Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

GROUP BOARDS IN COMMON - PUBLIC

GROUP BOARDS IN COMMON - PUBLIC

10 October 2024

09:00 GMT+1 Europe/London

Boardroom, Hull Royal Infirmary

AGENDA

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

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

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

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 10 October 2024 at 9.00 am to 12.30 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** Sean Lyons, Group Chair	Verbal	Information	**09:00**
1.2	**Patient Story** Amanda Stanford, Group Chief Nurse	Verbal	Discussion / Assurance	
1.3	**Declarations of Interest** Sean Lyons, Group Chair	Verbal	Assurance	
1.4	**Minutes of the Meeting held on Thursday, 8 August 2024** Sean Lyons, Group Chair	BIC(24)181 Attached	Approval	
1.5	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.6	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(24)182 Attached	Assurance	
1.7	**Group Chief Executive's Briefing** Jonathan Lofthouse, Group Chief Executive	BIC(24)183 Attached	Assurance	**09:25**
2.	**GROUP DEVELOPMENT**			
2.1	None			
3.	**BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS**			
3.1	**Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge** Sue Liburd & Dr David Sulch, Non-Executive Directors Committee Chairs	BIC(24)185 Attached	Assurance	**09:55**
3.1.1	**Establishment Review of Safe Staffing** Amanda Stanford, Group Chief Nurse	BIC(24)186 Attached	Discussion	**10:10**
3.1.2	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Stuart Hall & Sue Liburd, NED Maternity & Neonatal Safety Champions	BIC(24)187 Attached	Assurance	**10:20**
3.1.3	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Amanda Stanford, Group Chief Nurse	BIC(24)188 Attached	Assurance	**10:25**
BREAK – 10:35 – 10:50				

3.2	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)189 Attached	Assurance	**10:50**
3.2.1	**Winter Plan Update** Paul Bytheway, Group Chief Delivery Officer	BIC(24)190 Attached	Assurance	**11:05**
3.3	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Tony Curry, Non-Executive Director Committee Chair	BIC(24)191 Attached	Assurance	**11:15**
3.3.1	**Workforce Disability Equality Standard (WDES)** Simon Nearney, Group Chief People Officer	BIC(24)192 Attached	Approval	**11:30**
3.3.2	**Workforce Race Equality Standard (WRES)** Simon Nearney, Group Chief People Officer	BIC(24)193 Attached	Approval	
3.4	**Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)194 Attached	Assurance	**11:40**
3.5	**Audit, Risk & Governance Committees-in-Common Highlight Report & Board Challenge** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(24)217 Attached	Assurance	**11:50**
4.	**GOVERNANCE & ASSURANCE**			
4.1	**Board Assurance Framework & Strategic Risk Register – NLaG and HUTH** David Sharif, Group Director of Assurance	BIC(24)195 Attached	Assurance	**12:05**
5.	**OTHER ITEMS FOR APPROVAL**			
5.1	**None**			
6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
6.1	**Items for Information / Supporting Papers (as per Appendix A)** Sean Lyons, Group Chair	Verbal	Information / Assurance	
7.	**ANY OTHER URGENT BUSINESS**			
7.1	**Any Other Urgent Business** Sean Lyons, Group Chair / All	Verbal		**12:10**
8.	**QUESTIONS FROM THE PUBLIC AND GOVERNORS**			
8.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**12:20**
9.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
9.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Sean Lyons, Group Chair / All	Verbal	Discussion	**12:25**
10.	**DATE OF THE NEXT MEETING**			
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 12 December 2024 at 9.00 am**			

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

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – July 2024** Sue Liburd & David Sulch, Non-Executive Directors Committee Chairs	BIC(24)196 Attached
6.1.4	**Infection Control Annual Report** Amanda Stanford, Group Chief Nurse	BIC(24)199 Attached
6.2	**Audit, Risk & Governance Committees-in-Common**	
6.2.1	**Audit, Risk & Governance Committees-in-Common Minutes – July 2024 & August 2024** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(24)197 Attached
6.3	**Performance, Estates & Finance Committees-in-Common**	
6.3.1	**Finance, Estates & Performance Committees-in-Common Minutes – July and August 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)200 Attached
6.3.2	**Fire Annual Report & Work Plan** Group Director of Estates	BIC(24)201 Attached
6.3.3	**Security / LSMS Annual Report & Work Plan** Group Director of Estates	BIC(24)202 Attached
6.4	**Workforce, Education & Culture Committees in Common**	
6.4.1	**Workforce, Education & Culture Committee-in-Common Minutes – July 2024** Tony Curry, Non-Executive Director Committee Chair	BIC(24)203 Attached
6.4.2	**Guardian of Safe Working Hours Report – Quarter One** Dr Kate Wood, Group Chief Medical Officer	BIC(24)184 Attached
6.5	**Capital & Major Projects Committees in Common**	
6.5.1	**Capital & Major Projects Committees-in-Common Minutes - February and April 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)204 Attached
6.6	**Other**	
6.6.1	**Integrated Performance Report – NLaG and HUTH** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(24)205 Attached
6.6.2	**Documents Signed Under Seal** David Sharif, Group Director of Assurance	BIC(24)206 Attached
6.6.3	**Trust Boards & Committees Meeting Cycle – 2024 & 2025** David Sharif, Group Director of Assurance	BIC(24)207 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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

1.2 - PATIENT STORY

Amanda Stanford, Group Chief Nurse

1.3 - DECLARATIONS OF INTEREST

Sean Lyons, Group Chair

1.4 - MINUTES OF THE MEETING HELD ON THURSDAY, 8 AUGUST 2024

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(24)181 - Minutes of the Meeting held on Thursday, 8 August 2024.pdf

TRUST BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 8 August 2024 at 9.00 am
in the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Lee Bond	Group Chief Financial Officer
Paul Bytheway	Interim Group Chief Delivery Officer
Amanda Stanford	Group Chief Nurse
Dr Kate Wood	Group Chief Medical Officer
Tony Curry	Non-Executive Director (HUTH)
Stuart Hall	Vice Chair (HUTH)
Jane Hawkard	Non-Executive Director (HUTH)
Linda Jackson	Vice Chair (NLaG)
Sue Liburd	Non-Executive Director (NLaG)
Gill Ponder	Non-Executive Director (NLaG)
Dr David Sulch	Non-Executive Director (HUTH)
Prof Laura Treadgold	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Diana Barnes	Public Governor (attended via MS Teams)
Julie Beilby	Associate Non-Executive Director (NLaG)
Jennifer Clarke	Member of the Public
Claire Coley	Midwifery Support Worker (agenda items 3.2 – 10)
Joe Gibbins	UNISON (agenda items 3.2 – 10)
Ashley Harper	UNISON Regional Organiser (agenda items 3.2 – 10)
Myles Howell	Group Director of Communications
Jenny Jackaman	Maternity Support Worker (agenda items 3.2 – 10)
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Yvonne McGrath	Maternity Director (agenda items 1 – 3.1.3)
Simon Nearney	Group Chief People Officer
Dr Ashok Pathak	Associate Non-Executive Director (HUTH)
Raj Purewal	C2-Ai
Ian Reekie	Lead Governor
David Sharif	Group Director of Assurance
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

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

1. CORE BUSINESS ITEMS

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

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

Sean Lyons introduced Laura Treadgold the Hull University nominated Non-Executive Director (NED) for HUTH to the meeting.

The following apologies for absence were noted:

Kate Truscott	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG)

1.2 Patient Story

Yvonne McGrath shared the patient story of a lady who had recently delivered a baby at HUTH. The lady had been induced and experienced several long waits during her care. This had been due to capacity within the service which had led to delays for her being admitted to a hospital bed. It was reported that although she had experienced long waits, the care received from staff had been amazing and she had appreciated the delays were due to the capacity within the service.

Jane Hawkard referred to the comments made regarding capacity and queried whether this was normal. Yvonne McGrath advised that this was unfortunately the case which had meant ladies in labour had sometimes experienced long waits to be admitted to the labour wards. Yvonne McGrath reported that the induction of labour was increasing nationally. Stuart Hall advised there was awareness around the concerns on induction and the pressures on the service and queried whether any consideration had been given to move the lady elsewhere. Yvonne McGrath explained the service was now moving patients around more, however, there were some barriers in doing this that needed to be worked through. It was reported that the service was implementing a RAG-rating system for induction for how women were inducted.

Stuart Hall referred to the baby blues issue and queried whether that was being reviewed in terms of bringing resources up-to-date. Yvonne McGrath explained it was hoped this service would be put back in place as it was not currently supported.

Jonathan Lofthouse queried whether there was more of an issue with labour ward capacity at HUTH. Yvonne McGrath confirmed this was the case and this related to staffing issues.

Sean Lyons felt it was a very balanced story, noting that the care in the moment was positive, but recognised there was a need to focus on follow-ups too.

It was reported that a time-out session was due to be held in September 2024 for nursing and midwifery teams. At this, improvements would be discussed including the introduction of labour pathway as well as triage and postpartum support.

1.3 **Declarations of Interest**

Sean Lyons sought declarations of interest in respect of the agenda. In respect of recent striking, Linda Jackson declared she had two family members that were Maternity Support Workers (MSWs) at Diana, Princess of Wales Hospital (DPoWH).

1.4 **To approve the minutes of the Boards-in-Common meeting held on Thursday, 13 June 2024 – BIC(24)133**

The minutes of the meetings held on the 13 June 2024 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made:

- Dr Kate Wood referred to item 1.3, page two. The wording in respect of the minutes of the 11 April 2024 meeting stated there should be a change to say mechanical thrombosis. This needed to be changed to mechanical thrombectomy.
- Jane Hawkard referred to item 3.4, page 13. It stated it had been agreed to put in place a single plan from both external auditors. This needed amending to say a single plan for both internal auditors.
- Lee Bond, referred to item 1.6, page four. It stated that there had been a reduction of agency hours by 40,000, this should be amended to read 4,000.
- Lee Bond referred to item 3.2.1, page nine. It stated there were also increases in day case activity and the impact of the new theatre opening at HUTH. This needed to be amended to state theatres.
- Lee Bond, referred to item 3.2, page nine. It stated the Trust had applied for £30 million capital funding; this should be amended to read £992,000.

1.5 **Matters Arising**

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

Jane Hawkard referred to item 3.1 from the minutes of the meeting held on the 13 June 2024 where it had been reported one case may have been missed when reporting NLaGs Perinatal Mortality Review Tool (PMRT). It was felt this should have been included on the action log for this meeting. Amanda Stanford advised that confirmation had been received to advise that this was not the case. It was agreed this action would be added to the tracker for noting.

Action: Perinatal Mortality Review case action to be added to the tracker

Jane Hawkard referred to the previous minutes as Dr Kate Wood had informed the Trust Boards-in-Common a Never Event had occurred and further details of this would be shared once available. It was felt this should be added to the Action Tracker and this was agreed by the Trust Boards-in-Common.

