenges:
- Number of patients without a Decision to admit increasing - impacting on the ability to move patients from department.
- Regularly running at capacity in SDEC, impacting patient flow within the department.
- Use of urgent care service (UCS) rooms overnight to bed patients down resulting 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.
- Contiued increase in the number of patients attending ED.

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 (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)

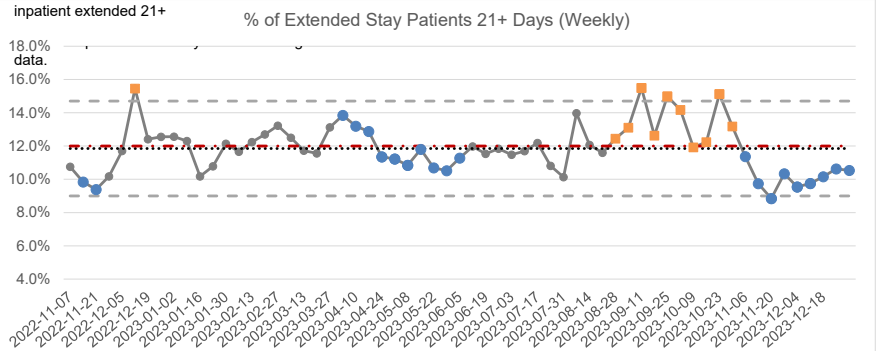
Mitigations:
- Care standards are in place to ensure that the patients are reviewed regularly with two hourly Board Rounds in place.
- Critical Medication Sheets are in place where required to ensure patients are receiving the medication they require whilst waiting for admission.
- Position statements 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

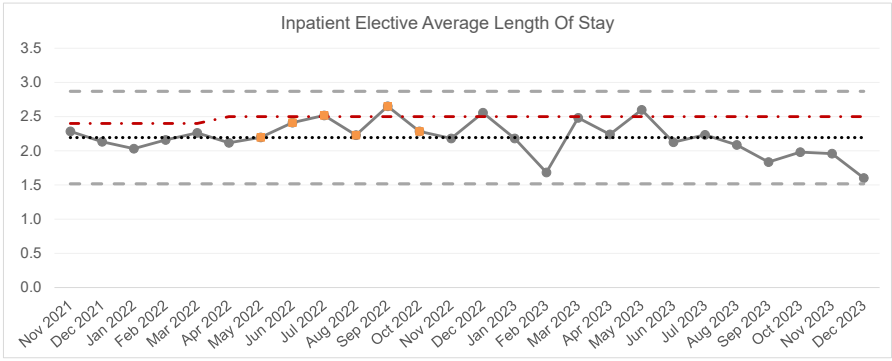


Dec 2023	Target	Variance	Assurance
40.7%	40.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

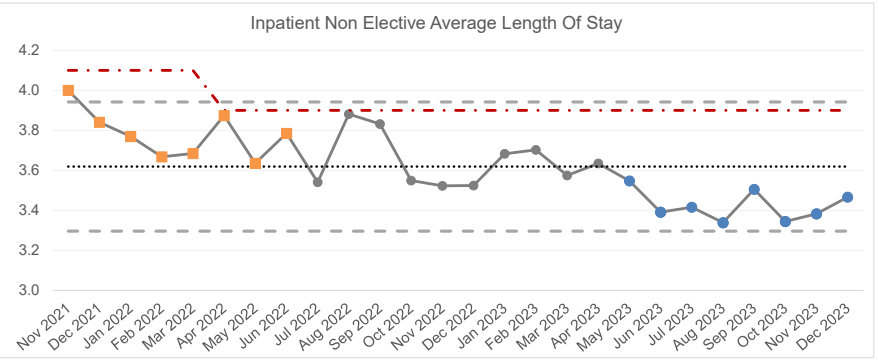
inpatient extended 21+



Dec 2023	Target	Variance	Assurance
10.5%	12.0%	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target



Dec 2023	Target	Variance	Assurance
1.6	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Dec 2023	Target	Variance	Assurance
3.5	3.9	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target

Data Analysis:
On target in discharging patients on same day of admission where appropriate . Elective and non-elective length of stay improved exceeding expected targets and long wait patients awaiting discharge has significantly reduced.

Challenges:
- Consultant vacancies impacting on service delivery
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- Infection prevention constraints remain

Key Risks:
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Virtual Ward step up model from primary / community care (ongoing)
- Dedicated OPAT nursing team to provide a hybrid model between outpatients and home delivery, North Lincs capacity increasing to 10 (ongoing)
- System wide action plan in place to support patient flow (ongoing)
- Development of General Internal Medicine / Geriatric Model to support improved patient discharges / flow (ongoing)
- Piloting Discharge Facilitation form at North Lincs, to improve referrals to care homes (ongoing)
- PSC conducting deep dive of NLAG to investigate why NLAG productivity is so high compared to England average (ongoing)
- Northern Lincs system No Criteria to Reside winter 5 high impact actions (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 with system partners to ensure there is 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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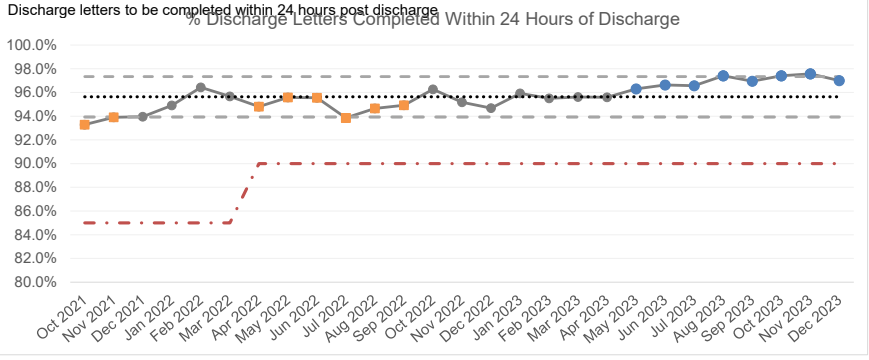
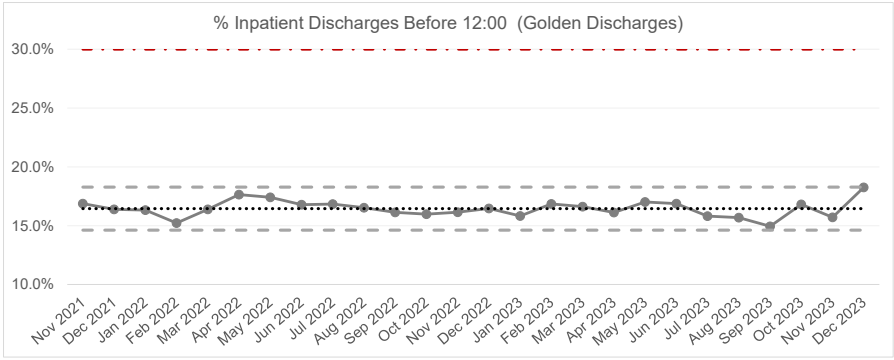
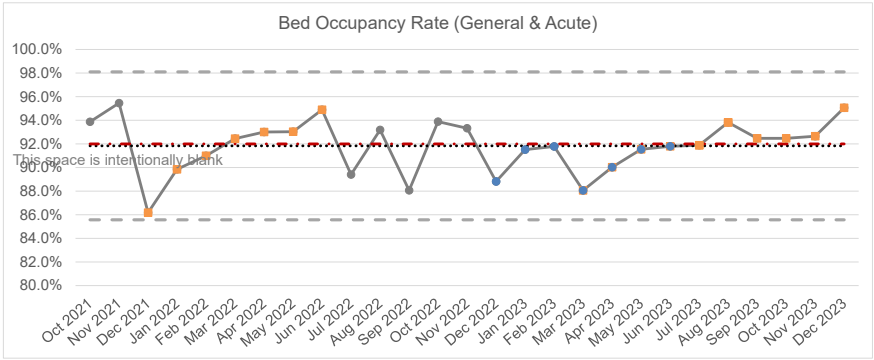
Discharge letters to be completed within 24 hours post discharge



Dec 2023	Target	Variance	Assurance
97.0%	90.0%	Special cause of improving nature or lower pressure due to higher values	Consistently passing the target



Dec 2023	Target	Variance	Assurance
18.3%	30.0%	Common cause - no significant change	Consistently falling short of the target



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Dec 2023	Target	Variance	Assurance
95.1%	92.0%	Special cause of concerning nature or higher pressure due to higher values	Inconsistently hitting passing and falling short of the target

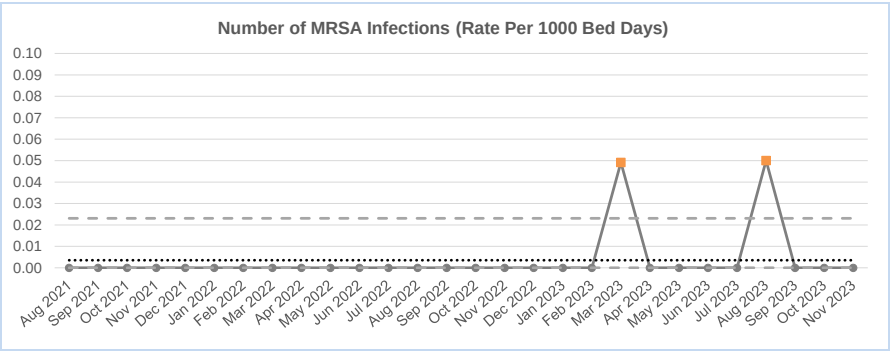
Data Analysis:
The Trust regularly exceeds the planned occupancy level this may impact on discharges being completed before 12noon, which are significantly below target. However, discharge letters completed within 24 hours is significantly above target and therefore an unlikely cause for delay.

Challenges:
- Consultant vacancies impacting on service delivery.
- Exit block due to Social Care constraints which include 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.

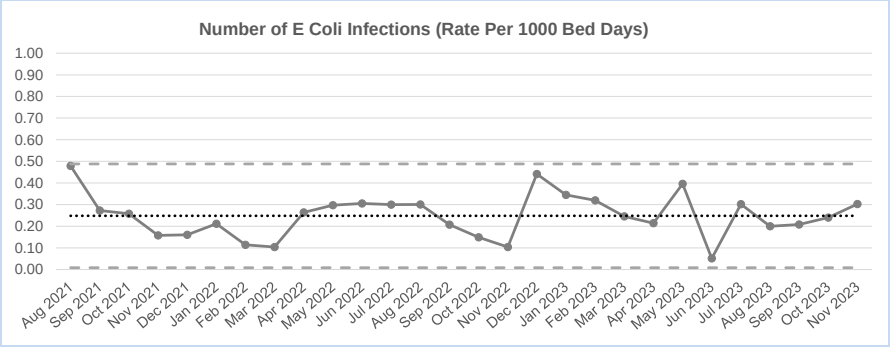
Key Risks:
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Virtual Ward step up model from primary / community care (ongoing).
- Dedicated OPAT nursing team to provide a hybrid model between outpatients and home delivery, North Lincs capacity increasing to 10 (ongoing).
- System wide action plan in place to support patient flow (ongoing).
- Delivery of new IAAU/SDEC New Builds (Q4 DPoW, Q4 SGH).
- Development of General Internal Medicine / Geriatric Model to support improved patient discharges / flow (ongoing).
- Piloting Discharge Facilitation form at North Lincs, to improve referrals to care homes (ongoing).
- PSC conducting deep dive of NLAG to investigate why NLAG productivity is so high compared to England average (ongoing).
- Northern Lincs system No Criteria to Reside winter 5 high impact actions (ongoing).

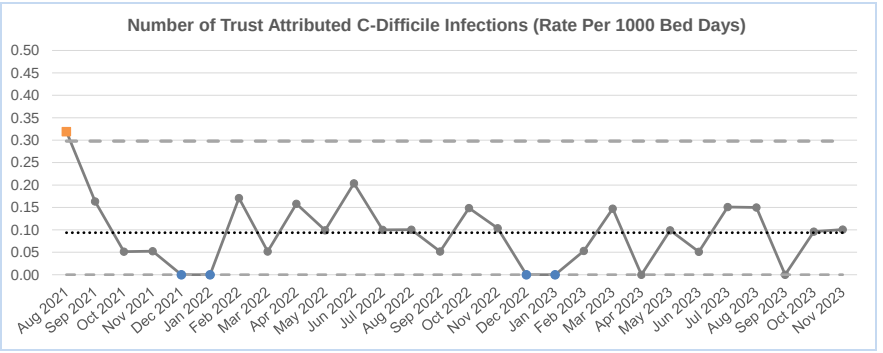
Mitigations:
- Admission avoidance/SPA developments continue to perform well.
- Community Frailty team working within care homes and operating direct referral from UCS and SPA.
- Homecare Team now fully established and providing homecare in North Lincolnshire.
- Single Point of Access available with 2-hour community response in place.
- Community Response Team GP supporting Category 3 & 5 calls.
- Daily meetings 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.



Nov 2023	*Target	Variance	Assurance
0.00	see analysis below	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Nov 2023	*Target	Variance	Assurance
0.30	see analysis below	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Nov 2023	*Target	Variance	Assurance
0.10	see analysis below	Common cause - no significant change	There is no target, therefore target assurance is not relevant

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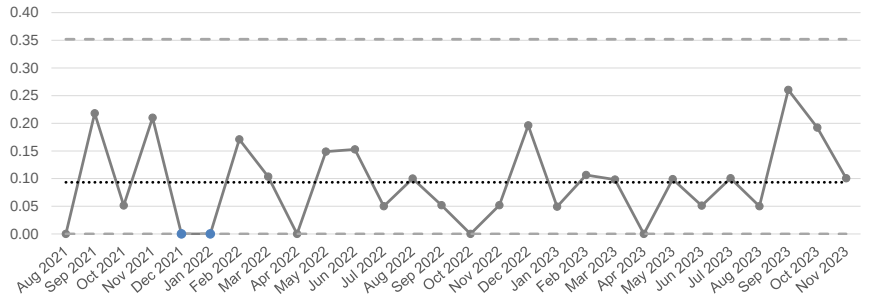
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 1 against an annual target of 1.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 15 against an annual target of 20.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 38 against an annual target of 46.

Commentary:
The figures for C-Difficile infections have remained static for this month. We have currently reported 13 in total with a national Threshold of 20. There is no national target for MRSA, MSSA however there is a target gor E.Coli and Pseudamonas Aeruginosa and we are performing well at all of thise organisms.



Nov 2023
0.10

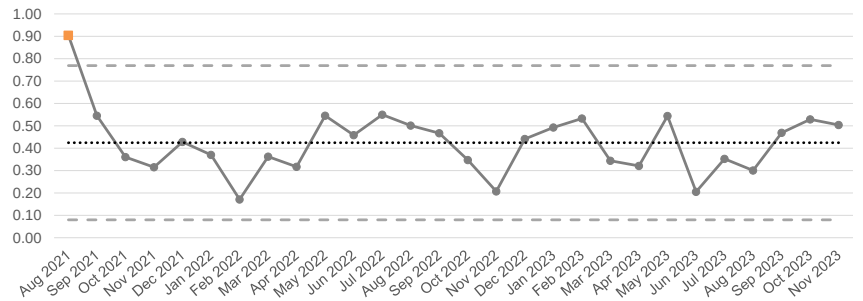
*Target
see analysis below

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Nov 2023
0.50

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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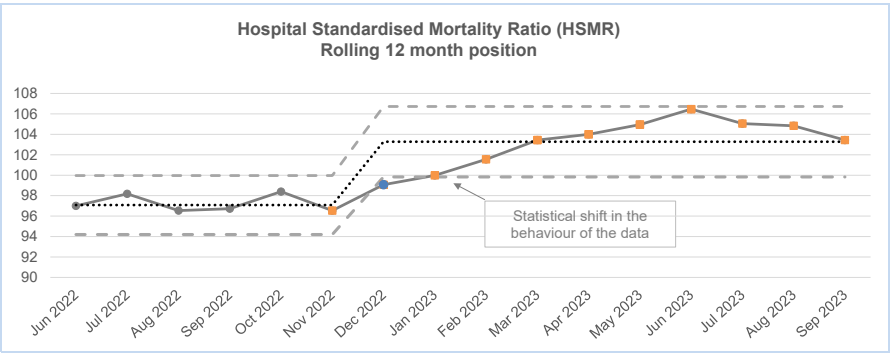
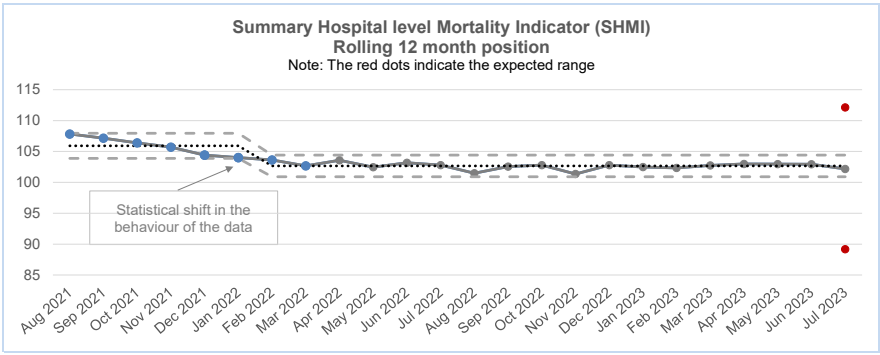
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 17, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 62 against an annual target of 75.