Action: Never Event action to be added to the tracker

1.6 **Action Tracker – Public – BIC(24)134**

The following updates to the Action Tracker were noted:

NLaG

- Item 4.5.1, 8 February 2024 – Chair of Health Tree Foundation Trustees' Committee – Extension of Tenure – Foundation Patron Role due to current Patron Standing Down. Sue Liburd advised one person had considered undertaking the role, however, they had now advised they were unable to commit to this. It was agreed further updates would be provided when available.

Trust Boards-in-Common

- Item 3.3.1, 13 June 2024 – Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH. Amanda Stanford reported that the team had worked on a Standard Operating Procedure (SOP) for midwives, and it was believed there were no issues. However, a snapshot audit was to be undertaken and would be shared with the Quality & Safety Committees-in-Common to ensure the process was working as it should be. This would then be reported to the Trust Boards-in-Common to enable this action to be closed at the meeting due to be held in October 2024.

1.7 **Group Chief Executive's Briefing – BIC(24)135**

Jonathan Lofthouse referred to the report shared. Since writing the report, Hull had experienced some rioting over the weekend following the tragedy in Southport. He noted that staff had responded with professionalism and that Simon Nearney had been on-call at the time. No staff had been put at risk during the incident and the organisation was working with local authorities that had also responded. Following on from events, several communications had been shared with staff to highlight where they could access support if affected by this. Jonathan Lofthouse thanked staff for working together during this period.

Jonathan Lofthouse advised the next Top 100 Leaders Event was scheduled for November 2024.

Ivan McConnell advised the Strategic Framework had recently been launched at the Top 100 Leaders Event. Care groups had been asked to commit to the delivery of the outcomes within this. Following the launch, there had been engagement with various groups and partners to ensure there was clear understanding.

Amanda Stanford explained that in terms of maternity services, work had been undertaken over the previous 12 weeks with the maternity team and site triumvirate which had enabled the significant gaps to be identified within the service. A paper had also been shared at Cabinet the previous week to highlight key risks and staffing gaps. The hard work completed to date was acknowledged following the receipt of the Section 31 letter at HUTH. The paper had set out what was required from a resource perspective. Focus would now be to align what was required in terms of Ockenden and National Guidance. The paper would be shared with the Quality & Safety Committees-in-Common in August 2024. Following this,

information would be shared with the Trust Boards-in-Common. Jonathan Lofthouse advised the paper would prompt the Boards to consider more substantial and long-term investments in the service to implement improvements.

Lee Bond advised that Philippa Russell had now commenced in post as the Operational Finance Director and Group Deputy Chief Finance Officer. She had considerable experience in acute care. It was reported that three capital schemes were progressing at Castle Hill Hospital (CHH) which included the expansion of the Endoscopy Unit and the Day Surgery Unit (DSU) with the ten theatres completed by the end of this financial year. The Learning and Innovation Centre was also progressing well. The Community Diagnostic Centres (CDCs) were due to open in October 2024 at Scunthorpe and Grimsby. Jonathan Lofthouse advised NEDs would have the opportunity if they wished to visit the new developments before they were commissioned.

Jonathan Lofthouse confirmed that two General Practitioner (GP) practices from this area would be taking part in the national pilot hosted by seven selected Integrated Care Boards (ICBs). This would be to assess changes required in primary care practice.

Paul Bytheway reported that the organisations continued to be in Tier one for cancer and regular meetings were in place to monitor this. As reflected in the Integrated Performance Report (IPR), there was more work to be undertaken with this at HUTH. The Elective Recovery Funding (ERF) from the Cancer Alliance was to be increased for first treatments which would be undertaken over coming months. The Urgent & Emergency Care Centre continued to make improvements; however, it was noted this needed to continue. The Unplanned Care Board continued to meet monthly to focus on what actions needed to be progressed. The Group were in a process with the system to do a six-week reset. This would support what would be required for the winter period in terms of the Winter Plan and Urgent Care Plan.

David Sharif advised that work was due to commence with care groups to review individual risks on the register. Ivan McConnell and David Sharif were also due to meet to discuss how the Strategic Framework document would be used to determine strategic priorities and risks. These would then be shared with the required Committees-in-Common for discussion.

Lee Bond advised that the Group were marginally on plan at month three. As a collective, the ICB were on plan at the end of the first quarter. Lee Bond described a degree of nervousness around finances at a regional level and due to this, the Group had been given a rating of 3+ based on the new system (scoring trusts one to four).

Simon Nearney advised that the organisational development (OD) teams were supporting the care groups to ensure development was in place. This support would be a mix of face-to-face sessions and online learning. The groups had been asked to focus on what their priorities were in terms of learning.

Lee Bond referred to the capital projects and advised there had been a notable achievement in month at CHH. Jonathan Lofthouse explained the new car parking at CHH had been completed in the area where the helicopter pad was previously located. This would enable several patient car parks to be moved closer to the site

over coming months, and in turn staff parking would move towards the rear of the site.

Helen Wright referred to the Emergency Department (ED) and queried whether HUTH was under-resourced in terms of staffing. Paul Bytheway explained that the new rotation had commenced this week and it had been reorganised to accommodate demand and capacity. It was expected that benefits would be seen on the North Bank with this in place. Meetings had also been held with the ED team to agree the concept of what level of resource was required going forward.

Helen Wright queried with David Sharif whether the meetings due to be held with the care groups would include risk mitigation as this was more difficult. David Sharif advised this would be the case, and that part of this would include focussing on areas of higher levels. Paul Bytheway advised that some meetings with the care groups had been held that week and that work around this had already commenced. The groups had been asked how they would also manage the risks. Helen Wright felt the target scores would also need to be updated as part of the process.

Helen Wright referred to the bridges to be supplied by Grant Thornton and queried with Lee Bond what the current position with this was. Lee Bond advised this had been submitted based on month four data. Discussions had taken place with a view on how this would progress further, it was noted no concerns had been raised so far. Lee Bond added that the organisation needed to increase pace in respect of this, however, reaching a break-even position would be a challenge. It was explained bridge was a visual technique to highlight where the Trusts were now and where they needed to be.

Dr David Sulch queried whether staffing changes within ED would provide enough physical space to accommodate the increase in patients. Paul Bytheway explained new ways of working were being put in place to free-up space in the department and monitor the performance and capacity. Work was also due to commence around those patients that were referred straight from their GP, that would normally be sent to ED. In future they would be sent straight to the assessment area.

Dr Ashok Pathak wanted to compliment Jonathan Lofthouse and the teams for the measures put in place during the recent rioting. He queried whether this had impacted any staff when travelling to work or if patient care had been affected. Jonathan Lofthouse advised he would respond to this query in the private Board as it related to staff. Dr Ashok Pathak then queried how the prioritisation of certain consultants' recruitment would be undertaken. Paul Bytheway explained this would be undertaken on ability, risk, and patient outcomes.

Sue Liburd queried whether the introduction of the new government meant there would be changes to the structuring of finances for the NHS, in particular capital and for digital improvements. Jonathan Lofthouse advised that he had attended a meeting that week where Wes Streeting had been in attendance. Mr Streeting advised that there were no plans to change NHS funding at the moment. It was advised there would be no increase in NHS investment during this calendar year. However, there was an aspiration, yet to be confirmed, that the £3.5 billion technology funding agreed for future years would still be made available.

Stuart Hall referred to the proposed strikes of GPs and queried whether it was felt this would mean increased attendances in the EDs. Jonathan Lofthouse believed this could be the case. In addition, he noted that those GP strikes were more problematic as it related to contractual changes rather than remuneration. The Department of Health did not currently have an immediate solution in respect of this, however, the risk stratification was quite substantial and would impact on acute facilities. Although, the British Medical Association (BMA) had advised they were seeking conversations with the government, the GPs had already signed up nationally to strike. It was felt that intervention from the government was required to mitigate the risks. Dr Kate Wood highlighted this was collective action and not industrial action.

Sean Lyons drew Board members attention to the good news stories at the end of the report. It was noted the Annual Report also included positives.

Jonathan Lofthouse referred to the flow campaign as highlighted in the report. The Group had wanted to create a brand that used language that would be understood by everyone. Sean Lyons queried how the impact of this would be measured. Simon Nearney explained there was a register for ideas that were received. It was advised a report could be shared on what the improvements would be made. It was agreed this would be shared at a future meeting.

Action: It was agreed Simon Nearney would share a flow campaign report at a future board meeting

2. GROUP DEVELOPMENT

2.1 Updates following the Collaboration of Acute Providers Meeting

Jonathan Lofthouse explained that Jonathan Coulter was now the lead Chief Executive for emergency and unscheduled care. Simon Morris was the lead Chief Executive for cancer. Jonathan Lofthouse reminded Board members that he was the lead Chief Executive for elective care. At the recent meeting, it had been agreed to commission KPMG (an external accounting firm) to undertake diagnostic work on clinical services considering longer-term contracts.

Jonathan Lofthouse reported that the single reporting oversight tool had gone live this month, enabling all three acute Trusts to display elective information in the same format across the system. It was noted that this ICB was the first to have this in place. This now meant all trusts could view theatre productivity and elective waiting times across the system.

Jonathan Lofthouse highlighted there was some risk of the Scarborough CDC build being behind the planned schedule. This issue was being raised with Board members as the organisations had a shared financial risk for under delivery in respect of CDCs. This was a shared risk of around £3 million through loss of income. Jonathan Lofthouse expressed some confidence that this would be remunerated through further planning in the next few weeks.

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

3.1 Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)136

Dr David Sulch referred to the report and drew the Boards' attention to the point raised regarding no assurance around the effectiveness of the Care Quality Commission (CQC) action plan. A further key agenda item related to the audiology service, although the Committees-in-Common had been assured that appropriate actions had been taken in respect of the service. There were ongoing concerns in respect of the future of the service and the possibility that there may be other smaller services that may be struggling that had not been highlighted. This had meant the Committees-in-Common had not been assured. It was felt this should now be triangulated further within those services.

Sue Liburd highlighted that at both meetings there had been concerns raised in respect of Summary-Hospital Level Mortality Indicator (SHMI) particularly at HUTH relating to fractured neck of femur, sepsis and secondary malignancies. As there had been limited assurance received, further reporting would be provided at the November 2024 meeting of the Committees. It was acknowledged that colleagues were undertaking considerable work around the CQC actions and there was confidence around the progress of this.

Sue Liburd referred to the Domestic Abuse Co-ordinator role which had been recruited to in February 2024 with 12-month funding. It was felt funding for this role should continue after that time due to the support it provided. This issue had been referred to the Workforce, Education and Culture Committees-in-Common. Lee Bond referred to the areas where the Committees-in-Common had requested additional assurance and queried whether any had more priority or risks over others. Sue Liburd advised SHMI was one of the main priorities and the revisiting of the CQC action plan due to this needing to be updated. Dr Kate Wood advised that although SHMI was very much a focus of the Committees, this was not an issue that would see improvements on a monthly basis as reporting would take some time. A Group-wide Mortality Strategy had to be introduced, in addition to a joint mortality meeting across the Group that had been implemented. It was noted that progress was being made but it would take some time for this to be seen. Dr David Sulch advised there was also a delay in the way SHMI was reported which also meant progress was not highlighted until afterwards.

Linda Jackson advised that the most important issues to be raised to the Trust Boards-in-Common should be detailed within section three of report. All the Committees-in-Common were spending a considerable amount of time discussing whether they were assured or not assured during the meeting. She advised further review would be undertaken around this for the Committees outside of the meetings.

Dr Kate Wood referred to the Audiology Services CQC Report as detailed at item 3.1.3. It was agreed an update would be provided during this item in light of the issues already discussed. Dr Kate Wood advised the Quality & Safety Committees-in-Common had received the NLaG Paediatric Audiology Incident Report at the June 2024 meeting following a national incident. At the same time, all organisations had received a national request to complete a gap analysis against audiology

services in totality. The report was a requirement by the CQC for assurance to be provided to the Board level. This had been discussed in depth at the Committees-in-Common and specific requirements were detailed in the first part of the report. Questions from the CQC were responded to within this. Dr Kate Wood wanted it to be noted that it had been recognised patients had been let down due to the correct structures not being in place. It was clear that now the organisations were working as a group and that lessons would be learned and addressed by the joint working.

3.1.1 **Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports – NLaG and HUTH – BIC(24)137**

Stuart Hall referred to the report and advised the service had started to evolve in several ways which included the relaunch of the Maternity Transformation & Advisory Committee (MTAC) and the introduction of the Champion Meetings. It was recognised the average time for being seen from arrival was now eight minutes which was within specified guidelines. Stuart Hall referred to other highlights within the report.

Sue Liburd added that since Yvonne McGrath had commenced in post, working together across the group had progressed including its leadership. A request was made to include comments around leadership and mitigations when reporting.

Action: Comments around leadership and mitigations to be included in reporting by Yvonne McGrath

Stuart Hall advised that the interviews for the Head of Midwifery at HUTH were due to take place over the next week with the current post holder leaving.

3.1.2 **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(24)138**

Yvonne McGrath referred to the HUTH Report and highlighted key points. It was advised there were risks around safety action two in terms of the Clinical Negligence Scheme for Trusts (CNST). This was due to the transferring of data from Lorenzo to Badgernet as some of this had not transferred correctly. This was being worked through with the digital teams. The development of a Maternity & Neonatal Dashboard had commenced which would include various indicators that would be underpinned with Statistical Process Control (SPC) charts to support the recognition of themes. This would also form part of the Integrated Performance Report (IPR). It was reported that HUTH were on track to achieve 90% compliance in terms of mandatory training against the CNST Standards for year six.

Several listening events had been arranged on the North Bank with further events also being arranged for the South Bank; this had been in partnership with the Organisational Development team. In terms of workforce, new staff were due to start in September 2024. It was recognised that there remained a gap around the triage service which would need to be improved. Jane Hawkard referred to the triage service and queried how this was still running with the current vacancy issue. Yvonne McGrath explained that the vacant roles in this area had been backfilled from community areas which had then created issues in those areas.

Sean Lyons referred to the changes in epidurals and queried whether this was something of concern. Yvonne McGrath advised this was in respect of the quality of

data so there was nothing of concern regarding care. Dr Ashok Pathak queried whether there had been any success in recruiting lactation consultants. Yvonne McGrath advised this was a complex issue due to its nature. It was explained HUTH offered training for consultants to undertake this so this could be provided.

Julie Beilby referred to the maternity dashboard as it used the phrase “normal birth”, a query was raised as to why it was detailed this way. Yvonne McGrath agreed with the point made and advised that the language used needed to be reviewed (it being an out-of-date term). A steer would be taken from colleagues on what narrative would be used in certain situations in the future.

Sean Lyons referred to the complaints and Patient Advice and Liaison Service (PALS) concerns detailed within the report as response times were lengthier. Yvonne McGrath explained they had improved and that a piece of work was being undertaken to address the backlog. Amanda Stanford advised this process was also being addressed in terms of incidents.

Yvonne McGrath referred to the NLaG Report and highlighted key points. She advised NLaG were in a good position in terms of CNST. It was reported training compliance for NLaG was on target. The Boards were advised of the frenotomy service that had been launched at NLaG as detailed within the report. One issue to raise in respect of mandatory training was the Safeguarding Adults compliance as detailed within the report. It was noted work to improve this position was in place.

Jane Hawkard referred to the safeguarding level three training compliance and queried when it was hoped this would improve. Yvonne McGrath explained additional training was in place and improvements were already being seen due to this. It was hoped this would reach 80% by the end of October 2024 and that 95% would be reached by the end of the year. Sean Lyons referred to the resuscitation training as there was low compliance numbers in some areas. Yvonne McGrath explained a plan was in place to address this. Sean Lyons queried whether there was any reason why this had happened. Amanda Stanford advised it was due to several issues around staffing levels and in some circumstances capacity around staff being able to be released for the training.

Linda Jackson commented that the new report had been far easier to read.

3.1.3 **Audiology Services CQC Response – BIC(24)139**

Dr Kate Wood had provided an update in respect of this paper in item 3.1.

3.2 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)140**

Gill Ponder referred to the report and highlighted the areas of limited assurance and areas of concern from the meetings held in June and July 2024. It was noted that plans were in place to improve the financial position which included accountability, controls and activity. It was felt there was limited assurance in those areas until improvements were shown in the financial reports. In respect of performance concerns had been raised in respect of ED and the Urgent Treatment Centre (UTC) as noted within the report. It was reported that a deep-dive had been undertaken and reported at the July 2024 meeting. Following on from this, assurance had been confirmed that detailed monitoring was in place including improvement plans.

Limited assurance had been provided in terms of cancer performance as noted in the report. The Cancer Improvement Programme would address those issues with priorities to focus on. There had been a request that the next deep dive in respect of this included progress against the previous agreed plans with the Care Alliance.

In respect of elective performance, it was noted referral to treatment targets (RTT) were not yet being achieved meaning there was limited assurance, however, improvement plans were in place.

Sue Liburd queried whether the decarbonisation plan was likely to be modified or changed. Jonathan Lofthouse advised that this was safe, and developments were being pursued on that basis. Sean Lyons referred to the UTC issues at HUTH and queried whether there was any improvement impact in respect of this. Jonathan Lofthouse advised that a meeting had recently been held with Simon Cox, Place Director for East Riding and this had been discussed. It was recognised there had been some challenges in terms of consistency of the service delivery following the move to the Hull Royal Infirmary (HRI) site including some other issues around the staffing and hours of its operation.

Dr Ashok Pathak queried what had happened to the building previously used at the UTC. Lee Bond explained some of this may be used for the temporary accelerated opening of the CDC. Sean Lyons queried whether there was confidence around the theatre productivity. Jonathan Lofthouse advised that in respect of the North Bank the position had returned to pre-2019/20 levels which had resulted in more income. There was also a range of business cases being considered at cabinet in terms of insourcing and outsourcing that would relieve services.

Tony Curry advised it had previously been confirmed that the Trust would establish the link between the delivery of service and the UTC and its beneficial impact. It was felt clarify around this would be useful. Paul Bytheway advised that the ambulance handovers had shown as an improvement. It was also recognised that all the metrics being shown did show improvements and that the UTC had made some differences although this was small at the moment. It was noted there were still many challenges to be worked through. Jonathan Lofthouse explained that in terms of this operating year, the organisations were meeting the recovery target and were on plan in terms of region.

3.3 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)141**

Tony Curry referred to the report and highlighted key points in particular those where the Committees-in-Common had not been assured. One related to the CQC actions and how realistic they were. A review of the outstanding actions would be undertaken led by Amanda Stanford with refreshed timescales. Mandatory training had been discussed and it had been identified there were some issues around this in particular areas. It was reported that a detailed paper had been received by the Committees around Culture, following the Barret Values Survey. There had been an overwhelming sentiment by the Committees that there was further work needed to be undertaken in terms of developing a positive culture in line with the Group's values. It was noted informal feedback had also been received from staff in terms of engagement which the committees had discussed. It had been agreed to escalate this to the Trust Boards-in-Common.

Sean Lyons recognised the positive work being undertaken, however, referred to the point made in respect of culture within the organisation not being where it should be. He felt that this needed to be recognised and addressed by the Boards to shape the culture of the workforce. Linda Jackson had attended the meeting and reported this was the most significant point that had been discussed where there had been little assurance. It had been recognised this was not at an acceptable level and needed to be addressed as a priority. Jonathan Lofthouse felt that at the time the survey had been undertaken there were issues that needed to be resolved in respect of staff which may have influenced the outcome. Simon Nearney explained he was the lead on this on behalf of the cabinet. Jonathan Lofthouse explained there were several issues that were being dealt with at the moment that affected staff culture that needed to be addressed. Several listening and learning events would be arranged through the communications team to be circulated shortly these would also be supported by senior colleagues. It was also recognised that there was a need to address a number of issues, including some of the environments staff worked in, along with communicating improvements to staff. It was noted that across the organisation there were more permanent staff now in post than there had been previously due to the reduction of bank and agency staff. Other changes had been made to the staff induction programme which had been launched in August 2024.

Simon Nearney explained there were certain areas that needed to be focussed on, one was in respect of the demands on some staff to their working requirements, the reduction of staff in some areas and the change in pathways. Decisions regarding changes were being made at pace and he felt the direct impact on staff needed to be recognised. A further issue was around performance in respect of outside restrictions.

Simon Nearney advised that the Boards were due to attend a time-out session which would focus on staff and culture in September 2024 to enable any issues to be responded to. Sessions had also been held with the care group management teams to review what could be done differently to make improvements in terms of morale and engagement with the Boards support.

Linda Jackson felt Board members needed to be more visible in respect of undertaking site visits with staff to identify what the issues were and then to commit to making changes following on from this. Sue Liburd felt it was important to hear from staff who were part of the staff networks to highlight those issues that staff were concerned about. Dr Ashok Pathak queried whether questionnaires were circulated to particular staff as it was felt circulating more widely may receive different responses. Simon Nearney reported that the teams did communicate with the staff networks to identify issues. It was noted that the care group teams were speaking out to request improvements. Sean Lyons recognised that the move to a group model had moved at pace, staff had also been impacted by the £84 million saving that then needed to be made. It was recognised that the Boards needed to take responsibility for how staff were feeling and for positive changes to follow.