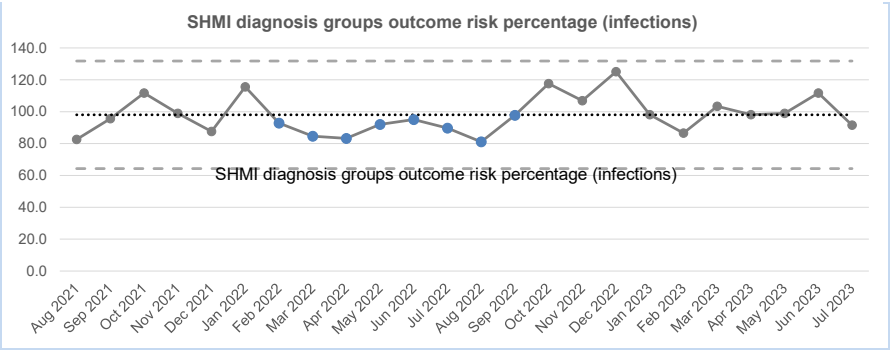
Commentary:
The Trust continues to monitor and perform well in it's organisms with no concerns currently. The IPC team continue to deliver good support to all clinical areas.



Sep 2023
103.4
Target
As expected
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Within 'as expected' range



Jul 2023
102.2
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'as expected' range



Jul 2023
91.6%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

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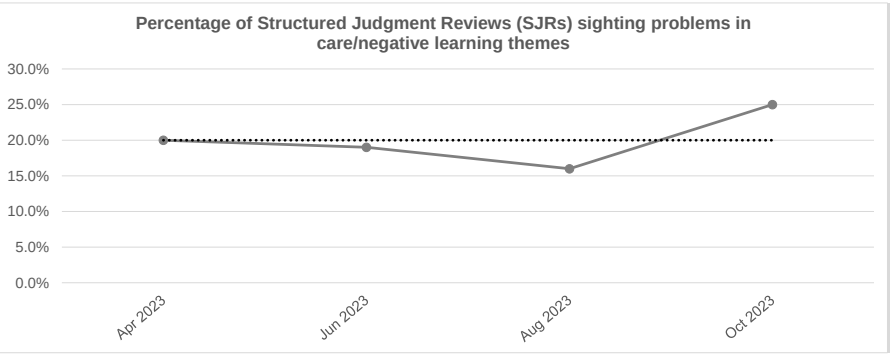
Data Analysis:
HSMR: Over the course of this year HSMR has risen and as such it is registering concern.
SHMI: Performance is stable and continues within the expected range. The data represents a rolling 12 month position.
SHMI diagnosis: Performance is stable and continues within the expected range.

Commentary:
The rolling 12 month SHMI data remains within the 'as expected' banding with the latest value of 102.02 for the period September 2022 – August 2023. The rolling 12 month HSMR value has reduced over the past 3 month period to a value of 103.4.

Following a rise in infection related SHMI diagnosis group data reported last month we have investigated the variance through interrogation of CHKS and triangulation of data from the data warehouse and NHS digital data. We have identified an anomaly in the previously reported infection related SHMI diagnosis group data as this did not include all infection related SHMI diagnosis groups due to limited data available from NHS Digital. The previously reported data set only included 4 diagnosis groups which was not representative of the full range of infection related diagnosis groups. We have therefore manually extracted SHMI data for 10 infection related SHMI diagnosis groups which shows common cause variation with mean value of 98 which is below the National average. No further intervention actions are required. SHMI data continues to be monitored through the Mortality Improvement Group.



Oct 2023
25.0%

Target
No target

Variance

There is insufficient data for variance and assurance

Assurance

There is insufficient data for variance and assurance

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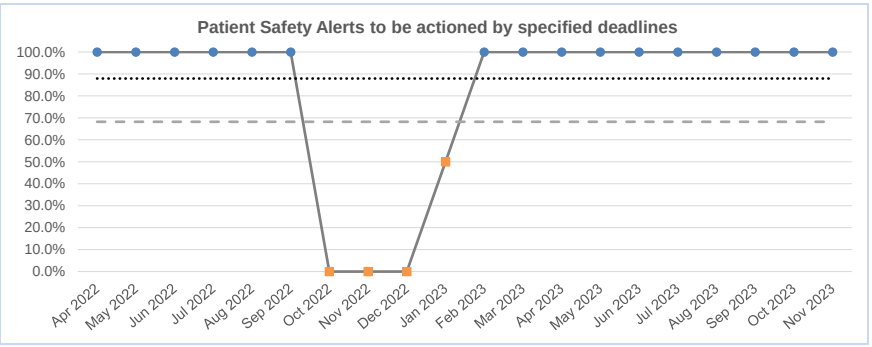
Data Analysis

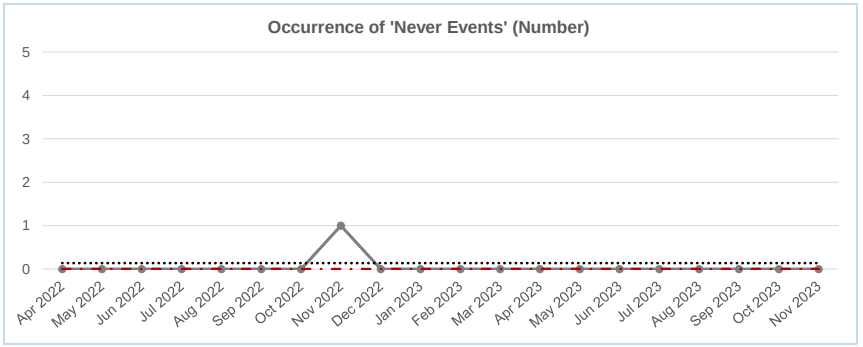
SJRs: This figure is not available every month. October 2023 is the most recent month for which data is available. The figures have ranged from 16% to 25%.

Commentary

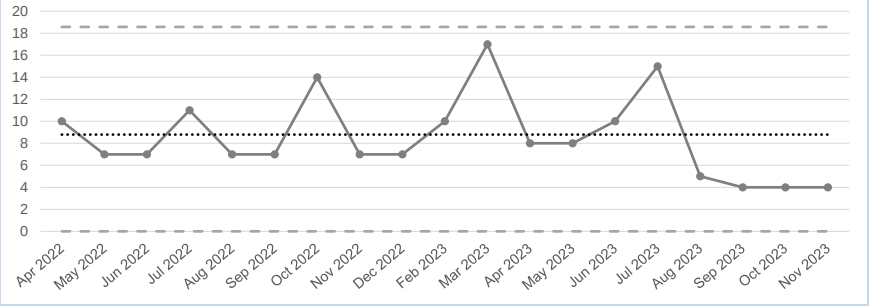
The percentage of SJRs sighting problems in care/negative learning associated with recognition of End Of Life (EOL) pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation was 25% in October. ReSPECT training continues to be delivered and over 40 clinical staff have completed Abbreviated authorship/ReSPECT training during October's Medicine Divisions Quality Safety and Audit meeting. Work has been completed to help improve the level of communication in our discharge summaries around DNACPR decisions and ceiling of care recorded on ReSPECT forms. A training video
for doctors to help recognition of EOL pathway at an earlier stage has been recorded and a tiered approach to training is in development.



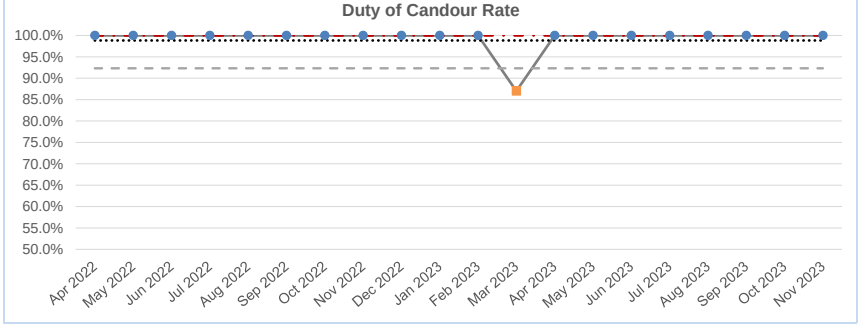
Nov 2023
100.0%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant



Nov 2023
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



Nov 2023
4
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

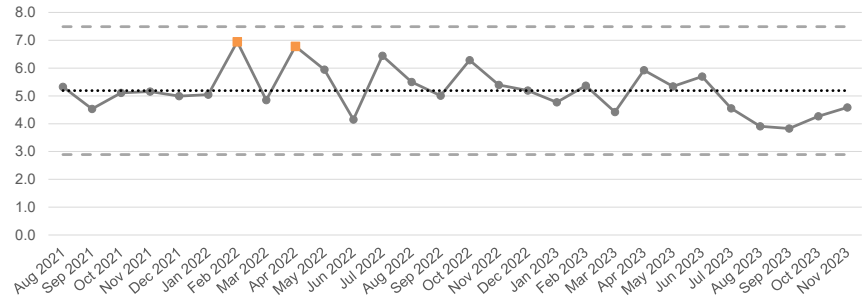


Nov 2023
100.0%
Target
100.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

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 within the expected range of variation.
Duty of Candour: Following a low figure in March the indicator has returned to regularly recording 100%.

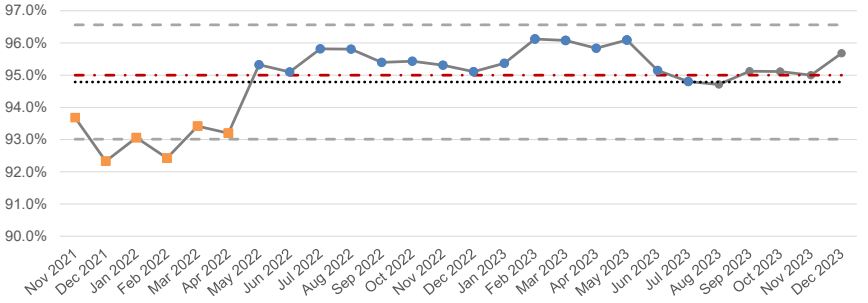
Commentary:
We continue to manage patient safety alerts, meeting national deadlines for the past 10 months.
Serious incidents reported are within common cause variation and duty of candour rate is maintained at 100%.

Falls on Inpatient Wards (Rate Per 1000 Bed Days)



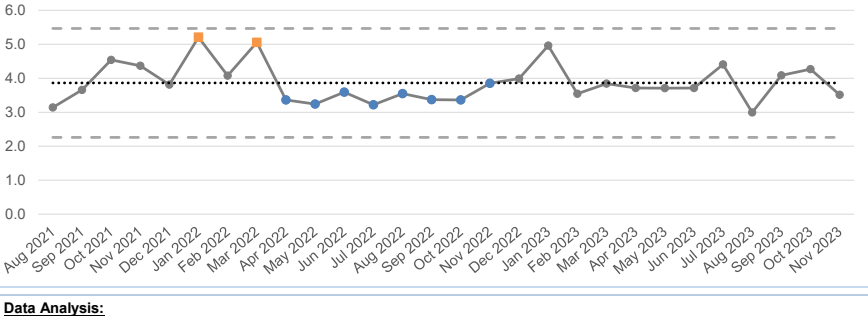
Nov 2023
4.6
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

Venous Thromboembolism (VTE) Risk Assessment Rate



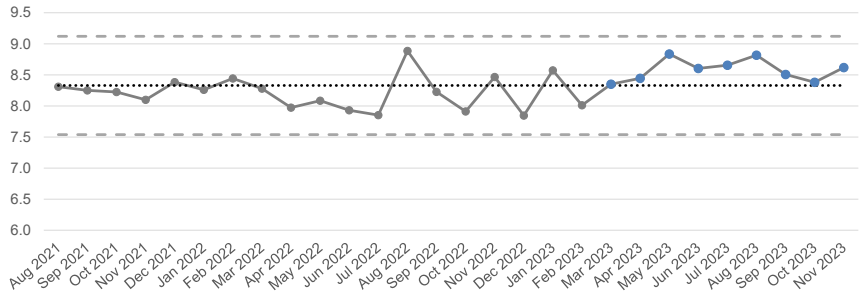
Dec 2023
95.7%
Target
95.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target

Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate Per 1000 Bed Days)



Nov 2023
3.5
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

Care Hours Per Patient Day (CHPPD)



Nov 2023
8.6
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:

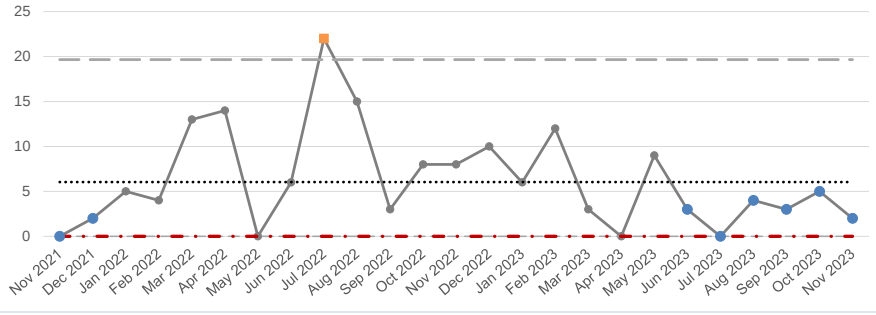
Falls on Inpatient Wards: Performance is stable and as expected.
VTE Risk Assessment: Performance is within the expected range but has moved out of improvement due to falling below the average of the data in August. The indicator can be expected to achieve and fail the target at random.
Hospital Acquired 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 nine months recording values higher than the average for the data.

Commentary:

Falls - the number of reported falls per 1000 bed days remains within the "as expected" range.
Pressure Ulcers - the number of reported pressure ulcers per 1000 bed days remains within the "as expected" range. All moderate harm incidents reported during November 2023 have been reviewed at the weekly scrutiny meeting with no new themes or learning identified.

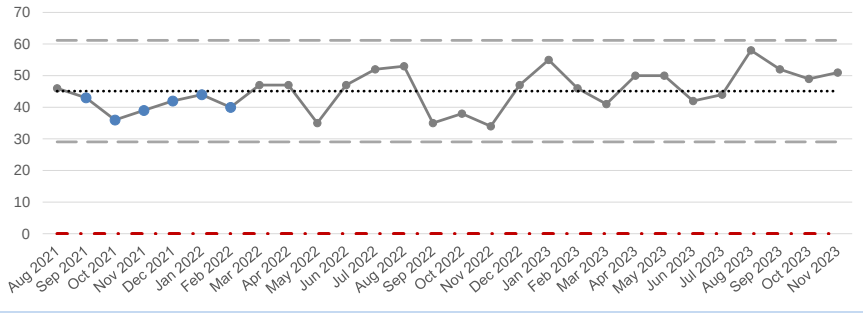
VTE risk assessment rate remains within common cause variation achieving 95.7% in December 2023.

Mixed Sex Accommodation



Nov 2023
2
Target
0
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

Community Acquired Pressure Ulcers (Number)



Nov 2023
51
Target
0
Variance
Common cause - no significant change
Assurance
Consistently failing the target

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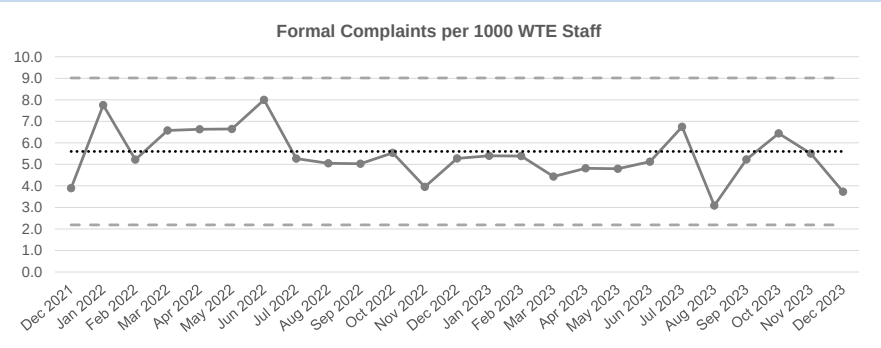
Data Analysis:

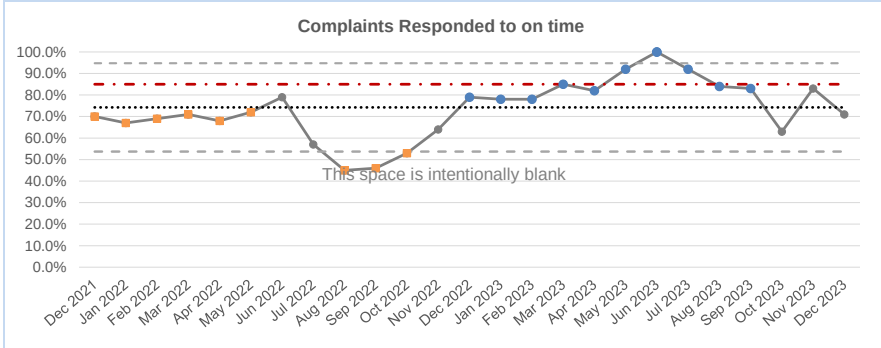
Mixed sex accommodation: Performance is within the data's expected range and will achieve and fail the target at random; the last six months have shown improvement.

Community Acquired Pressure Ulcers (Number): Performance is within the expected range of the data. However, the target is unlikely to be met without action.

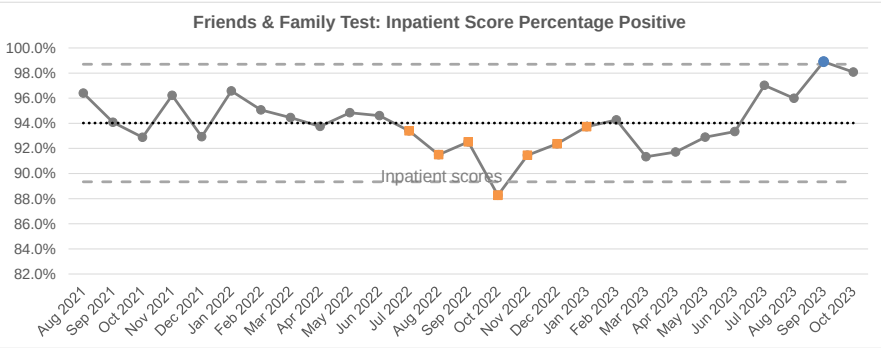
Commentary:



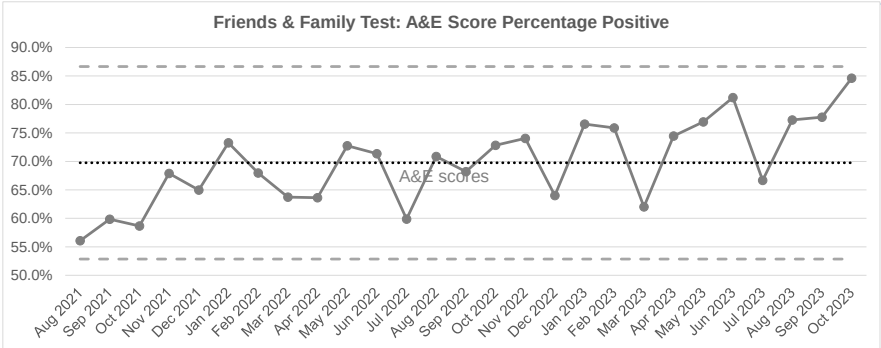
Dec 2023
3.7
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore assurance is not relevant



Dec 2023
71.0%
Target
85.00%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Oct 2023
98.1%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Oct 2023
84.6%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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: The majority of respondents continue to provide positive feedback. The data is largely stable and usually registering common cause variation.
FFT A&E: The majority of respondents continue to provide positive feedback. The data continues within the expected range.

Commentary:

Complaints

Formal complaints fell for a second consecutive month with 21 received for December, however complaints received do continue to be very complex in nature and require significant investment in time from the Lead Investigator(s) and Complaint Facilitator(s). Written responses provided appear to remain detailed and appropriate, as this is likely to attribute to the low levels of re-opened complaints as responses appear satisfactory to the complainants.

December performance declined to 71% - this can be attributed to 4 long standing complaints reaching conclusion and a delay over the Christmas / New Year period with the signing process causing 2 complaints breaching 60 days, these required CEO assurance that the responses were appropriate. These complaints were complex in their nature and did reach the CEO Office with limited time for completion, in addition to being at month end with shortened working weeks.

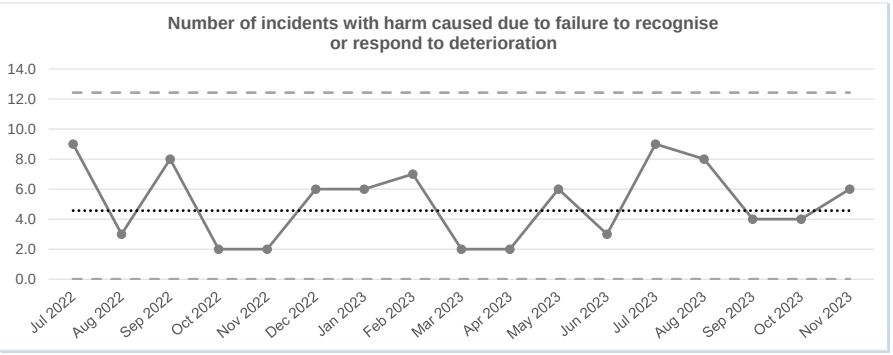
Work continues with the Complaint Facilitators to ensure the sign-off process is timely and avoids tight timescales when reaching the COS and/or CEO. Weekly One-to-Ones with the Complaints Manager & Facilitators, a Support & Challenge Meeting (Wednesdays) and Patient Experience Lead oversight will continue to enable focus remains on the 60 Day KPI.

Friends & Family Test

Healthcare Communications (HCC) Friends and Family Test (FFT) are now fully embedded within our Emergency Departments (ED), Maternity Services and Ward Inpatient Services. December responses show significant increases particularly within the EDs. Considering the increasing return rate the results maintain a largely positive feedback picture.

Increased responses for ED should begin to give us assurance that the departments are performing to a high level, whilst providing us with better oversight for theme analysis and identifying areas for improvement or focus. Further work will now continue in all areas to improve data triangulation against other data sets to inform Divisions around themes and/or concerns with the increased responses.

The Patient Experience Team will continue to work with all departments to provide monthly data including themes and performance through our FFT - Phase 2 of the FFT roll-out, which includes Community and Outpatient Services is currently on hold as the current priority is the essential roll-out of the Lorenzo Project. It is hoped that work can re-focus on Phase 2 in late spring.



Nov 2023	Target	Variance	Assurance
6.0	**No target**	Common cause - no significant change	There is no target, therefore target assurance is not relevant

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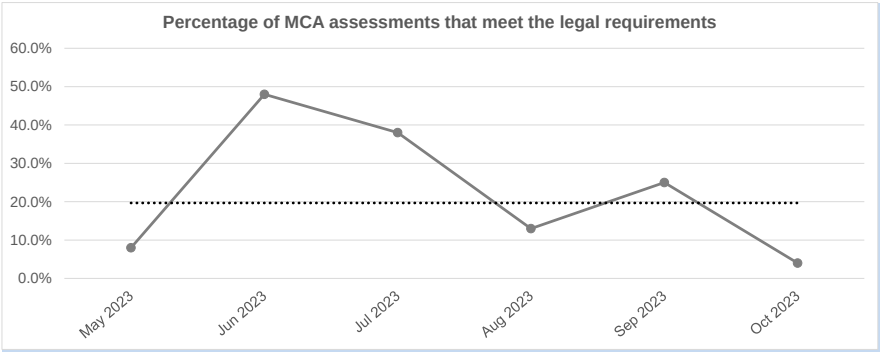
Data Analysis

Harm caused deterioration: Performance is stable and within the expected range of the data.

Commentary

5 incidents with low/minor harm were reported in November 2023 and 1 with moderate harm. 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 undertaking applying QI training to focus on deteriorating patient and escalation. Stop and check becoming embedded across all areas, encouraging use through night shifts. Agreed allocation of time for Clinical Sisters to focus on NEWS2 QI work with nursing teams.

Dec 2023	Target	Variance	Assurance
0	No target	There is insufficient data for variance and assurance	There is no target, therefore target assurance is not relevant



Oct 2023	Target	Variance	Assurance
4.0%	No target	There is insufficient data for variance and assurance	There is no target, therefore target assurance is not relevant

Oct 2023	Target	Variance	Assurance
0.0%	No target	There is insufficient data for variance and assurance	There is no target, therefore target assurance is not relevant

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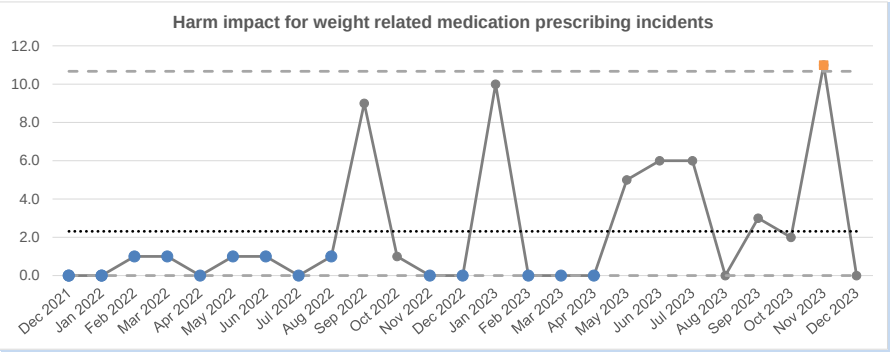
Data Analysis

MCA/DoLS contacts: Data is available for the most recent six months. For each of these six months there have been zero contacts with the MCA/DoLS team.
MCA Assessments: Performance has varied from 4% to 48%.
Best interests: Data is available for seven months. For six of these months the figure is 0%. In June a figure of 11% was recorded.

Commentary

It should be noted that the MCA/best interest data reported is related only to electronic documentation on WebV. Staff can also document MCA/best interest in paper notes which does not form part of the audit data. QI projects are underway on Ward 23, Ward 24/IAAU and the Stroke ward at SGH. 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. The MCA working group continue to meet to share learning and change ideas.



Dec 2023
0

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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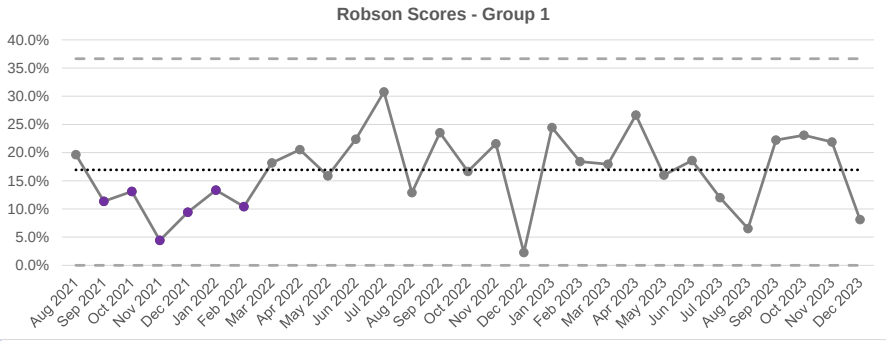
Data Analysis

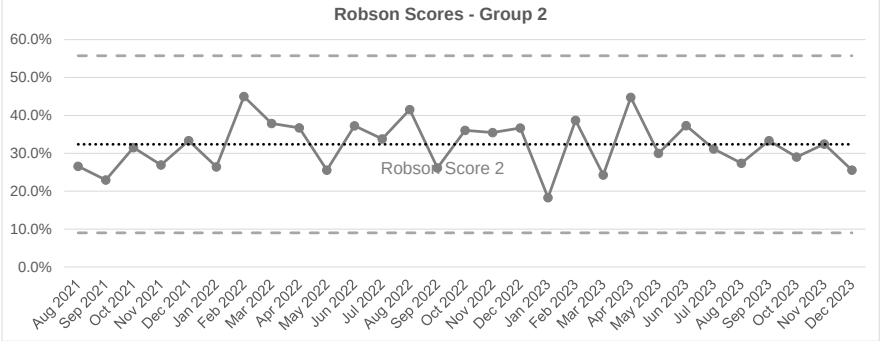
Harm impact: Performance continues to be sporadic ranging from zero to 11 over the past two years. The most recent figure is registering common cause however, due to the highly variable nature of this indicator this cannot be taken as indicative of any trend.

Commentary

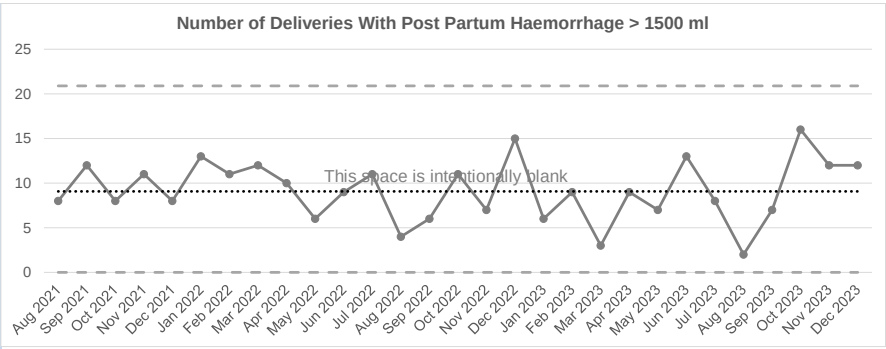
There were zero weight related prescribing incidents reported in December 2023. All medication related incidents are discussed at the Safer Medication Group to raise awareness and share learning.



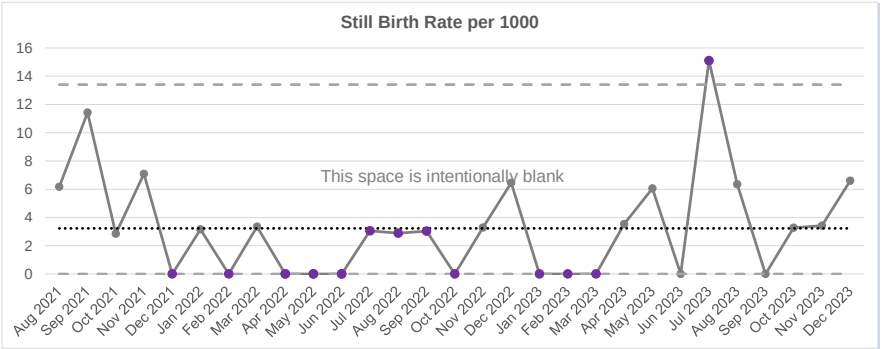
Dec 2023
8.1%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Dec 2023
25.6%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Dec 2023
12
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

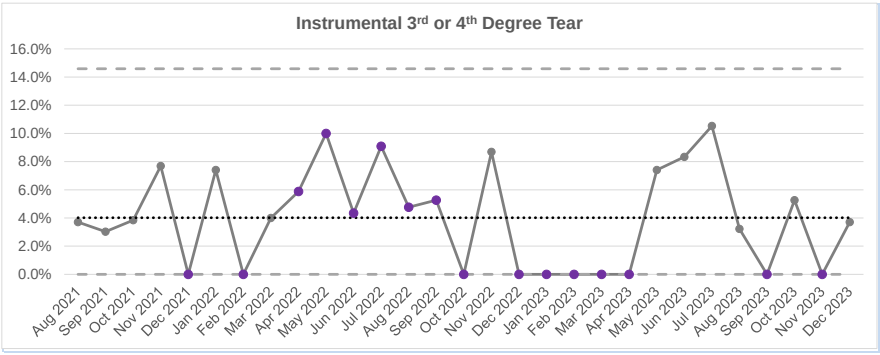


Dec 2023
6.6
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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:

Dec 2023	Target	Variance	Assurance
0.6%	No target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Dec 2023	Target	Variance	Assurance
3.7%	No target	Common cause - no significant change	There is no target, therefore target assurance is not relevant

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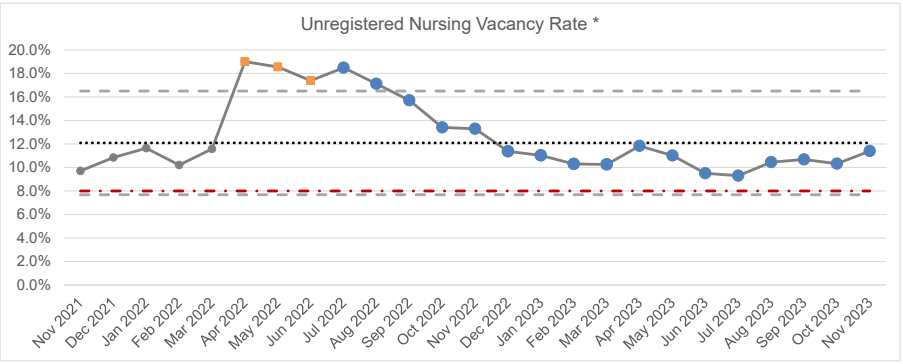
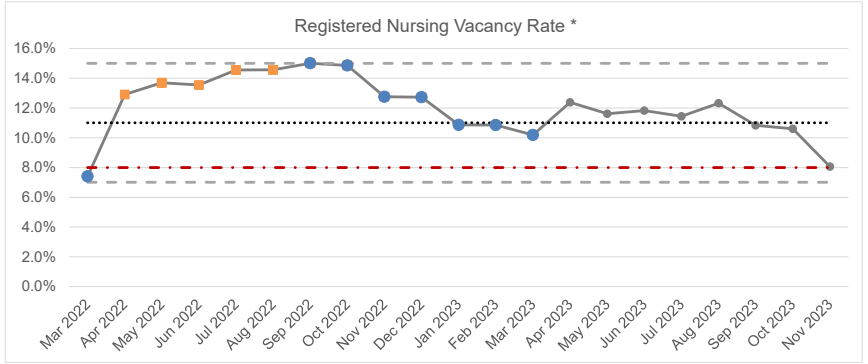
Data Analysis:
Spontaneous 3rd or 4th degree tear: Performance is stable and within the expected range.
Instrumental 3rd or 4th degree tear: Performance is stable and within the expected range.