Dr Kate Wood wanted to commend the Doctors Revalidation Report to the Trust Boards-in-Common and this was agreed.

3.3.1 **Freedom to Speak Up Guardian (FTSUG) Report – Quarter One – NLaG & HUTH – BIC(24)142**

Liz Houchin referred to the NLaG FTSUG Report and highlighted that a third of the concerns raised had been in respect of the care group structure. The main themes remaining were around Human Resources (HR) processes, behaviours and morale of staff. The HR issues were in respect of advice on policies and the need for required support and advice that had not been followed up.

Fran Moverley referred to the HUTH FTSUG Report and confirmed there had been an increase in referrals in quarter one compared to the previous year. Some of the themes were in respect of HR processes. Inappropriate behaviours had also been raised. Fran Moverley reported on other highlights within the report.

Both FTSUGs continued to work together in terms of introducing a group FTSUG Strategy. It was reported a request had been made from the National Guardian Office to produce a case study in respect of how they worked for a group within sovereign Trusts. Sean Lyons asked the FTSUGs if there was anything further the Boards could put in place to support. Liz Houchin felt that the proposals being made following discussions in the meeting meant the appropriate measures were being put in place to make improvements. It was agreed the financial strain for both organisations were leading to low morale in some areas. Jonathan Lofthouse reminded Board members that it was likely further savings would be required in the next financial year.

Julie Beilby felt staff should be able to contribute thoughts and ideas to improve as they were always passionate about what was delivered and patient care. This should be discussed in an open way whilst working with staff.

Amanda Stanford queried whether any concerns had been raised around discrimination and whether concerns were being raised in any particular characteristic groups; she further queried whether this could be provided in detail within the report. Fran Moverley advised this was captured separately but did not appear to be an overriding theme. Concerns had been received in respect of patients being discriminative and how staff should react to this. Liz Houchin advised NLaG had also received some concerns regarding discrimination and how the staff member felt in respect of this.

In respect of the Boards' time-out session Linda Jackson felt the Boards should review the difference of staff morale between both organisations as it appeared this was affecting staff more at NLaG.

3.4 **Audit, Risk & Governance Committees-in-Common Highlight Report & Board Challenge – BIC(24)143**

Jane Hawkard shared the paper and referred to key highlights from the report.

It was noted there had been low compliance rates in terms of the Annual Emergency Preparedness, Resilience & Response (EPRR) 2023/24 & Business Continuity Report against the NHS England (NHSE) Core Standards. A further updated had been requested by the Committees at the next meeting.

A report had been received in respect of the number of expired contracts following concerns raised. A request had been made for a further report to review this as noted within the report.

A request was made for there to be a single internal auditor appointed for the Group as the current contracts were due to end in April 2025. It had been agreed to go out to tender for this.

Sean Lyons queried whether any work was due to be undertaken in terms of the consolidating of contracts due. Jane Hawkard explained this had been reviewed in terms of consolidating the maintenance contracts across the Group.

3.5 **Capital & Major Projects Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)144**

Gill Ponder referred to the paper and noted key highlights. It was reported there had been limited assurance in respect of cyber security noting that a session on this would be held as part of the Board Development. Further updates would be shared with the committees. Dr Kate Wood referred to the point made in the wording within the report that it should state that there was limited assurance against the mitigation and not the risk rating.

The Committees had received reasonable assurance in respect of decarbonisation at the Scunthorpe General Hospital (SGH) site as noted within the report.

4. GOVERNANCE & ASSURANCE

4.1 **Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(24)145**

David Sharif shared the BAF and highlighted comments within the report. It was noted the high-level risks had not changed since the previous meeting. It was noted further work would be undertaken on the risk register reporting and that this would be shared periodically at the Trust Boards-in-Common with more discussion taking place at the Committees-in-Common. It was hoped part of the development of the Risk Strategy would include the appointment of a Group Head of Risk management Manager.

Dr David Sulch referred to the risk ratings for quality and finance, noting that the finance rating was higher than the quality rating. He felt it important to underline that this was not because it was felt finance was more important, the score was reflecting that delivering the financial target was more of a risk than delivering the quality of care. Dr Ashok Pathak referred to the patient harm as it appeared there had been no improvements made and queried whether there were any different measures to alleviate that. Amanda Stanford advised this covered a range of aspects that needed to be improved and reflected on. Once the strategy work was completed those risks would be revisited to ensure this reflected all aspects.

5. OTHER ITEMS FOR APPROVAL

5.1 Terms of Reference – Committees-in-Common – BIC(24)146

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

David Sharif shared the paper with the Trust Boards-in-Common and sought approval. It was reported all Terms of Reference had been approved at relevant Committees-in-Common and that this had been linked to the changes with the Standing Orders. David Sharif went on to highlight some of the changes included. Sean Lyons referred to the individual Terms of Reference and sought approval on each. Dr Kate Wood advised that the job title for Andy Haywood in some Terms of Reference needed amending, and this was agreed. Linda Jackson explained there had been some queries in respect of the wording in terms of how it referred to the Trust Boards-in-Common that would be updated. Some Committees-in-Common had been referring to this as the Group Board instead of the Trust Boards-in-Common.

The Trust Boards-in-Common approved the Terms of Reference referred to subject to the necessary amendments.

5.2 Modern Slavery Statements – NLaG & HUTH – BIC(24)147

Simon Nearney shared the paper with the Trust Boards-in-Common and sought approval. It was advised this had been approved at the Workforce, Education & Culture Committees-in-Common meeting.

The Trust Boards-in-Common approved the Modern Slavery Statement.

5.3 Premises Assurance Model (PAM) – BIC(24)148

Lee Bond shared the paper with the Trust Boards-in-Common and sought approval. It was advised this had been approved at the Performance, Estates & Finance Committees-in-Common. It was noted this was a statutory requirement for submission.

The Trust Boards-in-Common approved the Premises Assurance Model.

5.4 Scheme of Delegation & Powers Reserved for the Trust Board – BIC(24)149

Lee Bond thanked colleagues for the work underpinning the paper shared with the Trust Boards-in-Common and sought approval. It was noted this had incorporated the documents from both Trusts into a combined document. This was compliant and consistent with required guidance.

The Trust Boards-in-Common approved the Scheme of Delegation & Powers Reserved for the Trust Board.

5.5 **Standing Financial Instructions – BIC(24)150**

Lee Bond shared the paper with the Trust Boards-in-Common and sought approval.

The Trust Boards-in-Common approved the Standing Financial Instructions.

5.6 **Strategic Framework 2024-2029 – BIC(24)153**

Ivan McConnell referred to the paper and noted key points. This had emphasis on alignment with the organisations goals whilst ensuring it had been responsive to the changes in government policy and healthcare demands. It aimed to provide clear direction and support for staff and the service delivery. It would provide a clear map for staff to follow and ensure that delivery was consistent with the strategic direction of the organisation. The intention was for this to be completed by the end of December 2024. Work was being undertaken with the care groups to complete this.

Sean Lyons queried how this would evolve. Ivan McConnell advised a process was in place for this that would be worked through. Care group colleagues had also been asked for their priorities to ensure this was incorporated. Linda Jackson felt that there needed to be an understanding of how this would link into the BAF and how this would fit into that process. Ivan McConnell explained there was a process being worked through to ensure this took place. Dr Kate Wood felt there was a need to ensure that those working on the Strategies did not work in silo to ensure they linked together.

The Trust Boards-in-Common approved the Strategic Framework 2024-2029.

5.7 **Staff Charter – BIC(24)154**

Simon Nearney shared the Staff Charter and sought approval from the Trust Boards-in-Common. It was noted this had been created following some values sessions with staff. This had been approved at the Workforce, Education & Cultures Committees-in-Common. The report detailed how this would be shared and communicated to staff.

The Trust Boards-in-Common approved the Staff Charter with agreement to minor amendments around some of the wording.

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 **Items for Information / Supporting Papers**

- Quality & Safety CiC Minutes – May & June 2024
- Annual Medicines Optimisation Annual Report
- Performance, Estates & Finance Minutes CiC – May & June 2024
- Workforce, Education & Culture Minutes CiC – May & June 2024
- Medical Appraisal & Revalidation Annual Report
- Audit, Risk & Governance CiC Minutes – April & June 2024
- Audit Committee Annual Report – NLaG
- Audit Committee Annual Report – HUTH
- Capital & Major Projects CiC Minutes – February & April 2024
- IPR

- Documents Signed Under Seal – NLaG & HUTH
- Trust Boards & Committees Meeting Cycle 2024 & 2025
- Health Tree Foundation Annual Report & Accounts

7. ANY OTHER URGENT BUSINESS

Sean Lyons sought items of any urgent business from Board members.

Ivan McConnell referred to the Humber Acute Services Review (HASR) and advised there had been engagement with North Lincolnshire Council in respect of a local resolution process on HASR. There had been a request for more understanding around paediatrics and transport. This would be discussed further in the future.

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Sean Lyons sought questions from the public and Governors.

Ian Reekie referred to the volume of referrals that continued to rise. At a recent Trust Boards-in-Common meeting it had been reported that the ICB were to replicate a screening service that was in place in North Yorkshire. A query was raised as to when that service would be in place and whether it was felt this would mean a decrease in referrals. Jonathan Lofthouse explained that commissioners were now struggling to secure this for this region. The organisation's entire activity plan was calibrated on the delivery of this. Therefore, if this was not put in place there was an expectation referrals would be above plan. It was confirmed this had worked in North Yorkshire, however, this had been in place for several years.

Jennifer Clarke a member of the public recognised these were challenging times. She liked the fact that it had been recognised staff were important and that changes needed to be made as they were the most important asset, and that communication was key in providing harmony in the workforce.

Ashley Harper from Unison referred to the Workforce, Education & Culture Committees-in-Common Highlight Report as it mentioned a verbal update had been provided in terms of the band two and three issues within maternity. A query was raised as to whether this had included the recent strike action of the MSWs. Tony Curry advised the maternity situation had been discussed and there had been equally broad discussions on those bandings on the North Bank and South Bank. Simon Nearney advised it had been briefed around the various issues in terms of that role and this had included the strikes and that this had not yet been resolved. Ashley Harper queried whether the committees were aware of a published report in respect of the maternity workforce published in 2019 by Health Education England. This had included there were many inconsistencies around the duties those staff were undertaking, and that Trusts should consider this. Those workers had then not been re-banded until four years later in October 2023. A query was raised as to whether the committees were aware of that in particular. Simon Nearney confirmed they had been aware of the situation but may not be aware of the paper in particular that was being referred to. A further query was raised as to whether members of the Workforce, Education & Cultures Committees-in-Common would be willing to speak to the MSWs to discuss the job role as it was important NEDs were aware of what the staff were disputing. Sue Liburd explained she was a

member of that committee and was also the Maternity Safety Champion for NLaG and that she would be willing to meet with staff. Stuart Hall advised he was the Maternity Safety Champion for HUTH and that he would also welcome meeting with staff. Claire Coley who was a MSW wanted to highlight that the issues being raised related to more than the back pay, she felt Board members needed to visit the maternity service to see how staff were currently working in unsafe and difficult situations. She reported that the staff felt undervalued and insignificant, so it was important that those staff were spoken to.