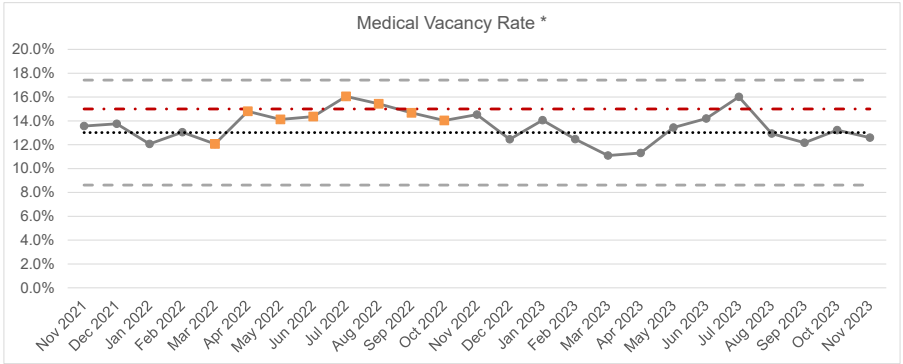
Commentary:



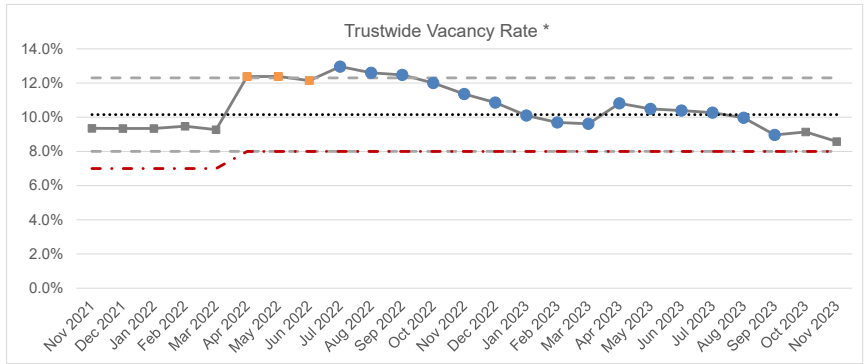
Nov 2023
11.4%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target



Nov 2023
8.1%
Target
8.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



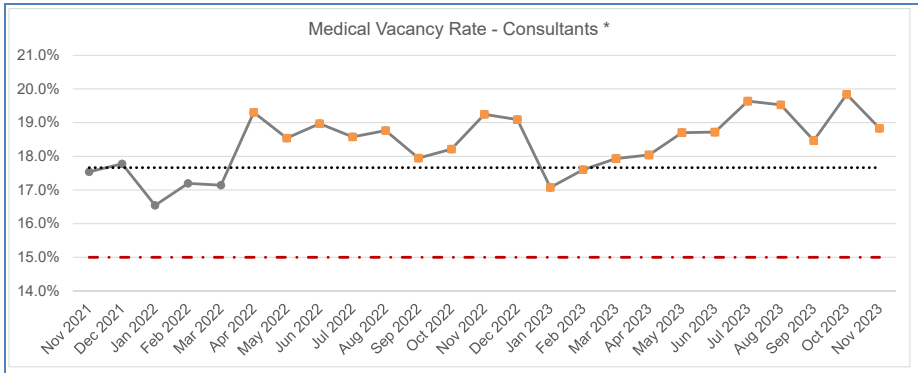
Nov 2023
12.6%
Target
15.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Nov 2023
8.6%
Target
8.0%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

Data Analysis:
Unregistered Nursing Vacancies: The data for December 2023 was not available at the time of production. An updated position will be available on the next iteration of the report.
Registered Nursing Vacancies: The data for December 2023 was not available at the time of production. An updated position will be available on the next iteration of the report.
Medical Vacancy Rate: The data for December 2023 was not available at the time of production. An updated position will be available on the next iteration of the report.
Trustwide Vacancy Rate: The data for December 2023 was not available at the time of production. An updated position will be available on the next iteration of the report.

Commentary:
The vacancy release date has prevented us from updating the vacancy data for December as it exceeds the production timeframe, this is mainly due to the bank holidays in December/ January preventing the reports to be ready. Two months' worth of vacancy data will be produced when we produce the IPR in February.



Nov 2023
18.8%

Target
15.0%

Variance

Special cause of concerning nature or higher pressure due to higher values

Assurance

Inconsistently hitting passing and failing the target

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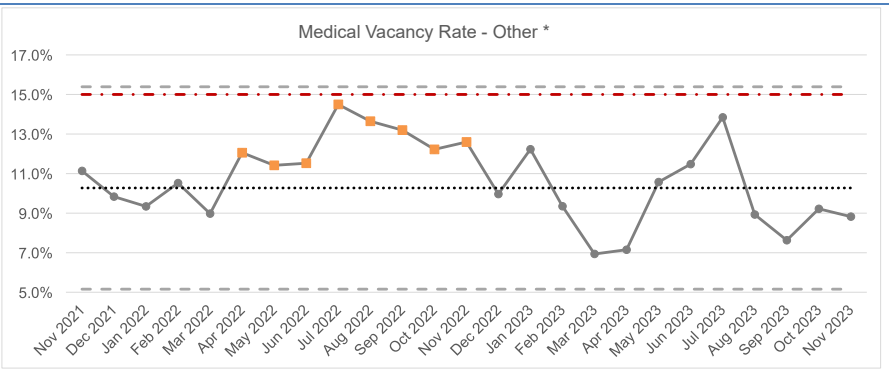

Nov 2023
8.8%

Target
15.0%

Variance

Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target

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Data Analysis:
Medical Vacancy Rate - Consultants: The data for December 2023 was not available at the time of production. An updated position will be available on the next iteration of the report.
Medical Vacancy Rate - Other: The data for December 2023 was not available at the time of production. An updated position will be available on the next iteration of the report.

Commentary:
The vacancy release date has prevented us from updating the vacancy data for December as it exceeds the production timeframe, this is mainly due to the bank holidays in December/ January preventing the reports to be ready. Two months' worth of vacancy data will be produced when we produce the IPR in February.

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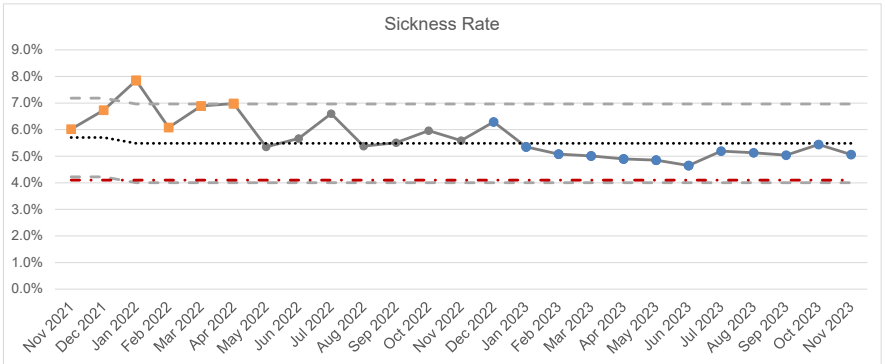
Dec 2023
10.4%
Target
10.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target



Nov 2023
5.1%
Target
4.1%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

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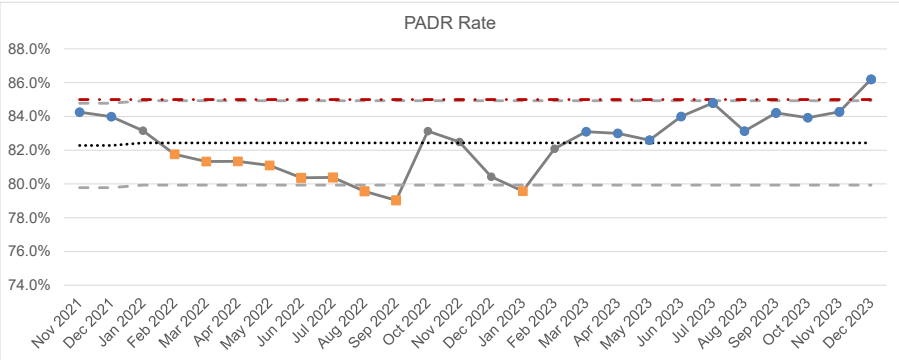
Data Analysis:
Turnover Rate: Performance has fallen outside of the lower process limit and is currently registering improvement due to recording values below the average. However, the target is unlikely to be met without action.
Sickness Rate: Over the past twelve months the indicator has registered improvement. As a result the target is now within the process limits, suggesting the target may achieve and fail at random.

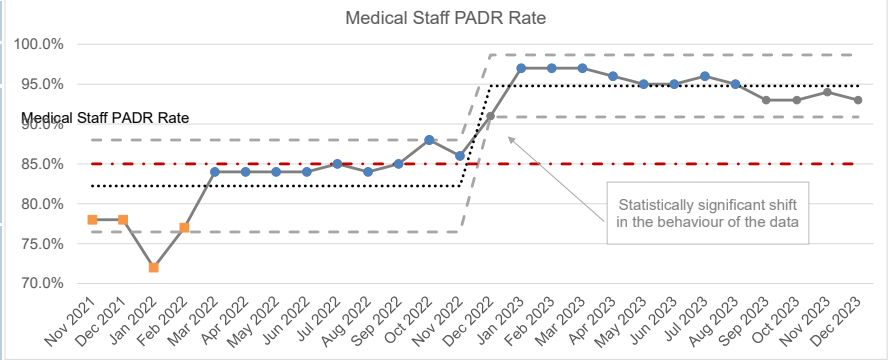
Commentary:

Turnover rate continues to improve each month and is now near target at 10.4% with better retention rates due to continuous engagement with teams and activities that have led to better staff involvement in decision making and service improvement.
flexible working schemes, FTSU, inclusivity events, staff networks, reward and recognition schemes, engagement events have created a better cohesion across the entire organisation as evidence through recent staff survey results and current turnover statistics.
development programmes across the organisation also contrinbute to supporting our staff growth and career development in the TRust. as a result we see reason for leaving the trust (a part from retirement 8%) mostly around
pay & opportunities 11%
relocation 14.7%
work life balance 13.1%
other reasons including personal reasons 30%

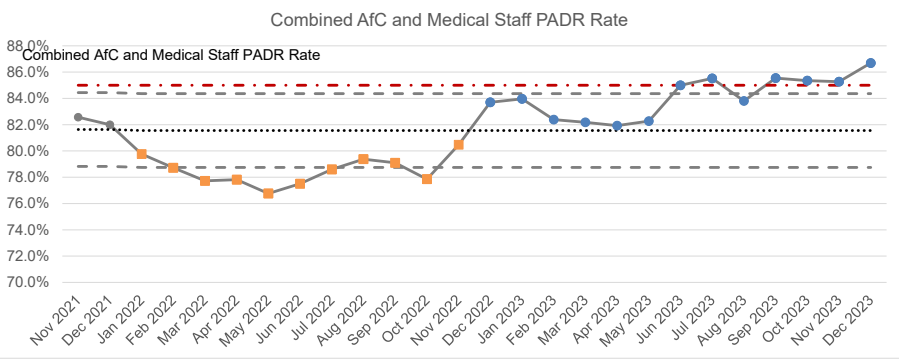
The sickness % has reduced this month and is sitting at less than this time last year. We saw a downward trend January 23 to June 2023 so it is hoped that we see the same trend and further sustain this. In order to achieve this, the HR team continue to work closely with managers to support and guide them in respect of management of cases, short and long term, and supporting health and wellbeing for example through stress risk assessments or agreeing reasonable adjustments. The line manager training is in the final stages of being reviewed to ensure that we are delivering the best quality training and we will be working more closely with occupational health to jointly deliver elements of this.



Dec 2023
86.2%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently failing the target



Dec 2023
93.0%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Consistently passing the target



Dec 2023
86.7%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently failing the target

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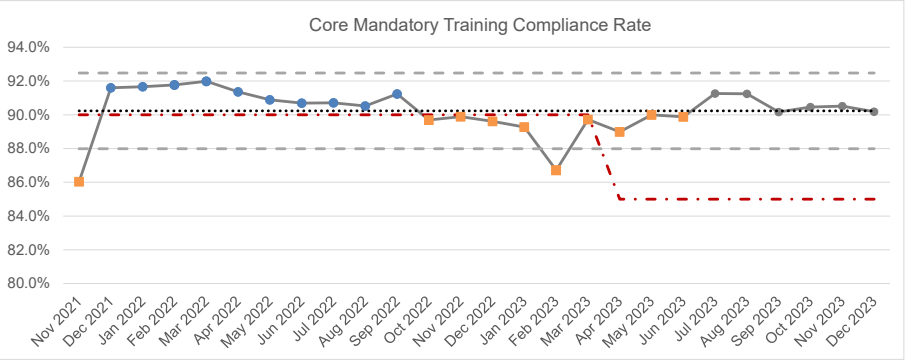
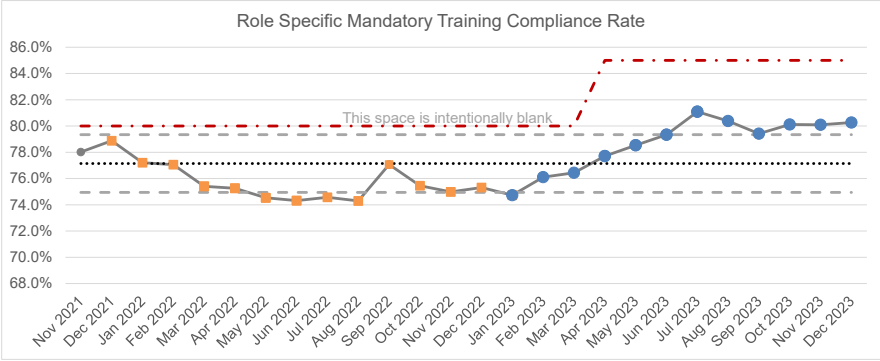
Data Analysis:
PADR Rate: The indicator has registered improvement for the last ten months with this month achieving the 85% target. However, the current data indicates that the target is unlikely to be continiously met without action.
Medical Staff PADR Rate: Performance remains in the expected range and has achieved the target for the past year.
Combined AfC and Medical Staff PADR Rate: The indicator has registered improvement for over a year. The target has been achieved on five occassions but this is not yet reliable.

Commentary:
The combined AfC and Medical Staff PADR compliance rate still remains above target at 86.7%, The AfC PADR rate has increased by 1.9% and now above target. The ESR Team continue to support managers around PADR compliance with myth busting, gentle reminders and education. Email reminders now include PADR's that are due to come out of compliance in the next month to remind managers before the deadline.

Commentary:
There has been no significant change since last report. Medical staff appraisal consistently passes the target.
Whilst there has been a dip below the mean range for appraisal compliance, this equates to 17 doctors who are out of compliance with appraisal. 4 of which have had their appraisal submitted since December 2023.
The rest of the doctors are being supported by the Revalidation Coordinator and Appraisal Clinical Lead to achieve completed appraisal status.
Appropriate escalation to CMO is enacted when there is little/no response to these efforts.
. For information, the weekly submission data of PADR % for medical and dental staff is higher than what is being reported via the workforce information dashboard. End of December, the Trustwide medical and dental % compliance was 95%. However, it is a known issue that the doctors on the appraisal system (L2P) are not matching with medical and dental staff on workforce dashboard which uses ESR to pull though information such as doctors names, specialty, and grade



Dec 2023
90.2%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Consistently passing the target



Dec 2023
80.3%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
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: The indicator has registered improvement for the past twelve months. However current data indicates that the target will not be met without action.

Commentary:

At 90.2%, Core Mandatory training remains 5% above the Trust target, with the significant majority of core competencies reporting >85% compliance @2.1.24. The following 3 competencies reported <80%, all of which are classroom-based provision.

Fire Safety reported 73.50% compliance @2.1.24, with 1842 out of compliance. Throughout 2023, 7863 enrolled on to this provision, with 3766 completing (48% completion). During this period, 1385 did not attend (DNA) the session they had enrolled on to (18% DNA). Fire Safety (classroom-based provision) has now been embedded into the Corporate Induction to ensure all new staff are secured a place for this competency within 2 months of employment. Level 3 Safeguarding Children reported 71.79% compliance @2.1.24, with 321 out of compliance. Throughout 2023, 961 staff enrolled on to this provision, with 422 completing (44% completion). During this period, 272 staff did not attend (DNA) the session they had enrolled on to (28% DNA).

Level 3 Safeguarding Adults reported 71.73% compliance @2.1.24, with 190 out of compliance. Throughout 2023, 748 staff enrolled on to this provision, with 271 completing (36% completion). During this period, 175 staff did not attend (DNA) the session they had enrolled on to (23% DNA).

Plans are now in place for gathering data to understand the main barriers to attending classroom-based learning and accessing eLearning. This data will then be analysed to consider amending practices / processes to support improvement in attendance / compliance. The L&D administration team also continue to work closely with subject specialist leads.

As with Core Mandatory, Role Specific Mandatory training remained stable this past month, and is sustaining its position just above 80%, 5% below the Trust target. Moving and Handling, Resus and Deteriorating Patient (ALERT) remain a clear focus for improving role specific compliance, all of which are classroom-based and significantly impacted by non-attendance.

Overall Moving and Handling provision (all modules) reported 81% compliance @2.1.24, with 829 out of compliance. This provision has seen a sustained improvement in compliance over the past 6 months. Throughout 2023, 4559 staff enrolled on to Moving and Handling modules, with 1974 completing (43% completion). During this period, 656 staff did not attend (DNA) the session they had enrolled on to (14% DNA).

Overall Resus provision (all modules) reported 70% compliance @2.1.24, with 1900 out of compliance. This provision has seen a slight improvement over the past 3 months but remains significantly below the Trust target. Throughout 2023, 6642 staff enrolled on to Resus modules, with 4642 completing (70% completion). During this period, 823 staff did not attend (DNA) the session they had enrolled on to (12% DNA).

Deteriorating Patient (ALERT) provision reported 53% compliance @2.1.24, with 427 out of compliance. During 2023, 647 staff enrolled on to this provision, with 298 completing (46% completion). During this period, 111 staff did not attend (DNA) the session they had enrolled on to (17% DNA). Staff Group – Medical and Dental continue to report the lowest compliance for Role Specific Mandatory training @ 56.16% on 2.1.24, with 2784 out of compliance. Analysis of classroom-based provision for this staff group shows that, during 2023, 6623 staff enrolled on to face to face sessions, with 3916 completing (59%), 816 withdrawing (12%), and 1188 not attending (DNA) (18%).

Additional actions during January 2024 to address concerns identified:

- Gather baseline data from all staff groups to assess the main barriers to attending classroom-based provision – via Mentimeter
- Gather baseline data from all staff groups to assess main barriers to completing eLearning timely – via Mentimeter
- Gather more detailed data from staff group – Medical and Dental to identify specific barriers to completing all required learning – via targeted MS Forms
- Analyse data collected to review practices / processes and set plans for supporting improvement in attendance and compliance

IPR Appendix - 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 16/01/2024

* 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	Dec 23	59.7%	92.0%	58	73 / 172	Nov 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Dec 23	751	353	57	73 / 169	Nov 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Dec 23	26.4%	1.0%	32	106 / 156	Nov 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Dec 23	47.3%	85.0%	19	106 / 131	Sep 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 23	61.5%	76.0%	39	102 / 143	Nov 23
	Urgent Care	Number Of Emergency Department Attendances	Dec 23	14,635	No target	45	80 / 143	Nov 23
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Dec 23	705	0	15	132 / 152	Nov 23
	Flow	Bed Occupancy Rate (General & Acute)	Dec 23	95.1%	92.0%	19	126 / 155	Q2 23/24
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Dec 23	6.7%	5.0%	53	54 / 157	Nov 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	Nov 23	0.00	No target	40	82 / 135	Oct 23
	Infection Control	Number of E Coli Infections	Nov 23	0.30	No target	61	53 / 135	Oct 23
	Infection Control	Number of Trust Attributed C-Difficile Infections	Nov 23	0.10	No target	96	6 / 135	Oct 23
	Infection Control	Number of MSSA Infections	Nov 23	0.10	No target	37	85 / 135	Oct 23
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Jul 23	102.2	As expected	42	69 / 119	Aug 23
	Safe Care	Number of Serious Incidents Raised in Month	Nov 23	4	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Nov 23	8.6	No target	36	122 / 190	Oct 23
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Dec 23	95.7%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Dec 23	3.7	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Percentage Positive Inpatient Scores	Oct 23	98.1%	No target	75	34 / 132	Nov 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Nov 23	5.1%	4.1%	48	111 / 213	Aug 23

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*	Dec 2023	59.7%	92.0%	**Alert**			Board
	Number of Incomplete RTT pathways 52 weeks*	Dec 2023	751	353	**Alert**			Board
	Total Inpatient Waiting List Size	Dec 2023	12,438	11,563	**Alert**			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Dec 2023	26.4%	1.0%	**Alert**			Board
	Number of Incomplete RTT pathways 65 weeks	Dec 2023	99	0%	**Alert**		n/a	Board
	Number of Incomplete RTT Pathways*	Dec 2023	39,996	No Target	**Alert**		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Dec 2023	13,465	No Target			n/a	FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Dec 2023	46.9%	37%	**Alert**			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Dec 2023	39,830	9,000	**Alert**			Board
	Outpatient Did Not Attend (DNA) Rate	Dec 2023	6.7%	5.0%	**Alert**			Board
	% Outpatient Non Face To Face Attendances	Dec 2023	19.4%	25.0%	**Alert**			Board
	% Outpatient summary letters with GPs within 7 days	Nov 2023	60.1%	50.0%	**Alert**			FPC
	Advice and Guidance as a Percentage of all Referrals	Dec 2023	7.7%	No Target			n/a	FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Dec 2023	83.2%	99.0%	**Alert**			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Dec 2023	31.8%	23.0%	**Alert**			FPC
	Patient Initiated Follow Up	Dec 2023	4.1%	5.0%	**Alert**			FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Dec 2023	47.3%	85.0%	**Alert**			Board
	Cancer Waiting Times - 104+ Days Backlog*	Dec 2023	25	0	**Alert**			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Dec 2023	13.3%	75.0%	**Alert**			Board
	Cancer Request To Test In 7 Days*	Dec 2023	47.1%	100.0%	**Alert**			Board
	Cancer Waiting Times - 2 Week Wait*	Dec 2023	96.2%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Dec 2023	92.3%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Dec 2023	77.5%	75.0%				FPC
	Cancer Request To Test In 14 Days*	Dec 2023	85.1%	100.0%	**Alert**			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Dec 2023	94.0%	96.0%				FPC
	Cancer Waiting Times - Cancer 62-day backlog	Dec 2023	112	9000.0%			n/a	FPC
	Cancer Waiting Times - 62 day Screening*	Dec 2023	33.3%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2023	61.5%	76.0%	**Alert**			Board
	Number Of Emergency Department Attendances	Dec 2023	14,635	10,114	**Alert**		n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Dec 2023	639	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Dec 2023	705	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Dec 2023	453	0	**Alert**			Board
	Number of UCS Attendances	Dec 2023	5,393	No target	**Alert**		n/a	FPC
	% UCS Waiting Times (4 Hour Performance)	Dec 2023	99.2%	92.0%				FPC
	Ambulance Handover Delays - Number 30-60 Minutes	Dec 2023	378	No Target			n/a	FPC
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Dec 2023	40.7%	40.0%				Board
	% of Extended Stay Patients 21+ days	Dec 2023	10.5%	12.0%	**Highlight**			Board
	Inpatient Elective Average Length Of Stay	Dec 2023	1.6	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Dec 2023	3.5	3.9				Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Dec 2023	97.0%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Dec 2023	18.3%	30.0%	**Alert**			Board
	Bed Occupancy Rate (G&A)	Dec 2023	95.1%	92.0%	**Alert**			Board
	Percentage of patients re-admitted as an emergency within 30 days	Dec 2023	9.6%	No Target			n/a	FPC
	Percentage of Daycase Spells From Elective Activity	Dec 2023	90.1%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Dec 2023	42.7%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Dec 2023	20.8%	No Target	**Highlight**		n/a	FPC
	% Inpatient Discharges Before 17:00	Dec 2023	66.4%	80.0%	**Alert**			FPC
Theatre	Theatre Session Utilisation (Core Capacity)	Dec 2023	93.0%	No Target			n/a	FPC
	Theatre In Session Capped Utilisation	Dec 2023	79.8%	No Target			n/a	FPC
	Theatre In Session Non-Capped Utilisation	Dec 2023	80.6%	No target			n/a	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)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Nov 2023	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Nov 2023	0.30	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Nov 2023	0.10	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Nov 2023	0.10	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Nov 2023	0.50	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Sep 2023	103.4	As expected	**Alert**	H	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Jul 2023	102.2	As expected			As expected	Board
	SHMI diagnosis groups outcome risk percentage (infections)	Jul 2023	91.6%	No target			n/a	Board
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Oct 2023	25.0%	No target		n/a	n/a	Board
	Percentage of in hospital deaths with anticipatory medication prescribed	Mar 2023	10.7%	No target		L	n/a	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Nov 2023	100.0%	No target		H	n/a	Board
	Number of Serious Incidents raised in month	Nov 2023	4	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Nov 2023	0	0		n/a	n/a	Board
	Duty of Candour Rate	Nov 2023	100.0%	100.0%		H	?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2023	4.6	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2023	3.5	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Dec 2023	95.7%	95.0%			?	Board
	Care Hours Per Patient Day (CHPPD)	Nov 2023	8.6	No target		H	n/a	Board
	Mixed Sex Accommodation Breaches	Nov 2023	2	0	**Highlight**	L	?	Board
	Community Acquired Pressure Ulcers (Number)	Nov 2023	51.0	0	**Alert**		F	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Dec 2023	3.7	No target			n/a	Board
	Complaints Responded to on time	Dec 2023	71.0%	85.0%			?	Board
	Friends & Family Test: Inpatient Score Percentage Positive	Oct 2023	98.1%	No target			n/a	Board
	Friends & Family Test: A&E Score Percentage Positive	Oct 2023	84.6%	No target			n/a	Board
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Nov 2023	6.0	No target			n/a	Board
	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Nov 2023	92.9%	90.0%		H	P	Q&S
	Recording of and response to NEWS2 score for unplanned critical care admissions	Sep 2023	72.0%	No target		n/a	n/a	Q&S
Mental Capacity	Number of contacts with the MCA/DoLS team	Dec 2023	0.0	No target		n/a	n/a	Board
	Percentage of MCA assessments that meet the legal requirements	Oct 2023	4.0%	No target		n/a	n/a	Board
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Oct 2023	0.0%	No target		n/a	n/a	Board
Sepsis	Percentage of paediatric primary sepsis screenings using national risk stratification criteria	Dec 2023	97.5%	No target		n/a	n/a	Q&S
	Percentage of Adult Sepsis screening completed within 15 minutes in response to elevated NEWS2 score	Dec 2023	28.6%	90.0%	**Alert**	H	F	Q&S
Prescribing	Harm impact for weight related medication prescribing incidents	Dec 2023	0	No target			n/a	Board
	Actual weight recorded on Web V within 24 hours of admission	Dec 2023	No Data	No target		n/a	n/a	Q&S
	Weight recorded on EPMA matches actual weight recorded in Web V	Dec 2023	No Data	No target		n/a	n/a	Q&S
Maternity	Robson Scores - Group 1	Dec 2023	8.1%	No target			n/a	Board
	Robson Scores - Group 2	Dec 2023	25.6%	No target			n/a	Board
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Dec 2023	12	No target			n/a	Board
	Still Birth Rate per 1000	Dec 2023	6.6	No target			n/a	Board
	Spontaneous 3rd or 4th Degree Tear	Dec 2023	0.6%	No target			n/a	Board
	Instrumental 3rd or 4th Degree Tear	Dec 2023	3.7%	No target			n/a	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 *	Nov 2023	11.4%	8.0%		L	?	Board
	Registered Nurse Vacancy Rate *	Nov 2023	8.1%	8.0%			?	Board
	Medical Vacancy Rate *	Nov 2023	12.6%	15.0%			?	Board
	Trustwide Vacancy Rate *	Nov 2023	8.6%	8.0%	**Alert**		F	Board
	Medical Vacancy Rate - Consultants *	Nov 2023	18.8%	15.0%	**Alert**	H	?	Board
	Medical Vacancy Rate - Other *	Nov 2023	8.8%	15.0%			?	Board
Staffing Levels	Turnover Rate	Dec 2023	10.4%	10.0%	**Alert**	L	F	Board
	Sickness Rate	Nov 2023	5.1%	4.1%		L	?	Board
Staff Development	PADR Rate	Dec 2023	86.2%	85.0%	**Highlight**	H	F	Board
	Medical Staff PADR Rate	Dec 2023	93.0%	85.0%			P	Board
	Combined AfC and Medical Staff PADR Rate	Dec 2023	86.7%	85.0%	**Alert**	H	F	Board
	Core Mandatory Training Compliance Rate	Dec 2023	90.2%	85.0%			P	Board
	Role Specific Mandatory Training Compliance Rate	Dec 2023	80.3%	85.0%	**Alert**	H	F	Board
Disciplinary	Number of Disciplinary Cases Live in Month	Dec 2023	6	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Dec 2023	6	12			?	WFC
	Number of Suspensions Live in Month	Dec 2023	3	No Target			n/a	WFC
	Average Length of Suspension (Weeks)	Dec 2023	0	No Target	**Highlight**	L	n/a	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

Performance and Activity Report (HUTH)

December 2023 Performance

November 2023 for Cancer data
Produced January 2024

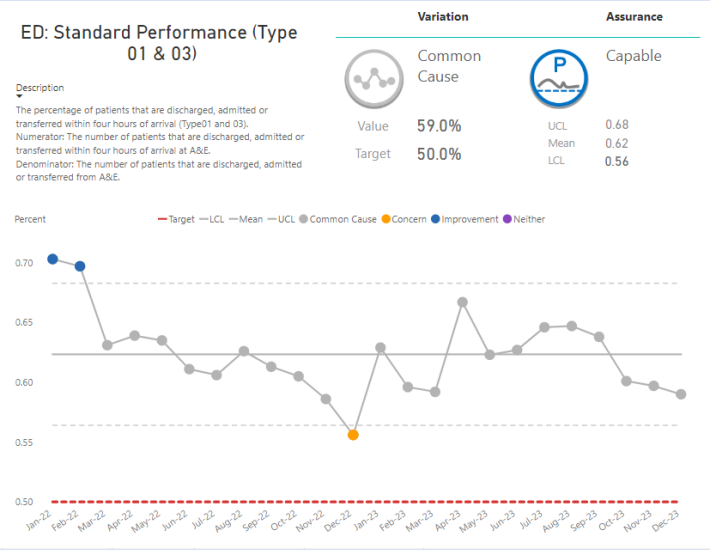
Table of Contents

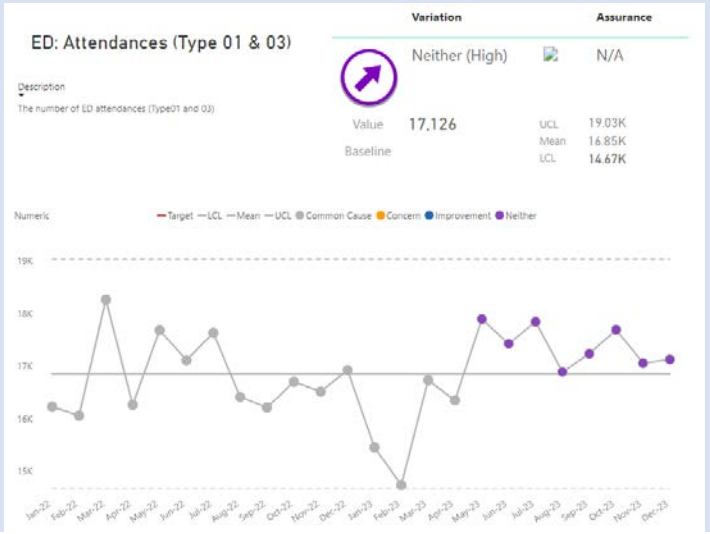
1. Executive Summary

Areas requiring improvement	
	performance with a daily average of 211 patients per day remaining within the hospital who have no medical need for
Cancer performance	• In November 2023, the Trust failed to achieve the cancer waiting times' national standards including the combined backlogs +63 days and FDS are the core metrics – improvements in 62-day and +63-day backlog standards can be seen • cancer referrals not yet seen patients) and 2,272 (which includes the urgent suspected cancer referrals not yet seen of patients who fall into the +63 day backlog metric. Year to date there has been a 10.7% increase in 2WW referrals • HUTH remains a Tier 1 provider for cancer performance with a NHSE assurance/recovery meeting. A further monthly • The number of patients waiting +63 days or more at 31 March 2024 should be no more than 148, with a revised

	• All tumour sites and associated services continue to recover following industrial action earlier in the year, manage the • The impact of industrial action affected theatre and OPA sessions through December and will into January. A number • Internally the 2/52 meetings with the top 4 tumour sites (colorectal, Gynae, urology and lung) are well established and • Late inter-provider transfers (IPTs) from within the HNY ICS primarily have an adverse effect on urology and lung;
Recovery of elective activity	

	analysis, particularly to identify procedures undertaken in outpatients, and improvement projects linked to outpatient pathways to support this operational requirement, and a range of performance discussions at Health Group level related to the comparison to the GIRFT standards in the Further Faster 17 specialities. • Many of the HUTH pathways have a discharge rather than follow up, so a reduction and/or transfer to PIFU would not be appropriate. Additionally, many OP follow up activities are actually a procedure, albeit not attracting an HRG and work is underway to quantify this activity and address any data quality issues, however the Further Faster work at speciality level is supporting an increase in PIFU as is the text validation of the overdue outpatient follow up backlog. • Mutual aid (largely and out-sourcing) continues albeit in limited numbers to improve waiting times and support the reduction of the overall size of the Trust's PTL.
Improving treatment times for long waiting patients	• At the end of December 2023, the Trust reported **11 x 78 week wait breaches**, an increase of 2 from the previous month. We are on track/under trajectory for the +65-week waiting patient cohort and predicting zero breaches at March 2024. • Enhanced internal governance processes continue to support the daily monitoring against the trajectories and on-going work to identify capacity internally and seek/take up offers of mutual aid from other providers. • 2,513 patients have waited more than one year/52-weeks for their appointment/procedure, this is below the trajectory of 5,157.
Reducing the delays in people leaving acute setting	• In December 2023, there were 211 (average) patients per day with NCTR, a rise of 19 per day vs. November 2023. • NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings.