Sean Lyons recognised there should be more awareness in terms of accommodating staff. Helen Wright referred to the feeling from staff that they were being ignored and thought there should be more understanding of this to address any issues. Amanda Stanford reported that listening events with staff were being held with Yvonne McGrath, however, it was recognised they should be extended more widely.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 There were no matters for referral to any of the other Board committees.

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 10 October 2024 at 9.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 12:47 hrs.

Cumulative Record of Board Director's Attendance 2024/25

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

1.5 - MATTERS ARISING

Sean Lyons, Group Chair

1.6 - ACTION TRACKER - PUBLIC

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(24)182 - Action Tracker - Public.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(24)182

BOARDS-IN-COMMON ACTION TRACKER

2024

ACTION TRACKER - CURRENT ACTIONS - 10 OCTOBER 2024

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
NLaG ACTIONS									
4.5.1	08.02.24	Chair of Health Tree Foundation Trustees' Committee - Extension of Tenure - Foundation Patron Role due to current Patron standing down		Sue Liburd to seek more understanding on what was requried of the Patron role	Sue Liburd	October 2024	It was agreed a further update would be provided at the October 2024 meeting.		
Boards-in-Common ACTION									
3.1.3	13.06.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Growth Scans		Amanda Stanford to provide further information regarding growth scans being reported	Amanda Stanford	October 2024	Update to be provided at the October 2024 meeting.		
1.5	08.08.24	Quality & Safety Committees-in-Common Highlight Report - Never Event		Dr Kate Wood to provide update on Never Event once details are available	Dr Kate Wood	October 2024	Update to be provided at the October 2024 meeting.		
1.5	08.08.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Perinatal Mortality Review Case		Amanda Stanford to confirm if the NLaG PMRT case had been missed from the report.	Amanda Stanford	August 2024	Amanda Stanford confirmed this case had not been ommitted from the reporting.		
1.7	08.08.24	Group Chief Executive's Briefing - Flow Campaign		Simon Nearney to share a flow campaign report at a future board meeting	Simon Nearney	April 2025	The Flow Campaign was launched in September 2024. A further Campaign Report will be shared at the April 2025 meeting.		
3.1.1	08.08.24	Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports - NLaG & HUTH		Comments around leadership and mitigations to be included in reporting by Yvonne McGrath	Amanda Stanford / Yvonne McGrath	October 2024	It was agreed further details would be included with the reporting.		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
1.7	11.04.24	Group Chief Executive's Briefing - Data highlighting a reduced number of ED attendances		Shaun Stacey to provide Boards with data highlighting reduced numbers in ED at HUTH due to the opening of the UTC	Paul Bytheway	June 2024	Information was to be shared with the Performance, Estates & Finance Committees-in-Common		
3.3.1	13.06.24	Freedom to Speak Up Guardian Annual Report		Fran Moverley & Liz Houchin to provide information on Senior Leaders training	Fran Moverley & Liz Houchin	August 2024	Information was circulated to Board Members		

Key:

Green	Completed - can be closed following meeting

1.7 - GROUP CHIEF EXECUTIVE'S BRIEFING

Jonathan Lofthouse, Group Chief Executive

REFERENCES

Only PDFs are attached

BIC(24)183 - Group Chief Executive's Briefing.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)183

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10 October 2024
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer / Author	Jonathan Lofthouse, Group Chief Executive
Title of Report	Group Chief Executive's Briefing
Executive Summary	This report updates the Trust Boards in Common on the announcement by the Secretary of State for Health and Social Care regarding population health and intense support. It also includes our celebration from the Golden Stars staff awards evening, for Black History Month and our anti-racist stance as an organisation. Further, it includes updates and the headlines of patient safety, quality, finance and performance.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Group Chief Executive Officer

Briefing to the Trust Boards in Common
Thursday 10 October 2024

1. Introduction

1.1 I am pleased to brief the Trust Boards in Common about the announcement made by the Secretary of State for Health and Social Care, the Rt Hon Wes Streeting MP, at the Labour Party Conference on 25 September 2024. Our Group and its two Sovereign Trusts have been recognised along with 18 others nationally for Accredited Interventional support in relation to elective waiting. Specifically the national initiative recognises high demographic and social economic impacts on working age adults who are currently unable to work because of elective clinical need. By accentuating treatment, community economic contributions should increase. I will provide further updates as the proposal takes flight over the coming months. Our Group was specifically referenced and will receive intensive support for our elective waiting list position. This recognition of our population's and the contribution we can make to improving the health of the local population to return to the workplace and contribute to economic growth is greatly welcomed. The opportunity we have as a Group organisation to adopt best-in-class national practice at scale with this level of investment and intensive support is an opportunity that we cannot afford to waste for our patients.

1.2 On behalf of the Chairman and myself, we express our sincere thanks to our staff for an excellent inaugural Golden Stars staff awards night, held on Friday 13 September 2024 at the DoubleTree Hilton in Hull. This was our first Group staff awards evening and was an excellent celebration of the talents and dedication of our hard-working staff. I provide more detail of the award winners later on in this report, so on behalf of the Chairman and myself, thank you to our staff for all of the nominations we received, to our panel of judges for their time to review and shortlist them, and to our staff, who celebrated each other's outstanding achievements for our patients.

1.3 This month is Black History Month and we have a series of events and staff stories to share in celebration of our diverse workforce. I am proud to share our Group's anti-racism statement and the work we are undertaking to support staff to report racist incidents through our Group Zero Tolerance reporting tool. We also have a set of guidance to support staff to manage patients who make racist remarks towards our staff, in line with the Secretary of State's clear statement last week. We are also equipping our staff to be upstanding and proud of our diverse workforce, asking staff to make pledges to be anti-racist and to be good allies.

1.4 I am very pleased to welcome Mark Brearley today as Interim Group Chief Finance Officer. Mark started with the Group on Monday 9 September 2024, coming from his interim role at University of Leicester Hospitals NHS Trust. Mark is a seasoned Chief Finance Officer and was previously Director of Finance at Hull and East Yorkshire Hospitals until 2007. We welcome Mark to our Group organisation.

1.5 Our Collaborative of Acute Providers (CAP) held its second facilitated development session on Monday 23 September 2024. This involved the Executive teams from the three acute providers in our ICB footprint. As Chair of our CAP, and Senior Responsible Officer for elective recovery for our ICB, I framed the objectives of the session to focus on prioritisation of the work programme for CAP, in order for the CAP to ultimately optimise its delivery for our patients, using the collective resources and talents of the four acute Trusts. It was a productive session and further strengthened our partnership working as a collaborative.

1.6 We were proud to host Professor Stephen Eames, Teresa Fenech, Nigel Wells, Erica Daley, Alex Seale and Helen Kenyon from our ICB to walk-around our emergency and acute care provision at Diana, Princess of Wales Hospital, Scunthorpe General Hospital and Hull Royal Infirmary on 20 and 30 September 2024. The ICB senior leadership team is visiting all Emergency Departments within the ICB to have greater 'ward to board' understanding of the current pressures in our urgent and emergency services (UEC), as well as to see the positive

benefits of local investment in UEC estate and patient pathways.

1.7 The feedback from our ICB colleagues was positive. Professor Eames and his team have fed back their sincere thanks for the open and honest discussions the ICB team had with our staff, who were proud to showcase the more integrated UEC model on the south bank, but also outline the pressures that all three sites are under, even before winter pressures start.

2. Patient Safety, Quality Governance and Patient Experience

2.1 I have previously briefed the Trust Boards in Common that both Trusts within our Group are in Tier 1 in NHS England's Elective Recovery Programme National Tiering Process, and also in Tier 1 for cancer recovery.

2.2 We remain fully compliant with meeting the requirements of this tiering programme and the level of scrutiny this brings to our organisation. There is no change to our tiering status, but there is acknowledgement of the progress we are making, particularly on patients with long waiting times for elective treatment. As an ICB within the North East region, Humber & North Yorkshire currently has the highest elective recovery performance in relation to 65wk wait patients.

2.3 The July 2024 position for Hull University Teaching Hospitals NHS Trust against the 62-day cancer target was 49.7%. This is a decrease since the last update to the Trust Boards in Common, which was May's figure of 62.8%.

2.4 The July 2024 position for Northern Lincolnshire and Goole NHS Foundation Trust against the 62-day cancer target was 54.8%, an improvement since May 2024, which was 47.1%.

2.5 The focus within our Site triumvirate to Cabinet meetings on quality, governance and patient safety has specifically included risk management and ensuring that Care Groups are identifying and actively mitigating operational risks within their clinical services.

2.6 This is the bottom-up element to our Group approach to risk management. This will inform the Board Assurance Framework risk assessment against our new Group Strategic Framework. Further detail will be provided under agenda item BIC(24)195 Board Assurance Framework & Strategic Risk Register – NLaG and HUTH.

3. Urgent and Emergency Care and Planned Care

3.1 The headline data position for Urgent and Emergency Care and Planned Care are included in today's Board pack in paper BIC(24)205. Starting with our Group organisation's performance on ambulance handover and the four-hour Emergency Department standard for August 2024 are set out below.

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

3.3 On a 'footprint' basis, the north bank collective four-hour performance for August 2024 was 74.1%, which is a small improvement. The plan requirement was a performance of 75.4%. The Unplanned Care Board has received short and medium-term recovery plans co-produced at Place level, with final assurance and acceptance of plans underway at system level. We are undertaking a six-week reset patient flow campaign underway to engage and motivate staff across the pathway and improve quality and patient experience.

3.4 The ambulance handover position for the north bank in August 2024 saw performance worsen after improvement seen in quarter 1. This is linked to patient volumes in ED and ability to flow patients out to assessment spaces, enabling space in the department for ambulance crews to handover. This requires further work.

3.5 The south bank 'footprint' performance in August 2024 for all Type 1 and Type 3 activity

including the UTC in Goole, was 73.5% against a plan position of 74.3%. The Place level plans include North and North East Lincolnshire, to provide further opportunities for improvement, particularly linked with ambulance handover and flow.

3.6 The ambulance handover position for the south bank in August 2024 worsened but remains below the peak in ambulance handover delays seen in February 2024. Improvement actions on flow continue, particularly ensuring assessment space is available in a timely manner to enable ambulance handovers.