What the chart tells us

The 4-hour performance delivery remains fairly static, significantly below the required standard.

In December 2023, performance was 59.0% for all attendance types and is above the revised improvement trajectory.

Intervention and Planned Impact

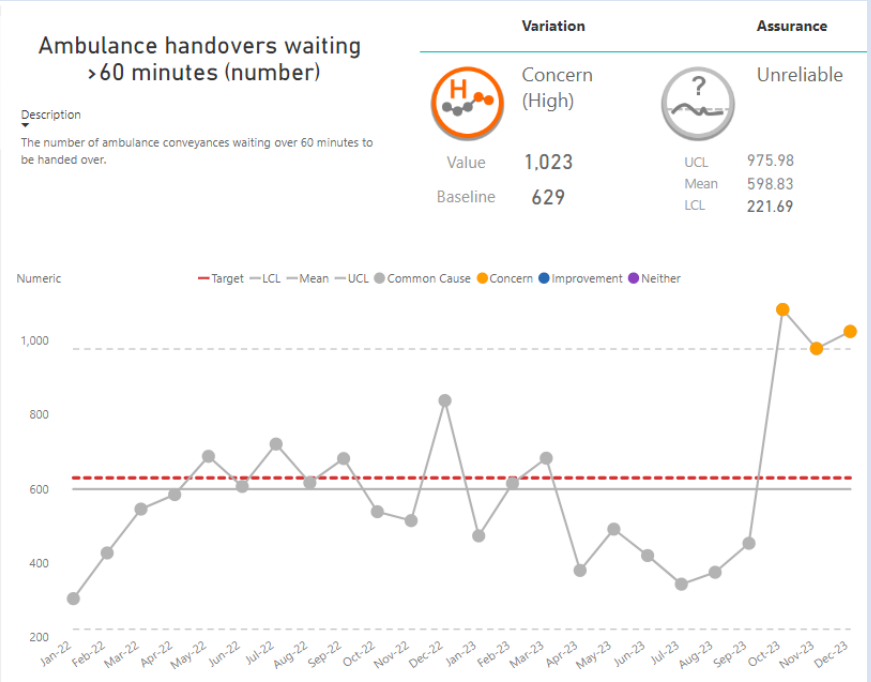
- Work has progressed well on the co-located UTC which is due to be operational for February.
- Improvement work continues on the ground floor program the new SOP for SDEC suitable patients is being finalised with implementation planned for February.

Risks / Mitigations

- Continued delays in flow and discharge are a significant impediment to an improvement in the initial assessment and majors' area; with some impact on ECA as rooms are occupied for an extended period.
- Continued/escalating industrial action by medical colleagues may impact both on Time in ED and flow across the Trust.

4-Hour Performance - Type 1 & 3 Combined	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target:	51.0%	55.0%	59.0%	63.0%	67.0%	71.0%	74.0%	77.0%	75.0%	75.0%	76.0%	76.0%
Revised Trajectory:								48.0%	50.0%	55.0%	58.0%	76.0%
Actual:	**66.7%**	**62.3%**	**62.8%**	**64.6%**	**64.7%**	**63.8%**	**60.1%**	**59.7%**	**59.0%**			

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 1,023 waits over 60 minutes reported in December 2023, which equated to 28.7% - a deteriorating position.

Intervention and Planned Impact

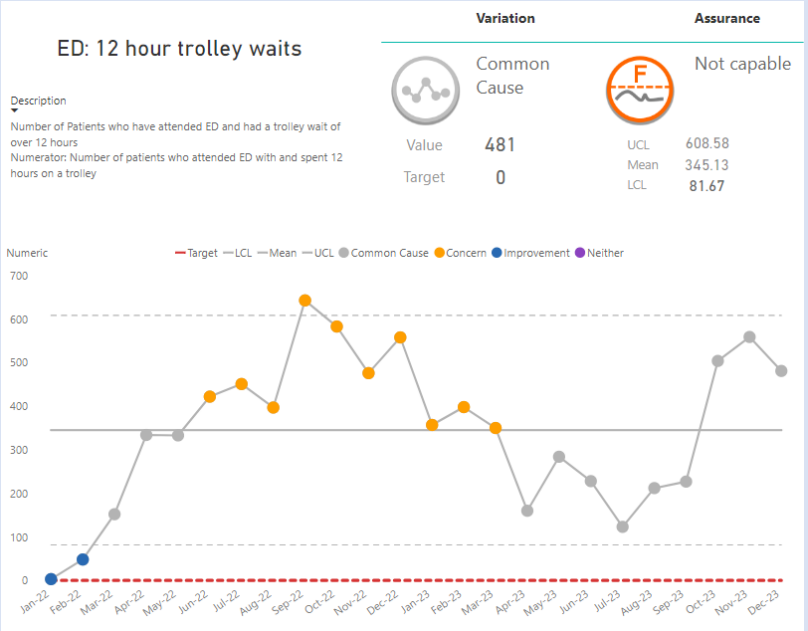
- The Rapid Process Improvement work continues to be embedded, this has led to improved coordination and safety of patients, the department are currently working on a 45min handover plan for implementation in March 24

Risks / Mitigations

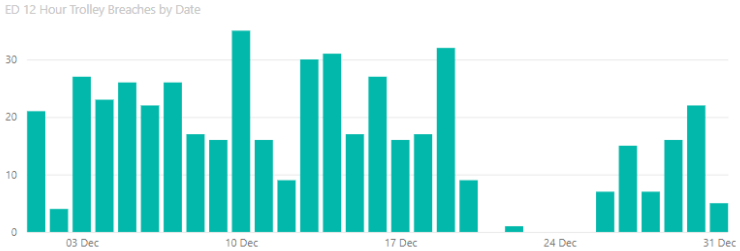
- Flow remains challenged as the number of patients with No Criteria to Reside, who are unable to be discharged, continues to be higher than baseline.
- YAS are unable to use the EPR to capture the early handover of Resus Patients. This is still currently being tested.

Ambulance Handover within 30 mins	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target:	53.5%	63.6%	68.6%	80.3%	85.3%	90.1%	95.4%	87.5%	87.9%	87.9%	93.5%	100.0%
Actual:	64.9%	62.8%	64.9%	73.6%	68.0%	65.9%	43.8%	47.7%	46.4%			

4. 12 Hour Trolley Waits (from DTA to Depart)



Day of Week Number	1 Mon	2 Tue	3 Wed	4 Thu	5 Fri	6 Sat	7 Sun	Total
ED Departures (Type 01)	1,418	1,489	1,477	1,497	1,904	1,642	1,701	**11,128**
ED 12 Hour Trolley Breaches	56	74	76	64	72	69	83	**494**
ED 4 Hour Standard Performance (Type 01)	48.2%	43.7%	42.9%	46.6%	44.4%	42.0%	46.3%	**44.8%**



What the chart tells us

There were 481 x12 hour trolley wait breaches in December 2023.

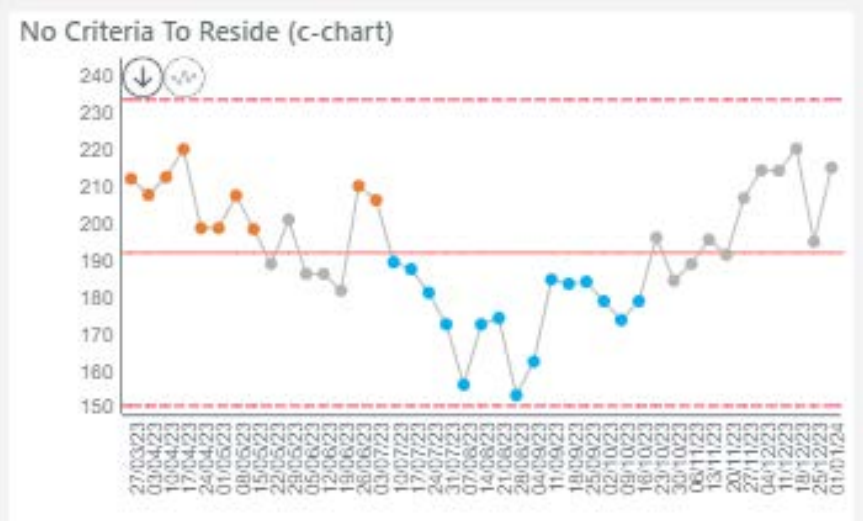
Intervention and Planned

- December 2023 saw a slight decrease in the number of 12 hour Trolley waits, a Ward flow improvement program has been set up to improve local processes, this is due to have an impact from March 24.

Risks / Mitigations

- High numbers of No Criteria to Reside patients, outside of the NCTR bed base are occupying acute beds reducing for acute work.

5. No Criteria to Reside



What the chart tells us

On average, there were 211 patients per day with No Criteria to Reside in December 2023. There was an average impact of 3.8 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 3,896 lost bed days in December 2023.

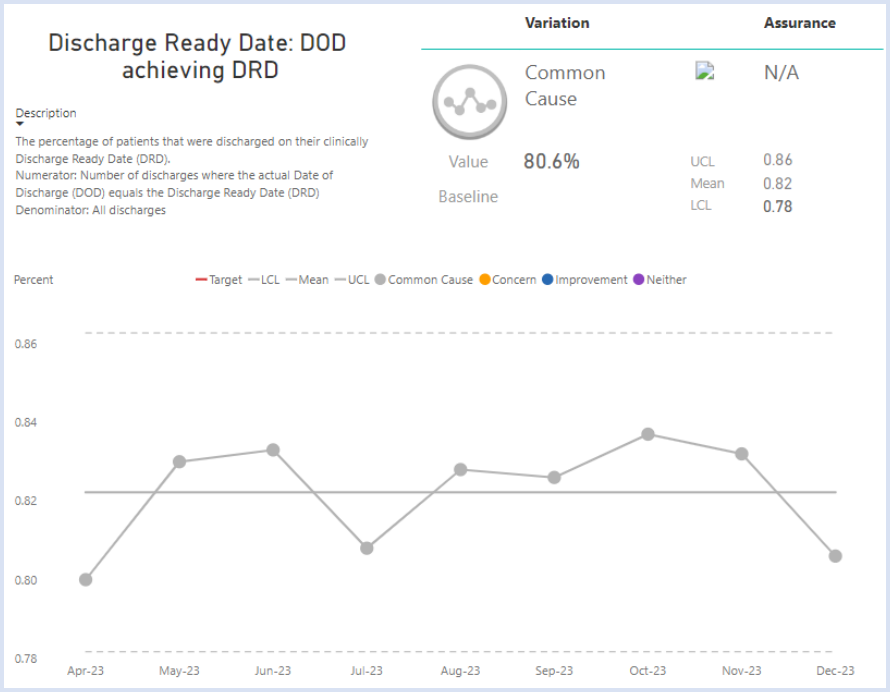
Intervention and Planned Impact

- A voluntary Services Coordinator was delayed, interviews are in Feb 24 to support across the Hospital wards to help identify patients that would benefit from voluntary services to enable earlier discharge.
- A Second IDL Dr will begin 11th January to reduce time patients are waiting for discharge medication
- YAS patient flow team will begin on 22nd Jan to help improve Transport issues by maximising crew utilisation

Risks / Mitigations

- Domiciliary capacity remains lower than demand.
- Towards the end of November 2023 we started to see increases in IPC issues in the community and the Trust restricting the ability to discharge patients to alternative setting

6. Discharge Ready Date



What the chart tells us

Discharge Ready Date is a new metric implemented by NHS England in July 2023. The recovery plan committed to the development of a new metric for discharge to help better record and monitor when patients are ready for discharge, and to encourage that process to begin earlier. This new metric will measure the time between a patient no longer meeting the Criteria to Reside (their "Discharge Ready Date") and their actual date of discharge.

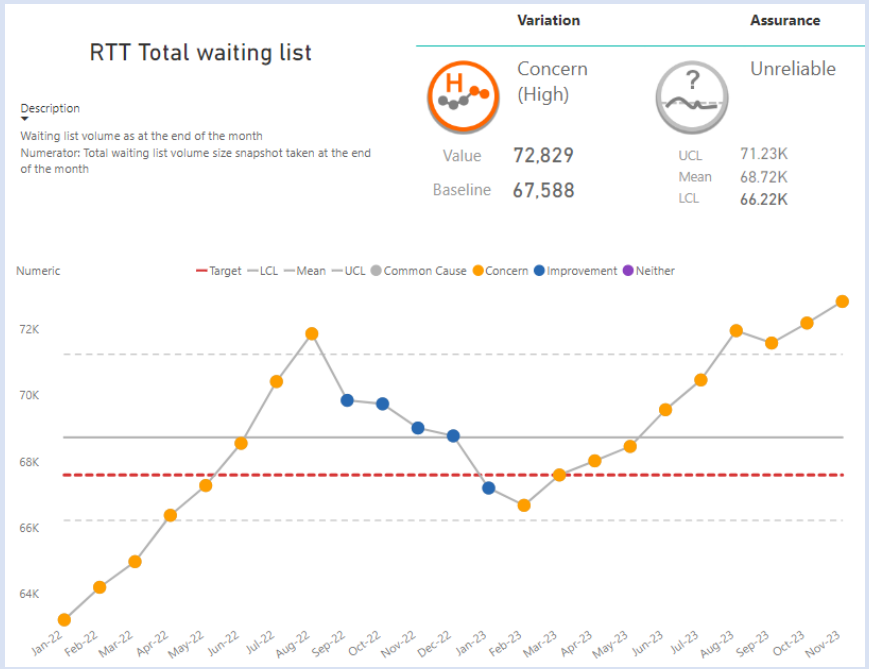
In December 2023 80.6% of patients were discharged on their Discharge Ready Date. The national average for achieving the Discharge Ready Date is 86.2%. The average days from Discharge Ready Date to Discharge for HUTH was 5.0 which is better than the national average of 6.2.

Intervention and Planned Impact

- Focus on Pathway 0 patients discharging on day of becoming NCTR across all Health Groups

Risks / Mitigations

- Repatriations to other organisations rarely occur on the same day but are recorded as NCTR



What the chart tells us

The Trust's total waiting list volume (WLV) has increased, impacted by bank holidays and industrial action during 2023/34. At the end of December 2023, the waiting list volume provisional position is 72,821. The total WLV is above the trajectory of 66,549.

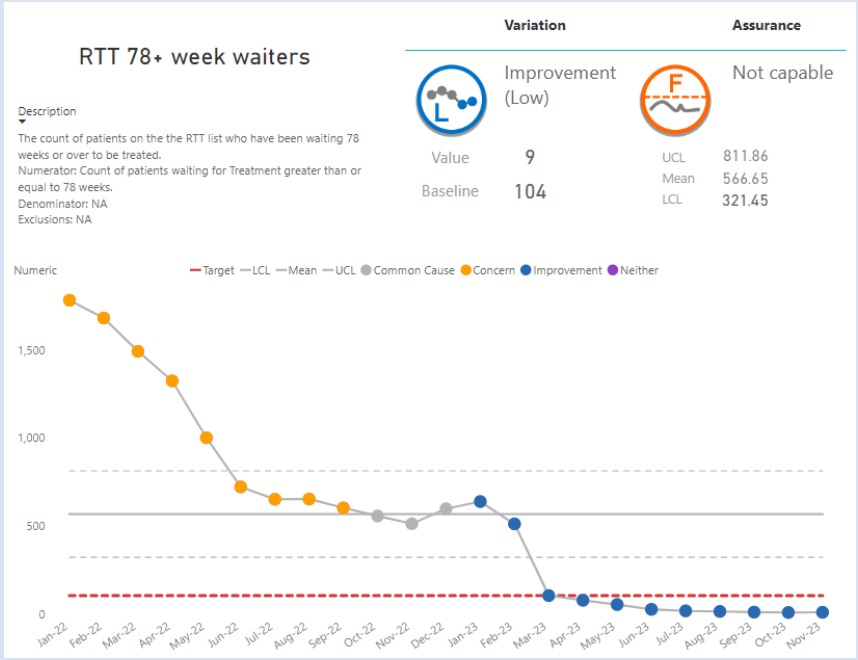
Overall, referrals are up 5.2% on the previous year.