3.7 In respect of elective care, the 65-week position remains under heavy scrutiny. This is an improving position for both sovereign Trusts. At the time of writing this report (25 September 2024), the forecast for end of September was 35 breach risks for HUTH, predominantly in paediatrics and plastic surgery. There are plans in place to improve this position however there are some breaches that are anticipated due to unreasonable notice and patient choice The forecast for the end of September 2024 for NLaG was 15 breaches for 65-week breaches, predominantly due to patient choice.

3.8 The waiting list position (RTT) received a deep dive at the Performance, Accountability and Finance meeting in September 2024. This has mapped waiting list volume growth as well as referral increases on both banks of the river this calendar year. Of the current waiting list, 58% of the waiting list volume on the north bank is awaiting first outpatient appointment; 22% of patients on the waiting list have been waiting 52+ weeks. The current waiting list volume is just over 79,000 patients. On the south bank, the waiting list volume is 43,280, and an increase has been seen in waiting list volume and the performance against the 18-week standard fell by 2% last month.

4. Strategy and partnership developments

4.1 Cllr Ross and Cllr Handley, the respective Leaders of Hull City Council and the East Riding of Yorkshire Council, wrote to all stakeholders following the agreement by the Government of the Hull and East Yorkshire Mayoral Combined Authority (MCA) devolution deal.

4.2 The details of the Hull and East Yorkshire devolution deal include control of annual capital funding; further financial control over investment in key local priorities (specifically building the green economy and national net zero infrastructure, such as the expansion of the Siemens wind turbine facility and rail facilities); local powers on public transport provision, education provision and involvement in determining national strategy.

4.3 On the same day, the Government also supported the submission for the Greater Lincolnshire Devolution deal, submitted by North Lincolnshire Council, North East Lincolnshire Council and Lincolnshire County Council.

4.4 The specifics included in the Greater Lincolnshire deal include local decision-making powers on capital investment, skills and education provision, housing, transport and investment in specific net zero and economic priorities for the population of Greater Lincolnshire.

4.5 Both devolution deals are subject to legislation being laid before Parliament. This will be in the form of Statutory Instruments. These will enable the first Mayoral Elections to take place in our localities, which are anticipated to be held in May 2025. The Statutory Instruments will also codify the specific decision-making powers that are being devolved to our local geographies.

5. Financial Performance and Estates and Facilities updates

5.1 In respect of the Group financial position, the Month 5 position was reported to the Performance, Estates and Finance Committee in September 2024 and the assurance and escalations report at agenda item BIC(24)189.

5.2 The Month 5 position reflected at the Performance, Estates and Finance Committee on 24 July 2024 is that: the Group's in-month deficit was £6.6m, circa £1m adverse to plan. Group Capital spend was £7.6m, which was £16.2m behind plan, largely due to some slippage on the

Community Diagnostic Centres. The Group reported delivery of £26.0m in cost improvements against a year-to-date target of £22.5m, which was £3.5m better than plan. Cash balance was rated green at £39.5m and will be monitored closely. The Group spent £4.9m less on agency, bank and overtime costs than the same period in 2023/24. This is now in line with the NHS England 3.2% target of total pay expenditure.

5.3 As noted previously, I am meeting fortnightly with my Cabinet and the site triumvirate teams to provide challenge and robust decision-making on the £84m savings requirement we have for 2024/25 as a Group organisation. We have approved a cross-Group transformation plan on four key areas: theatre productivity, No Criteria to Reside, outpatients and diagnostics. We do know we have yet to identify some of the savings requirements for this financial year and I will update the Trust Boards in Common about plans to mitigate this.

5.3 Work continues at pace on our capital developments, particularly those at Castle Hill Hospital and the Community Diagnostic Centres. As noted above, there has been some slippage on these capital schemes that will impact on some patient activity starts. I will provide further information about this at the Trust Boards in Common meeting.

6. Workforce Update

6.1 I am very pleased to report that we remain on track to be fully recruited for registered nursing staff across the Group in November 2024. My thanks to our colleagues in nursing leadership positions for recruiting and keeping in touch with our new recruits, particularly those who are newly qualified or newly in-country. Thank you also to our recruitment teams and our Practice Nurse Development teams and Clinical Nurse Educators for their significant support now and when our colleagues arrive with us.

7. Equality, Diversity and Inclusion (EDI)

7.1 During Black History Month which runs from 1 – 31 October we are running a series of events and initiatives to promote this year's theme of 'reclaiming narratives'.

Our EDI staff and allies will be all of our five main hospital sites during the month to meet colleagues and answer any queries they have regarding Diversity and Inclusion. We will be sharing details of how to contact Freedom to Speak Up Guardians and raise concerns, use our zero tolerance framework and reporting tool, signpost to services and how to get involved with staff networks across the group.

We are also inviting BAME staff to share with us their stories so that we can create our own narrative on the achievements of our colleagues and their personal experiences of working in the NHS. These will be featured across Bridget and our social media accounts.

On Friday 25 October a panel discussion will be taking place in the Medical Education Centre at Hull Royal Infirmary at which colleagues will discuss their stories in front of a live audience as well as current equality, diversity and inclusion themes.

8. Good News Stories and Communications Updates

8.1 New pain management and MSK contract for NLaG

Around 21,000 people impacted each year by musculoskeletal problems such as back, knee and elbow pain are to benefit from a new service delivered by specialist physiotherapy and pain management teams in Northern Lincolnshire.

Northern Lincolnshire and Goole NHS Foundation Trust, part of NHS Humber Health Partnership, has been awarded a £10.2m contract in partnership with Connect Health to deliver pain management and musculoskeletal (MSK) services for the next four years.

Hospital-based and community therapy teams will work with Connect Health, the UK's largest independent community healthcare provider of MSK, pain management and mental health services, to care for people with MSK problems.

8.2 Respiratory project identifies significant undiagnosed COPD

Early findings from a collaborative project between Hull's respiratory team and international biopharmaceutical group, Chiesi, were presented at an international conference this weekend. Respiratory nurse specialists Kayleigh Brindle and Karen Watkins joined Professor Michael Crooks in travelling to Vienna to present at the 2024 European Respiratory Society (ERS) Congress 2024.

Here, they addressed thousands of delegates with exciting early findings from the FRONTIER project, in which patients who previously attended an NHS Lung Health Check and who reported symptoms of lung disease and/or had emphysema on their CT scan were invited back for further COPD* testing.

During the first phase of the project, 201 people took part and over two thirds of those, 136 people, went on to receive a COPD diagnosis. The NHS Lung Health Check primarily screens for cancer, and these findings demonstrate that the checks also present a notable opportunity to identify and enable timely treatment for other respiratory illnesses.

8.3 Women's health physiotherapy

Our specialist women's health physiotherapy services are providing a vital lifeline for women previously too scared and embarrassed to leave their home.

Here at NHS Humber Health Partnership our dedicated and highly skilled team of specialist pelvic health physiotherapy team provide the very best care for women with pelvic health problems.

The team are working with hundreds of women suffering with pelvic floor dysfunction which can leave them with urinary and faecal incontinence, pelvic organ prolapse, pelvic pain and more.

The service, which is provided at Grimsby, Scunthorpe, and Hull currently sees on average 130 women per week.

8.4 Falls Awareness Week and initiatives

Around one in three adults over the of 65 in the UK will have at least one fall in a year – and for those over the age of 80, the risk increases to one in two. During Falls Awareness week in September we launched two new initiatives designed to tackle this issue.

Run by our Physiotherapy team, the Falls Prevention Group is designed to reduce the risk of falls in some of our frailer patients, by working with them on everything from diet to exercise, as well as identifying potential risks around the home.

The pilot was launched in the Community Hub at Sir John Mason House in Winterton and the aim is to run further sessions from there.

Meanwhile, at Hull Royal Infirmary the Falls Service has launched an initiative to identify inpatients who are at risk of having a fall. Patients who spend longer than they need in hospital beds are at increased risk of falling, mental health problems, losing their independence or readmission through a physiological process known as "deconditioning".

People over 65 attending Hull's Emergency Care Area now fill in a questionnaire soon after they arrive at hospital to identify those at risk of deconditioning.

Anyone attending after a fall, who has fallen in the past year or who uses a walking aid uses a dedicated section of the waiting area and is given information about community services to help prevent future falls or hospital attendances.

8.5 Flow initiatives

Flow is a whole system approach to improve care in our region and make us more efficient in everything we do. Since July we've been promoting this campaign to our staff and asking them

to tell us about their Flow initiatives. Each month the best project wins £5k to spend on their services and patient care.

Flow – waiting list validation
The first winners of our £5,000 award for best Flow initiative were Neurosciences and Endocrinology who have been undertaking work to validate their waiting lists.

Under the leadership of Mr Anuj Bahl and Dr Mo Aye, their work has discharged patients to Patient Initiated Follow Up pathways, released outpatient capacity for patients needing a face-to-face appointment and also escalated patients who needed to be seen more urgently.

The work not only empowers patients to articulate their needs, but it also reduces unnecessary appointments and speeds up treatment time for those who do need to be seen.

Flow - outpatient stem cell treatment
In the past 12 months, 32 of the 41 haematology patients receiving stem cell transplants underwent outpatient PowerPICC Solo lines insertion, improving their experience and helping them to avoid the more invasive treatment performed in theatre. As well as a positive response to patient feedback about their care, it's saved the group almost £50,000.

Infection rates, once experienced by around a quarter of patients who had catheters inserted, have plummeted to a handful of cases. Staff have also performed the procedure on three patients from hospitals in Leeds who come to the Queen's Centre in Cottingham as part of their shared care.

Flow – outpatient biopsies and diagnostics
Patients requiring biopsies and some invasive diagnostics for lung conditions were being admitted to a hospital ward for their procedure. This meant that the bed could not be used for patients requiring urgent unplanned care.

The Planned Investigation Unit (PIU) at Scunthorpe General Hospital is now providing services on an 'outpatient' basis. The results ae that these patients don't need an inpatient bed and can have their procedure as an 'outpatient'. This is helping flow through the hospital by freeing up inpatient beds.

Jonathan Lofthouse
Group Chief Executive
25 September 2024

2 - GROUP DEVELOPMENT

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

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

Sue Liburd & David Sulch, Non-Executive Chairs

REFERENCES

Only PDFs are attached

BIC(24)185 - Quality & Safety Committees-in-Common Highlight Report.pdf

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)185

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	Sue Liburd, David Sulch – Chairs of CIC
Contact Officer / Author	Sue Liburd, David Sulch
Title of Report	Quality and Safety CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on Thursday 29 August 2024 and Thursday 26 September 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • HUTH Maternity – investment position and staffing issues **The Boards-in-Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the Time-out discussions in item 3. Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

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

	10 October 2024
	Quality and Safety Committees in Common
	29 August 2024, 26 September 2024 (Time out)
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common (Q&S CiC) at their meeting(s) held on 29 August 2024 and the Time-Out session held 26 September 2024, including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

29 August 2024

- *Board Assurance Framework*
- *Integrated Performance Report*
- *IPC BAF*
- *Maternity and Neonatal Assurance Report*
- *Maternity Position*
- *PSIRF/Serious Incidents*
- *CLIP Report*
- *Mortality including Learning from Deaths (Q1 Report)*
- *CQUINs*

26 September 2024 – Time Out

- *Terms of reference – its frequency, membership and scope*
- *Current workplan – noting the need to focus on key issues*
- *Quality structure - Information flows, relationships to other CICs*
- *IPR Data Quality*
- *Committees-in-Common Triangulation*
- *Review of key Q&S CIC reports – content, length, executive summaries and their action orientation*

3.0 Matters for reporting / escalation to the Trust Boards

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

29 August 2024

a) HUTH Duty of Candour performance was poor and a full review of the process and data was being carried out. It was agreed that the planned improved performance would be reported through the IPR at each future meeting.
b) Group – Complaints compliance at HUTH was poor with the average days to close a complaint being 56 against the 40-day target. NLAG were still using 60 days as a target but both Trusts would convert to 40 days from March 2025.
c) HUTH – Maternity – There were still obstetric consultant recruitment issues but the biggest risk was the Clinical Director post which was not proving attractive due to it only requiring 2 PAs and lack of belief that the role would be able to make a difference.
d) The CiC had a significant discussion regarding the HUTH Maternity Position paper and the £2.5m investment required. The CIC supported the investment and suggested a comprehensive business case was submitted to the Boards-in-Common in October 2024. A number of suggestions were given such as ICB contribution vs the Trust contribution and what the offset would be if plans were achieved.

26 September 2024

a) The Terms of reference was discussed and it was agreed that the scope set out in the TOR should be aligned to the reports being presented to the CIC. The key work of the CIC would be based around the Clinical Strategy, the Quality Strategy, the BAF and Risk Registers, Quality Priorities, Learning from incidents and any hot topics. A changed membership was discussed, with Delivery officer attendance in the core membership, attendees and other senior managers attending when required, such as patient safety officers.
b) The workplan was reviewed and a lower frequency of meetings discussed and the timing of reports. Once updated this would be presented to the Boards-in-Common for approval.
c) The operational and governance structures underneath the Quality and Safety CIC was discussed and how reports would be changed to incorporate assurance for Q&S CIC.
d) Data quality was flagged as a key risk (and noted across the organization) and a consistent QI methodology with greater visibility was raised as a gap in assurance.

4.0 Matters on which the committees have requested additional assurance:

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

a) The Group training numbers for maternity were much improved with the overall compliance being 90%, New Born Life Support 86% and Fetal Monitoring at 95%. The improvements were commended by the CIC.

b) Limited assurance was given regarding Group Infection Prevention and Control performance. There was a risk around basic hygiene and how this would be

managed in the future. Bacteremia rates and surgical site infections were a risk to HUTH and this was being worked through.

c) SHMI rates NLAG were better than the expected levels but the HUTH rates remained high. Work was ongoing to share best practice and processes to address the HUTH rates.

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

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

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

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to:

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

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

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

30 August 2024

3.1.1 - ESTABLISHMENT REVIEW OF SAFE STAFFING

Amanda Stanford, Group Chief Nurse

REFERENCES

Only PDFs are attached

BIC(24)186 - Establishment Review of Safe Staffing.pdf

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)186

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10 October 2024
Director Lead	Amanda Stanford, Group Chief Nurse
Contact Officer / Author	Amanda Stanford, Group Chief Nurse
Title of Report	Trust Board and Safe Nursing and Midwifery Staffing
Executive Summary	The purpose of the report is to ensure Trust Board members are fully informed of the requirements of the National Quality Board in relation to Safe Staffing. The report sets out the context in which the Executive Chief Nursing Officer has responsibility for ensuring safe staffing for nursing and midwifery, that the approach supports and guides the operational management and deployment of nursing staff daily to ensure there is the right number of staff, with the right skills, in the right place to deliver safe and effective patient care. The approach to setting safe staffing levels has been developed using the safe and sustainable staffing framework - 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place and the right time: Safe Sustainable and productive staffing, published by the National Quality Board (NQB) in July 2016 and NHS Improvement Developing Workforce Safeguards (2018). Safe staffing can be complex and takes account of multiple factors; patient acuity and dependency and skill mix as well as numbers. Most Trusts have implemented the Safer Nursing Care Tool to enable staffing establishments to be reviewed and set on a twice yearly basis with a Safer Nurse and Midwifery Staffing Report being presented at Board. For midwifery staffing BirthRate+ Tool is used to set midwifery staffing levels. Both tools account for acuity and allow the application for professional judgement The Safer Nursing Care Tools (SNCT) calculate clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement guides Chief Nurses in their safe staffing decisions. The tools: Provide organisational level metrics to monitor impact on the quality of patient care and outcomes Give a defined measure of patient acuity and dependency Are able to support benchmarking activity in organisations when used across trusts Embrace all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources Include staffing multipliers to support professional judgement Provide accurate data collection methodology. The SNCT Tool was updated in 2023 and this is now the only tool recommended for use to set safe staffing levels in nursing

	The Developing Workforce Safeguards (2018) outline the requirements for all trusts with in-patient beds to publish their staff fill rates (actual versus planned) in hours, taking into consideration day and night shifts for both registered and non-registered staff. This needs to be presented as Care Hours per Patient Day (CHHPD), the use of CHPPD was a recommendation from the Carter Report (2016) and was designed to reduce unwarranted variation. SNCT had been implemented and embedded at NLAG however at Hull University Teaching Hospitals (HUTH) this was not the case and an amended approach had previously been used. SNCT has now been rolled out and the data collection has been completed through August. The Safer Staffing Report for Nursing and Midwifery is due to be presented at Trust Board in December 2024. BirthRate+ tool has been commissioned for both HUTH and NLAG but will not be completed until January 2025. The final Safe Staffing Reports aims to triangulate patient safety metrics, people metrics and acuity of patients to set proposed safe staffing levels for every inpatient ward, ED and maternity wards. Community staffing using SNCT is currently being developed and once approved will be applied to community staffing.
Background Information and/or Supporting Document(s) (if applicable)	Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing, National Quality Board, 2016 Operational productivity and performance in English NHS Acute Hospitals: unwarranted variation, Carter, 2016 Developing Workforce Standards, NHS England, 2018
Prior Approval Process	Not Applicable
Financial Implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not Applicable
Recommended action(s) required	☐ Approval ü Information ü Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS Humber Health Partnership

Developing the Approach for Setting Safe Staffing Levels

1.0 Introduction

In 2013, the National Quality Board (NQB) set out ten expectations and a framework that supported Trusts to make informed decisions regarding workforce that was evidence based and that fundamentally had patient safety as a key priority. Putting people first remains a collective and individual responsibility and is central to the delivery of high-quality care that is safe, effective, caring, and responsive. This was in response to the findings of the Francis Inquiry into failings at Mid Staffordshire General Hospital which found that low staffing was a significant contributor to poor standards of care. A key recommendation of the Inquiry was to develop guidance for setting nurse staffing levels.

The National Quality Board set out clearly the requirements of NHS Trusts and health economies to use their available resources in the most efficient way possible for the benefit of the communities they serve. The Board carries the responsibility of ensuring staff are deployed in such a way that maintains safety and ensures services are sustainable and productive. There should be clear lines of accountability for all professional staff groups. There should be collaborative decision making between clinical and managerial staff, reporting to boards. NHS provider boards should have a proactive approach to reporting, investigating and acting on incidents and to driving continuous improvement.

The three key principles set out by the NQB were:

Right care: Doing the right thing, first time, in the right setting will ensure patients get the care that is right for them, avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.

Minimising avoidable harm: A relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduce costs associated with litigation.

Maximising the value of available resources: Providing high quality care to everyone who uses health and care services requires organisations and health economies to use their resources in the most efficient way for the benefit of their community – any waste has an opportunity cost in terms of care that could otherwise be provided.

The publication of this report took into account the recommendations of Lord Carter's Report also published in 2016. This report focussed on the need to reduce unwarranted variation and recommended the development of a 'Model Hospital' so that Trusts could see what good looks like.

Midwifery staffing levels have been developed using the BirthRate Plus tool for longer and is now well established as an evidence-based tool. The Ockenden Report however has brought renewed focus on midwifery staffing levels and the increasing acuity of women.

There are no staffing tools to determine Allied Health Professional colleagues.

2.0 Policy Context

2.1 National Quality Board Guidance, 2016

In 2016, NQB provided an updated safe staffing improvement resource that built on the initial guidance *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time* (NQB, 2016).

This updated guidance focussed on the development of quality metrics and set out the requirements from the Carter Report (2016) of using Care Hours per Patient Day (CHPPD).

The guidance also clearly set out the need for triangulation of several data sources to ensure safe staffing levels are agreed.

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff	**Right Skills**	**Right Place and Time**
1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	2.1 mandatory training development and education 2.2 working as a multi-professional team. 2.3 recruitment and retention	3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.3 Carter Report, 2016

The report reviewed the productivity of the NHS, the key recommendation for Safer Staffing in this report was the implementation of Care Hours Per Patient Day (CHPPD). The aim of implementing CHPPD was to reduce unwarranted variation across the NHS with setting staffing levels. CHPPD enabled benchmarking across organisations and forms part of Model Hospital data.

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers Total number of inpatients

CHPPD since its introduction in April 2018 focussed on acute and acute specialist trusts:

> including all inpatient areas that provide care over a 24-hour period but not accident and emergency departments.
>
> excluding ward-based areas in community hospitals that provide day care/day-case services.

In 2023 NHSE published updated guidance on CHPPD to include community and mental health trusts plus a wider workforce that includes registered and non-registered AHPs and all registered and non-registered Nursing Associates

CHPPD must include:

> all clinical staff within the ward establishment and budget who are rostered and contribute to care provision.

this may include specific roles such as enhanced care, facilitating patient groups, or other activities, including ward leadership.

CHPPD should not include:

ward-based areas in community hospitals that provide day care/day-case services (eg day surgery and other diagnostics)

it should not include professionals who deliver interventions to patients on the ward but work across several wards/services/pathways and therefore are not rostered as part of the ward.

2.4 Workforce Safeguards, 2018

In 2018 the *Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing, NHS Improvement, October 2018* published to provide further clarity on the responses required of Trusts in relation to Safer Staffing. The guidance set out 14 recommendations for NHS Trusts to follow when reviewing and setting safe staffing levels.

Effective workforce planning is essential and plays a key part in effective financial management as well as critical for the delivery of safe and effective care. Establishments in nursing and midwifery should be done annually with a mid-year review supported by a Safer Staffing Report to Trust Board. It is essential that this process is based upon three key components:

Establishment reviews take into account the following:

patient acuity and dependency using an evidence-based tool (as designed and where available)

activity levels

seasonal variation in demand

service developments

contract commissioning

service changes

staff supply and experience issues.

where temporary staff have been required above the set planned establishment

patient and staff outcome measures.