Intervention and Planned Impact

- Targeted HG & speciality meetings continue to reduce waiting, improve utilisation and achieve increased clock stops
- Mutual aid/in-sourcing and out- sourcing to support the total WLV reduction.
- Capacity alerts in x6 pressured specialities are live – monitoring arrangements to consider the effectiveness and impact (5x specialities – referral rate reducing, with ENT referral rate flat)
- Text validation delivered as a BAU validation process from 2023/24.
- Text validation of the OP Follow Up Backlog commenced during October 2023 with good discharge and PIFU rates from first 4 specialities
- RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning.

Risks / Mitigations

- Increase in GP referrals – referral triage and A&G in place to mitigate
- Patients with No Criteria to Reside does not reduce
- Infection rates including the management of contacts reduces beds available and/or affects staff availability
- Increase in non-elective demand displacing elective capacity
- Impact of any Industrial Action
- Impact of increased urgent suspected cancer referrals which displace routine referrals



What the chart tells us

At the end of December 2023, the Trust reported 11 x breaches of the 78-week target, against a forecast position 11, with the majority of the breaches (9) in gynaecology.

The current position (at 15.1.24) is 72 total 78 week patients to treat by the end of January 2024. 79% of these have an appointment/TCI date booked before the end of the month.

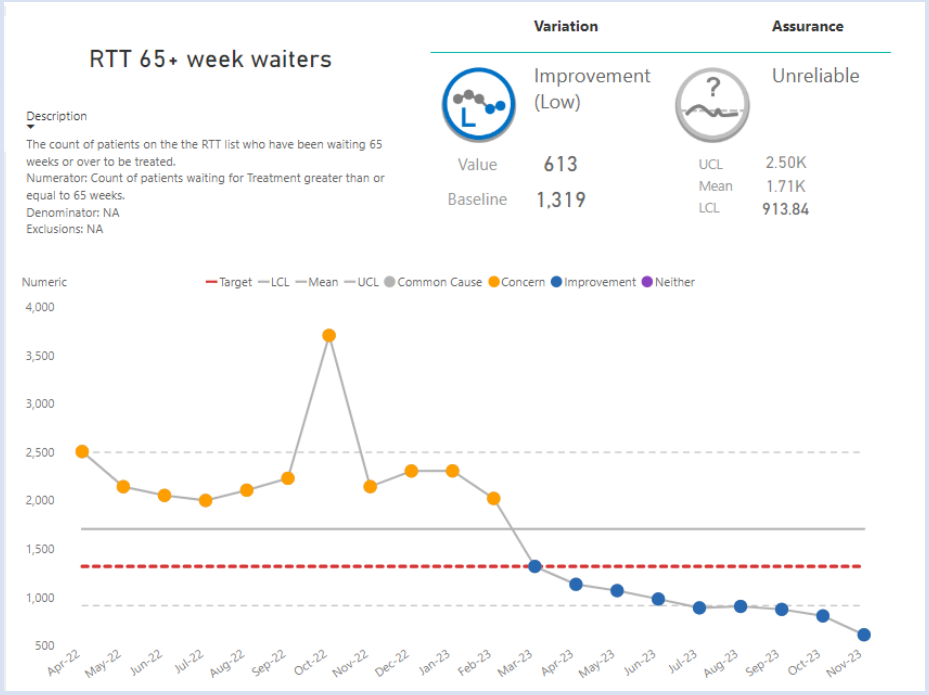
The forecast outturn position is 11 breaches, of which x8 are complex gynaecology (endometriosis) and 3 in Colorectal Surgery (complex robotic) due to consultant sickness.

Intervention and Planned Impact

- Continued focus at speciality level of patients dated and/or risks now focussed to achieve zero 78-week waits.
- Clinical Admin Service continue to proactively contact patients with TCIs/appointments to check they are attending/if treatment is still required – small number of removals
- Continuing to in-source capacity and/or use WLIs and mutual aid where possible to support pressured specialities.

Risks / Mitigations

- Current patients dated are treated as planned – delivered through micro-management
- IPC risks including affecting staff absence & bed availability
- NCTR and/or acute demand – impacting on elective bed base
- Priority 2, cancer and trauma demand – including ICU capacity & delays in repatriation (in & out of network)
- Patient choice & willingness to accept alternative providers and/or do not meet criteria
- Impact of BMA industrial action during 2023/24
- Speciality capacity risks:
  - Gynaecology (capacity for complex endometriosis)
  - Ophthalmology (corneal transplant donor material)
  - Colorectal Surgery (complexity x2 surgeon robotic cases)



What the chart tells us

December 2023 provisional 65w+ waits stands at 572 against a trajectory of 797.

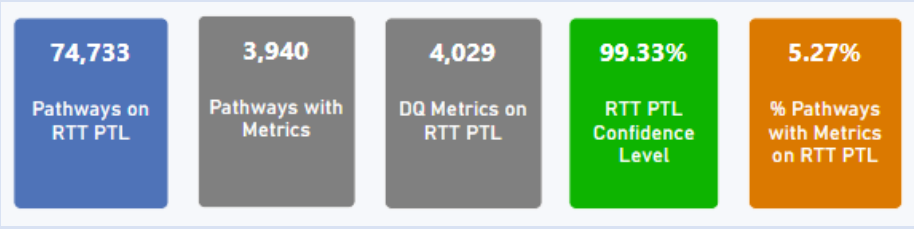
Intervention and Planned Impact

- Continued focus at speciality level of patients dated and/or risks now focussed to achieve zero 65-week waits by the end of March 2024.
- Specialty level trajectories in place with all on track except for Plastic Surgery (currently +20 to plan).
- Weekly performance meetings in place with specialties with large volumes to clear

Risks / Mitigations

- Patient choice
- Capacity constraints
- Urgent / 2ww demand for appointments
- Industrial action planned

10. RTT Data Quality – LUNA Dashboard



What the chart tells us

In accordance with the Protecting and Expanding Elective Capacity update to the Trust Board in September 2023 – this new metric has been added to the Performance and Finance Report from September 2023 onwards.

The Trust has oversight with systems and process in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.37% confidence level for RTT PTL data quality.

The Trust's current position is 93.3% of all RTT pathways >12 weeks have an up-to-date validation comment.

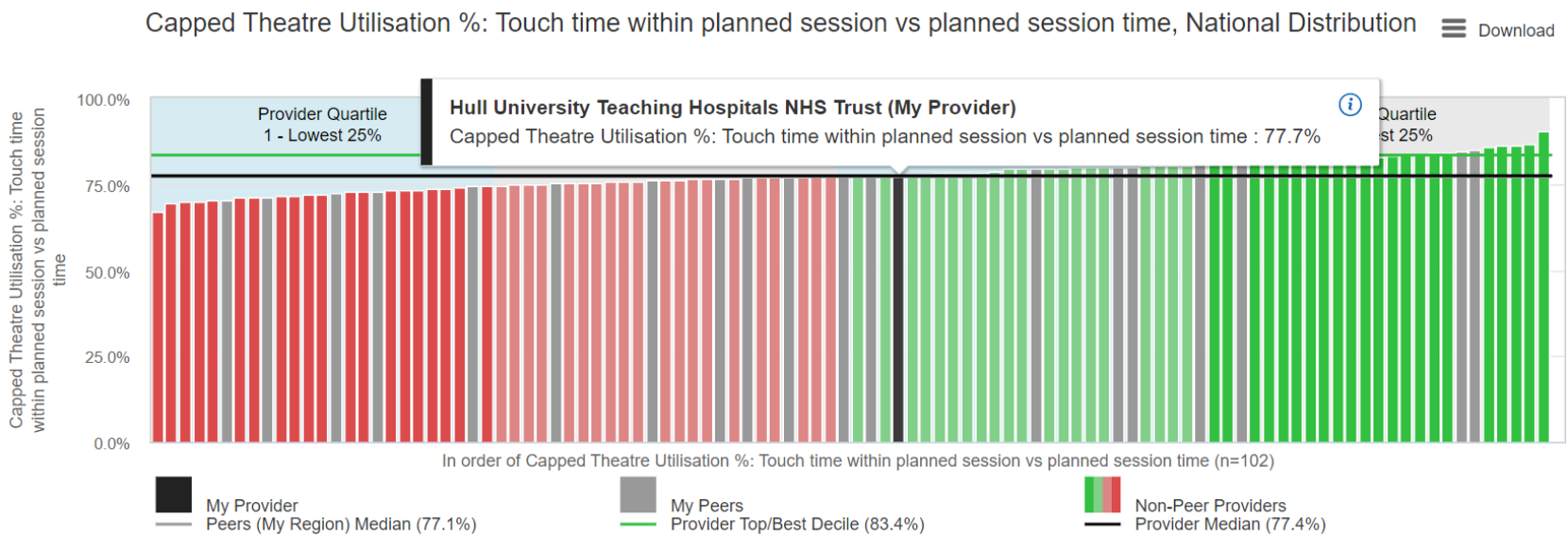
Intervention and Planned Impact

- Business as usual process in place between the Performance and CAS teams
- For those patients who are waiting over 12 weeks the Trust is able to maintain a 90% validation rate and does not require any digital support.
- BI data quality reports are used to monitor weekly and escalation processes are in place.

Risks / Mitigations

- Training support to new starters in place to reduce RTT errors

11. Capped Theatre Utilisation



What the chart tells us

The elective recovery standard is a minimum of 85% capped theatre utilisation.

Data from Model Health for 2023/24 (at 3.12.23) shows capped theatre utilisation at 77.7% against a peer median of 77.1% and in the third quartile nationally.

There is considerable variation in performance, with further work on-going with regards to data quality, theatre scheduling timings update, understanding the definitions and the Model Health outputs compared to the internal monitoring.

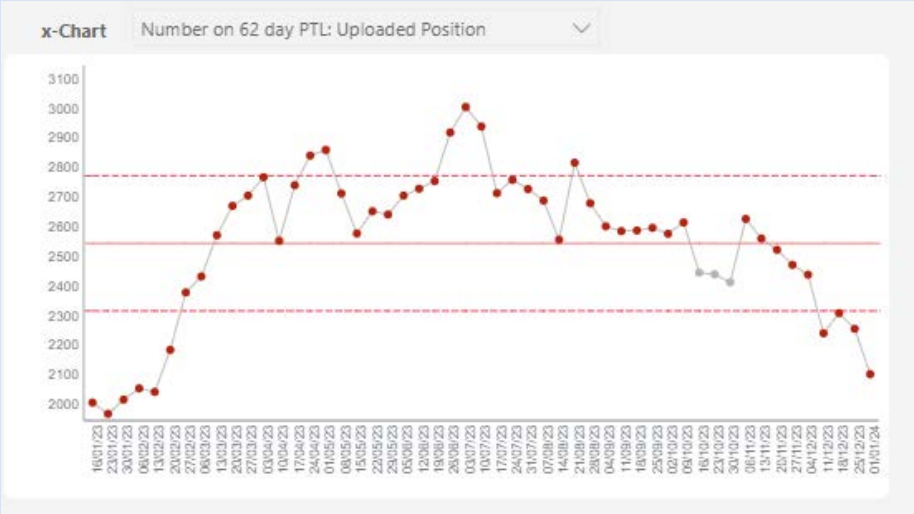
Intervention and Planned Impact

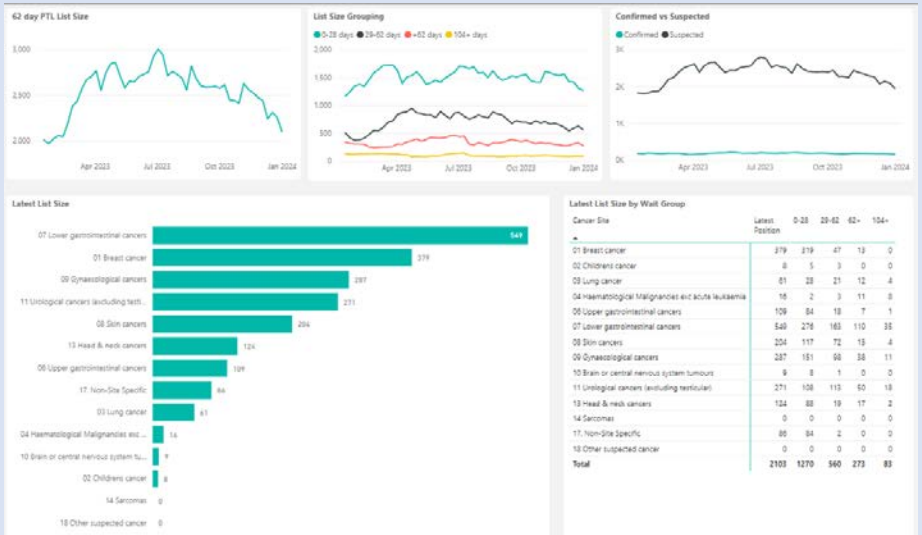
- Review of theatre timetable and configuration of ORMIS sessions – elective/acute split
- Theatre timings continued to be reviewed and updated in the scheduler – with the scheduler being the key source of information when booking lists
- Some changes to consultant job plans required to utilise the Trust standard 4-hour theatre session
- Model Health to share the reporting methodology so that the capped theatre utilisation can be replicated for internal reporting at Trust and specialty level.
- All BI dashboards to be aligned to capped theatre utilisation methodology.
- Surgery HG implemented a Theatre Productivity Meeting from July 2023 and joint Theatres and CAS (TAPS) meetings at speciality level.

Risks / Mitigations

- Late starts and/or cancellations on the day as a result of being unable to confirm beds including ICU beds
- Inaccurate theatre timings used in ORMIS
- Consultant job plans do not match theatre schedule
- Use of elective theatres for acute/urgent capacity – i.e. neurosurgery and trauma
- Patients unfit, DNA or are found not to need the surgery on the day

12. Cancer 62 day Waiting List Volume





What the chart tells us

At week commencing 3rd January 2024, the Cancer PTL was 1,591 (excluding urgent suspected referrals not yet seen) and 2,272 (including urgent suspected cancer referrals not yet seen).

In December 2023, the Trust received 2,026 referrals which is lower when compared to November 2023 (2,521), but an increase of 219 when compared to December of the previous year.

Following a bid for monies through the Cancer Alliance, the Trust has been successful in securing £1.1m of national funding and a further £0.2m local funding for a number of schemes identified to contribute to improving FDS, improving 62-day RTT and reducing the 63+ backlog.

The Colorectal backlog for 63+ days is under trajectory (168) for November 2023 at 150. Additional lists in Endoscopy continue to reduce the waiting times for the diagnostic phase of the pathway.

Gynae-oncology backlog for 63+ days is under trajectory (32) for November 2023 at 28. A PMB pathway change was implemented in November 2023 to support an improvement in FDS & reduce the number of patients in the diagnostic phase, this is apparent in November 2023 performance with FDS continuing to improve.

Urology continue to improve on the 63+ day backlog and was meeting their trajectory in November 2023. Additional haematuria clinics have been confirmed to continue to run through December 2023 and January 2024 which will see the backlog reduce to almost zero with subsequent performance improvement.

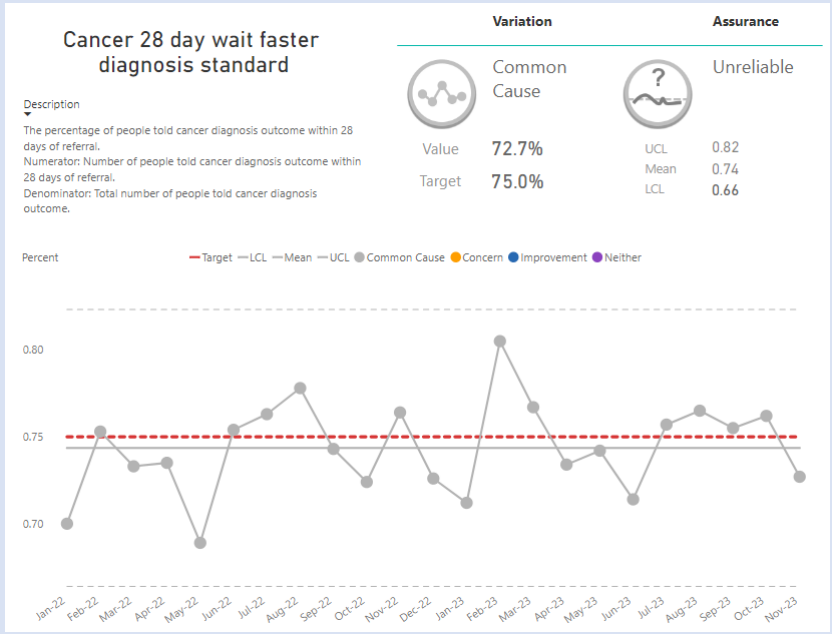
Intervention and Planned Impact

The capacity and/or pathway issues fall into 5 broad categories and remain so as follows:

Imaging/Diagnostic - waiting times/capacity review underway supported by the Operational Improvement Team to ensure that national timed pathways are achieved where possible.

	• Colonoscopy – in-sourced endoscopy capacity plus mutual aid from NLAG • Additional funds for backlog clearance for endoscopy, gynaecology & urology Histology capacity/delays – on-going review/monitoring of TATs, many tumour sites are supported by a single histopathologist and/or rely on outsourced capacity. HNY CA recovery funding supports administration capacity related to out-sourcing. Tracking capacity and decision making – Additional tracking resource to support the increased PTL volume to maintain tracking timeliness is in place. Updated SOPs and competencies for tracking staff have been implemented with the teams, with clear escalation processes and timescales against the optimal pathways. The DNA/patient cancellation SOP will be finalised in December 2023 with template clinical letters for discharge to GPs for safety netting. The SOP has been agreed at internal meetings and is now with the LMC and National Cancer Team for their comments. A tool provided by the IST is to be used to ensure that there is correct establishment in all areas of the tracking/MDT teams. Colorectal and Gynaecology are the first tumour sites to be reviewed through this tool. Radiotherapy capacity/delays – Due to the radiotherapy workforce constraints a prioritisation framework is used to allocate the treatment resource. Following successful recruitment, the team have developed a recovery plan which has been in place from November 2023 (this will take 12 months to catch up). Mutual aid arrangements with United Lincoln Hospitals continue for 2 patients per month. Transformation Opportunities across all tumour sites continue to be explored.
	Risks / Mitigations • Improvement projects are delayed and/or do not produce expected results • Diagnostic capacity continues to be constrained • Referral rates since April 2023 above baseline & plan for 23/24 • Awareness campaigns and high profile cases

13. Faster Diagnosis (28-day) Standard



What the chart tells us

The Faster Diagnosis Standard (combined) November 2023 failed the 75% target (HUTH plan 76%) with performance of 74.7%. Further validation has been undertaken up to 10th January which has resulted in a revised performance of 75.5% which will be uploaded at the next 6 monthly revision/submission.

The planning guidance requires delivery of the 75% standard by March 2024, with HUTH committing to a stretch target of 80% with additional financial support.

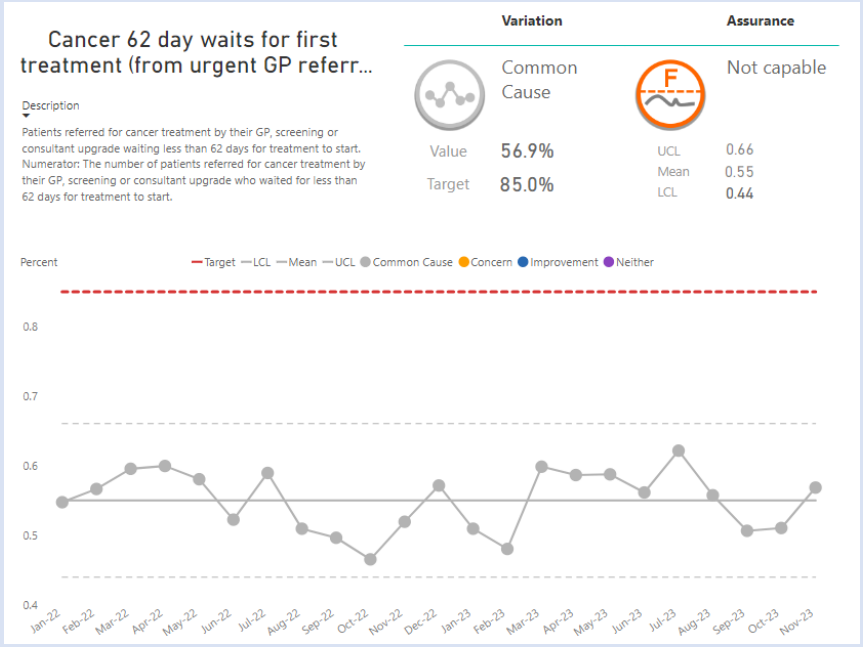
Intervention and Planned Impact

- On-going improvement projects to support the delivery of national timed pathways:
  - Lower GI (nurse triage)
  - Gynae-oncology (PMB pathway)
  - Urology (radiographer stepdown and result communication)
  - Lung walk in chest x-ray service
  - Frailty triage from February 2024
- Continue improvement in tracking and escalation processes to ensure 28-day FDS is achieved

Risks / Mitigations

- Potential further industrial action
- Delivery of the operational improvement projects is delayed
- Urgent suspected cancer referrals – patients do not attend 1st OPA within 14-days

14. Cancer 62 day Performance



What the chart tells us

November 2023 performance is 57.1%, an improvement when compared to October 2023 at 52.2%; performance at the 85% target has not been achieved for some time.

Significant numbers of patients are in the diagnostic phase of their cancer pathway, however, this continues to decrease with the additional capacity being delivered through the cancer alliance monies. The Radiotherapy constraints & some surgical capacity issues are limiting the delivery of the 62-day treatment standard.

With the investment provided, HUTH has committed to achieving 65% by 31 March 2024.

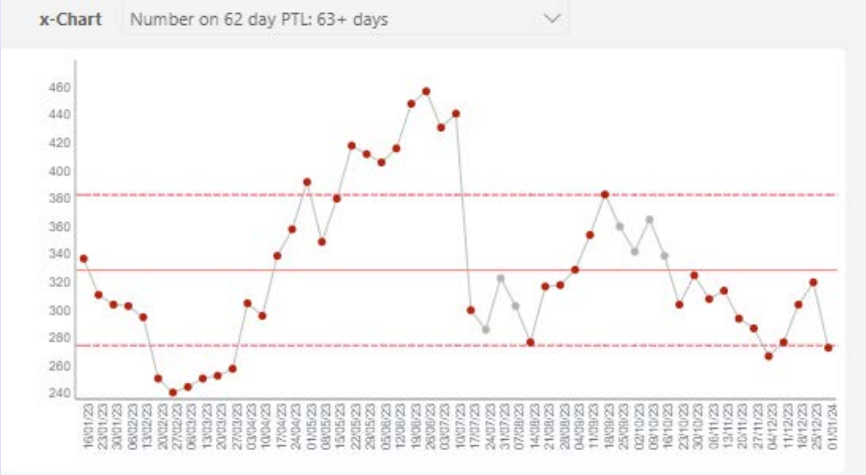
Intervention and Planned Impact

- Endoscopy/Colonoscopy -sourced capacity and mutual aid from NLAG will support, whilst HUTH workforce are completing competency to scope independently.
- A national Endoscopy webinar was held in September 2023 looking at mitigating harm in colonoscopy waiting lists – external support to review endoscopy productivity will support the sustainability of the capacity
- Improvement work at the front end of the LGI pathway went live during October 2023, this will reduce the pathway by 7 days when fully implemented
- Radiotherapy capacity/patient prioritisation continues to adversely affect performance, a 12-month recovery plan commenced November 2023
- Urology –mutual aid from NLAG & in-sourced haematuria clinics will reduce the backlog of patients awaiting a diagnosis
- Gynae-oncology – the revised PMB pathway will be live from 6 November 2023, this should reduce the diagnostic phase and increase 62-day RTT performance

Risks / Mitigations

- Referral rate impact on the cancer PTL & waiting times; referrals continue to be high in specific tumour sites
- Cancer awareness campaigns – bowel screening, breast awareness, etc.
- Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times)
- Mobile CT capacity continues to be provided by the IS

15. Cancer 63 day+ Performance – Lower GI, Urology, Skin



What the chart tells us

At the end of December 2023 the number of patients 63 days and over was 277 compared to 294 at the end of November 2023, an improving position against a revised trajectory of 290 at the end of December 2023.

This metric was added in response to the Elective Recovery Self-Assessment requirements specifically - FIT with referral (Lower GI), tele-dermatology (Skin) and npMRI (urology).

Intervention and Planned Impact

The Lower GI +63 day backlog is 123 at the end of December 2023 against a revised trajectory of 160. Colorectal urgent suspected cancer referrals with a FIT test/result slightly deteriorated at 72.8% for end of December 2023. There is work for the Cancer Alliance to support to increase the rate to a target of 80%.

In-sourcing significant endoscopy capacity, as well as mutual aid support from NLAG, is improving the Lower GI position. The LGI Nurse led triage went live on 23 October 2023 and is intended to remove up to 7 days at the front end of the pathway (removes a two-step triage process).

The Urology backlog continues to improve in both the 63+ and 104+ backlog. The FDS standard is an improving position and the additional haematuria clinics continue to reduce the backlog.

Risks / Mitigations

- Referral demand
- Delivery of FDS in Lower GI and Urology
- Backlog of diagnostic capacity is not addressed through additional capacity
- Further industrial action
- Improvement project actions do not deliver the expected benefit

16. Elective Recovery Fund

Activity data up to	08/01/2024		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
			*Actual activity for current month is projected using working days; actual activity is based on data submitted to SUS								
			Plan activity is from health group submissions with corporate adjustments for a small number of specialties								
Indicative Activity Requirement (% of baseline):			104%	104%	104%	104%	104%	104%	104%	104%	104%
Ceiling target for follow up activity (% of baseline):			75%	75%	75%	75%	75%	75%	75%	75%	75%
TRUST TOTAL	New	Baseline	17,637	17,096	16,632	18,386	14,792	17,746	18,482	17,249	15,263
		Plan	13,078	14,532	15,985	15,258	15,985	15,258	15,985	15,985	13,805
		Actual*	13,942	16,240	16,787	16,347	15,412	15,752	16,950	17,436	13,630
		Plan %	107%	112%	105%	107%	96%	103%	106%	109%	99%
		19/20 Baseline %	79%	95%	101%	89%	104%	89%	92%	101%	89%
	Follow Up	Baseline	33,158	37,048	34,967	38,951	32,800	35,396	40,453	36,572	31,595
		Plan	31,562	35,069	38,576	36,822	38,576	36,822	38,576	38,576	33,315
		Actual*	33,451	39,235	40,392	38,524	39,198	39,184	41,853	43,034	34,681
	(minimise)	Plan %	106%	112%	105%	105%	102%	106%	108%	112%	104%
	(minimise)	19/20 Baseline %	101%	106%	116%	99%	120%	111%	103%	118%	110%
	Day Case	Baseline	6,080	6,198	5,817	6,488	5,948	6,167	6,688	6,244	5,702
		Plan	6,121	6,801	7,481	7,141	7,481	7,141	7,481	7,481	6,461
		Actual*	5,616	6,621	6,648	6,547	6,638	6,574	6,872	7,229	6,074
		Plan %	92%	97%	89%	92%	89%	92%	92%	97%	94%
		19/20 Baseline %	92%	107%	114%	100.9%	112%	107%	103%	116%	107%
	Ord Elect	Baseline	1,203	1,276	1,296	1,341	1,177	1,275	1,403	1,383	1,244
		Plan	1,079	1,199	1,318	1,258	1,318	1,258	1,318	1,318	1,139
		Actual*	1,016	1,075	1,177	1,064	1,046	1113	1,235	1,289	1,090
		Plan %	94%	90%	89%	85%	79%	88%	94%	98%	96%
		19/20 Baseline %	84%	84%	91%	79%	89%	87%	88%	93%	88%

Trust ERF Performance by Month

ERF Category	1	2	3	4	5	6	7	8	9	Grand Total
Daycase	100%	108%	101%	98%	93%	101%	105%	111%	105%	102%
Elective	103%	96%	88%	88%	85%	93%	95%	100%	97%	94%
OP 1st Att	106%	114%	104%	107%	96%	106%	107%	115%	99%	106%
OP 1st Procedure	110%	128%	127%	123%	112%	110%	110%	111%	109%	116%
OP FUP Procedure	124%	127%	122%	120%	111%	113%	123%	132%	119%	121%
Grand Total	**104%**	**106%**	**98%**	**97%**	**92%**	**100%**	**102%**	**108%**	**101%**	**101%**
YTD Position	**104%**	**105%**	**102%**	**101%**	**99%**	**99%**	**100%**	**101%**	**101%**	

What the chart tells us

Recovery of elective activity in December 2023 against the operational plan delivered:

- New Activity 99%
- Follow up Activity 104%
- Day Case Activity 94%
- Ordinary Elective Activity 96%

Elective Recovery Fund

The target has been revised from 106% to 104% to reflect the strikes, and further reduced to 103% in November 2023, to reflect the impact of industrial action in Q3. YTD the Trust is at 101% ERF at month 9.

Intervention and Planned Impact

Access to HOB and ICU capacity is a limiting factor in relation to IP elective recovery. Additional funding to support HOB expansion at HRI however, physical space and workforce is limiting the delivery respectively.

Consultant vacancies and absence, plus the Junior Doctor and Consultant Industrial Action impacted during 2023/24– cancer performance, OPA and elective activity.

Day case delivered 99% of plan (activity) in December 2023 (107% of 19/20).

OP 1st attendances (activity) achieved 99% of the plan in December 2023 and 89% of 19/20 baseline.

OPFU (activity) continue to over-perform at 104% of the plan and 110% of the 19/20 baseline, income is capped at 85% of 19/20 baselines; further information received in regard to the 2023/2024 planning round will see follow ups with a procedure removed from the requirement to reduce by 75%, which will likely improve the achievement of this metric for HUTH.

Focussed review of OPFU rates and comparison to regional and national performance is continues with the development of OP Transformation Plans at Health Group speciality level. Many procedures are counted/coded in the HUTH follow-ups – work is underway to understand if this activity could be excluded from the reduction in follow up rates by escalation through national expert reference groups and forums.

Risks / Mitigations

- On-going anaesthetic staff shortfalls – rolling recruitment in place and development of Anaesthetic Assistant roles
- Elective activity and elective bed base is not ring-fenced through winter or Covid surges
- OPFU continue to be in excess of 75% of 19/20 baseline at March 2023

17. Non-Elective Activity

Activity data up to	08/01/2024		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
			*Actual activity for current month is projected using calendar days; actual activity is based on data submitted to SUS								
			100%	100%	100%	100%	100%	100%	100%	100%	100%
TRUST TOTAL	Non-elective	Baseline	4,735	4,952	4,603	4,765	4,531	4,537	4,850	4,745	4,790
		Plan	4,928	5,093	4,928	5,093	5,093	4,928	5,093	4,928	5,093
		Actual*	4,847	5,150	4,992	5,086	4,953	5,078	5,286	5,072	5,264
		Plan %	98%	101%	101%	100%	97%	103%	104%	103%	103%
		19/20 Baseline %	102%	104%	108%	107%	109%	112%	109%	107%	110%

What the chart tells us

Non-elective activity in December 2023 was higher than the baseline of 19/20.

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)046

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 February 2024
Director Lead	Lee Bond, Group Chief Financial Officer
Contact Officer/Author	Tony Curry, HUTH Charitable Funds Chair
Title of the Report	HUTH Charitable Funds Committee – Year-End Accounts and Annual Governance Report
Executive Summary	The HUTH Charity is running down its fund balances with a view to transfer all remaining funds to the WISHH Charity (independent from the Hospital Trust). Approval from the Department of Health is required before the funds are transferred over in full. The Charitable Funds Committee met on 29 January 2024 to approve HUTH's Charity annual accounts.
Background Information and/or Supporting Document(s) (if applicable)	The minutes of the meeting held on 29 January 2024 to approve the Year-End Accounts are available for the Boards in Common should they require further information or assurance.
Prior Approval Process	The HUTH Charitable Funds Committee reviewed the draft Accounts at its meeting in November 2023.
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:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committee Highlight / Escalation Report to the Trust Boards

	8 February 2024
	HUTH Charitable Funds Committee
	29 January 2024
	Yes

1.1 This report sets out the items of business considered by the Charitable Funds Committee at their meeting held on 29 January 2024 including those matters which the committee specifically wishes to escalate to either or both Trust Boards.

2.1 The committee considered the following items of business:

- *Year-end Accounts and Annual Governance Report*
- *Letter of Representation*

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

a. Approval of the year-end HUTH Charity Accounts and Annual Governance Report

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

a. The Committee discussed the year-end HUTH Charity Accounts and Annual Governance Report. The external auditors (Mazars) had identified no significant internal control deficiencies. There were no unadjusted or adjusted misstatements identified.

5.0 Matters on which the committee has requested additional assurance:

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

a. *Transfer date of the HUTH Accounts to the WISHH Charity. This would be discussed further at the next meeting of the Committee.*

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 has proposed the following change(s) to the risk rating or entry:

- *The BAF was not considered in this meeting.*

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- *Note the approval of the year-end HUTH Charity Accounts.*

Tony Curry – HUTH Charitable Funds Chair
29 January 2024