With this guidance organisations are assessed as to their compliance using a ‘triangulated approach’ to deciding staffing requirements described in NQB’s guidance (2016). This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. It is based on patients’ needs, acuity, dependency and risks, and trusts should monitor it from ward to board.

2.6 Care Quality Commission Fundamental Standards

The approach is designed to provide assurance to Boards that decisions made regarding workforce would promote patient safety and quality and that they would be compliant with the Care Quality Commission (CQC) Fundamental Standards, in particular Regulation 18

> ***Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).***
>
> ***Providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. The approach they use must reflect current legislation and guidance where it is available. In determining the number of staff and range of skills required to meet people's needs, they should consider the different levels of skills and competence required to meet those needs, the registered professional and support workers needed, supervision needs and leadership requirements.***
>
> ***Staffing levels and skill mix must be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.***
>
> ***There should be procedures to follow in an emergency that make sure sufficient and suitable people are deployed to cover both the emergency and the routine work of the service.***

3.0 Safer Nursing Care Tool and SafeCare

The Safer Nursing Care Tool (SNCT) is a NICE endorsed evidence-based tool used by the majority of NHS Trusts to enable the development of safe workforce models for adult inpatient wards, emergency departments, paediatric inpatient wards and adult acute assessment units. Work is ongoing to develop a community tool for setting establishments in community. SNCT was developed by the Shelford Group Chief Nurses, in 2023 it was updated. It enables the triangulation of workforce models including registered to non-registered ratios, patient acuity and patient outcomes to determine safe staffing levels across a range of acute inpatients areas.

In Northern Lincolnshire and Goole NHS FT (NLAG) SNCT methodology has been well established with a small number of staff trained or undertaking the training as SNCT Fellows. At HUTH SNCT had not been deployed and a different process was used to set establishments for adult inpatient wards with no staff trained in SNCT.

SNCT methodology requires data to be collected over a period of one calendar month to support an assessment of the nursing needs of the patient cohort. From an evidence base 40 days is the optimum data collection period but early pilots showed that data collection tended to reduce thereafter, pragmatically SNCT supports a 30-day data collection period to address variation in acuity and patient numbers. SNCT builds in a 22% uplift into establishments which is slightly higher than HUTH and in line with NLAG.

There should be a robust governance framework to support safe staffing that is captured and set out in a Trust Safer Staffing Policy that outlines the establishment review process and effective rostering. Rosters should be reviewed and signed off at local level and should be supported by Roster key performance indicators.

Whilst SNCT supports the bi-annual review of staffing establishments it is equally important that nursing leaders monitor safe staffing daily – through SafeCare. A review of staffing is undertaken and entered onto the Trust systems at set times throughout the day. This enables areas of risk to be identified quickly and prompts a timely response. SafeCare supports the daily deployment of staff if needed to areas that are identified as higher risk and enables oversight of safe staffing across the organisation. As part of this process the use of 'Red Flags' are fundamental, these are incidents that may happen over 1 24 hour period that should be reported and equally provoke an immediate response by the Ward Manager of Matron, these will include delays to medication or care, reduction or shortfall in planned establishments on the day of more than 25% or eight hours.

As the bi-annual establishment reviews are fundamentally about patient safety, a skilled workforce and financial sustainability the review process should include HR and Finance colleagues in the sign off process.

3.1 Professional Judgement

As part of the SNCT there is an approved Professional Judgement Framework for nursing staff to apply as part of the establishment setting process. This enables and guides senior nurses.

Professional judgement prompts a series of questions to be applied during the process of establishment setting to ensure scrutiny of the data collected.

3.2 Measure and Improve

The guidance published since 2016 onwards emphasises the importance of triangulation of several data sources alongside workforce models to enable Trust Boards to make an informed assessment and receive assurance regarding safe staffing is deployed and that there are robust governance processes in place.

A range of metrics should be used as part of the establishment process including:

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	**Example indicators** *Italics = published indicator*	**Existing local sources**
Patient and carer feedback	Patient and carer feedback provides insight into the quality of their own care, and often extends into observations of the wider care environment and staff capacity	*Friends and Family Test (inpatient and maternity)* *National patient surveys overall rating of care and questions related to staff capacity*	Local patient FFT data[50] submitted to UNIFY (published monthly but earlier data available to providers) National patient surveys[51] Local complaints and compliments data
Staff feedback	Staff feedback provides insight into their own and their colleagues' capacity, capability and morale, and of their perception of the quality of care	*Staff Friends and Family Test (place to be treated/place to work)* *National staff surveys (place to be treated/ place to work and questions related to workload)* GMC trainee survey *(questions related to workload)*	Local staff FFT data[52] submitted to UNIFY (published monthly but earlier data available to providers) National staff surveys[53] Annual GMC trainee survey[54] Local staff 'barometers' or feedback routes Local incident reports of lack of sufficient staff numbers, capacity or skills[55]
Access to care	While staffing capacity will never be the sole factor, lack of staff capacity will affect access to care; for example, operations will be cancelled if any key staff in theatre or ward are unavailable	Cancelled elective operations – proportion of last minute cancellations *Those not treated within 28 days of a last minute cancellation*	UNIFY submissions (published quarterly but earlier data available to providers)
Completion of key clinical processes	Clinical process measures provide a very early indication of changes in the quality of care delivery, so action can be taken before outcomes are affected Processes are often the responsibility of a specific staff group, and so can help pinpoint staffing capacity issues for that group	Medication omitted for non-clinical reasons (registered nursing staff) Observations/Early Warning Scores not taken/calculated as planned (nursing staff) MRSA screening/decolonisation completion rates VTE risk assessment completion (medical staff) Mobilisation within 24 hours of surgery (AHPs) *National Clinical Audits (range of staff)*	Electronic prescribing systems Electronic patient records Electronic observation systems Pathology databases National Clinical Audits with continuous local data submission (eg Stroke Sentinel Audit) UNIFY submissions (published quarterly but earlier data available to providers) Local audits, CQuINS, process measures collected for local QI projects (eg Medication Safety Thermometer for omitted medication[56])

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	**Example indicators** *Italics = published indicator*	**Existing local sources**
Harm during healthcare	While a wide range of measures need to ensure the system of care supports staff to do the right thing, some types of harm are particularly likely to be affected by staff capacity Pressure ulcer prevention typically requires constant nursing intervention in terms of skin care and position changes, and therefore monitoring of pressure ulcers can help pinpoint staffing capacity issues for that staff group Effective inpatient falls prevention relies on identifying underlying medical causes, medication review, early mobilisation, and nursing observation. Therefore monitoring falls can help pinpoint staffing capacity issues across medical, pharmacy, AHP and nursing staff	*Pressure ulcer prevalence* Pressure ulcer incidence *Prevalence of inpatient falls* Incidence of inpatient falls	Safety Thermometer data (published monthly but earlier data available to providers) alongside local assessments of data completeness[57] Local incident data on falls and pressure ulcers and subsequent investigations alongside local assessments of data completeness[58] *'Occurred in this trust'* field in National Hip Fracture Database Local data on post-admission transfers to orthopaedics as potential indicator of serious injury from falls

Whilst the focus is on patient safety and quality it is important that effective rostering of staff and having a robust workforce plan is also critical to the efficient utilisation of resources and good financial governance. Having effective rostering and agreed workforce models contribute significantly to reducing temporary workforce expenditure.

3.2 BirthRate Plus

In midwifery the BirthRate Plus tool is used to determine safe midwifery staffing levels and has been well established in maternity services for many years. The principles however

remain the same and require triangulation of key quality and safety and workforce metrics alongside acuity. There are nuanced differences in the calculation of workforce requirements for tertiary centres compared to DGH services.

The requirements for reporting to Trust Board remain the same with a Safer Midwifery Staffing Report required on a bi-annual basis. It is essential that the Trust should commission a full BirthRate Plus staffing review every three years with a desk top review in the intervening period.

4.0 Trust Board Responsibility

The NQB Guidance (2016) clearly sets out the responsibilities of the Board in the context of Safe Staffing. Whilst the provision of safe nurse staffing is very much the responsibility of the Chief Nurse members of a Unitary Board are accountable for ensuring the organisation has the right culture, leadership, and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

5.0 Actions

SNCT has been rolled out across HUTH to ensure we have a coherent Group process for assessing safer staffing across nursing and midwifery.
A group Safer Staffing Policy is being agreed and will come through to Board as part of the Safer Staffing Reports the policy will include the establishment review process and roster sign off process and will be clearly linked to delivery of safe care and financial sustainability.
Safer Staffing Policy will set out the process for skill mix reviews in the intervening periods between establishment reviews.
Establishment reviews have been completed following the SNCT data collection throughout August. Going forward this will be completed in March and September with a Safer Staffing Paper being presented at Cabinet, Workforce, Education and Culture Committee and Trust Board in June and December each year.
Training of nursing leaders on use of SNCT has been implemented with staff being identified to complete the MSc in Safer Staffing to ensure that we have the skills to deploy SNCT effectively.
The Site Directors of Nursing are responsible for overseeing the Establishment Review process and setting workforce models across their areas.

3.1.2 - MATERNITY & NEONATAL SAFETY CHAMPIONS OVERVIEW

ASSURANCE / ESCALATION REPORTS - NLAG & HUTH

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

REFERENCES

Only PDFs are attached

BIC(24)187 - Maternity Neonatal Safety Champions Report.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front sheet

Agenda Item No: BIC(24)187

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10 October 2024
Director Lead	N/A
Contact Officer/Author	Sue Liburd, Non-Executive Director Stuart Hall, Non-Executive Director
Title of the Report	**Maternity & Neonatal Safety Champions Report**
Executive Summary	This report sets out the activities undertaken by the Non-Executive Maternity & Neonatal Champions to provide assurance to the Board in the provision of high quality, safe maternity, and neonatal clinical care. The Maternity & Neonatal Safety Champions continue to be proactive in engaging with staff across NLaG and HUTH. This activity is specifically documented in detail in the individual maternity reports produced by the Maternity teams and is summarised in this report. The report sets out matters of risk to escalate which include the instability in some senior leadership roles, but note the positive progress made which has included the appointment of a Group Director of Midwifery who commenced in post in June 2024.
Background Information and/or Supporting Document(s) (if applicable)	The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that the following are in place: • High quality clinical care; • Maternity & neonatal service & facilities; • Workforce numbers; • Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback); and • Effective team working.
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐Other – please detail below:

Maternity & Neonatal Safety Champion's Report For August and September 2024

Executive summary:
The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that: • High quality clinical care; • Maternity & neonatal service & facilities; • Workforce numbers; • Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback); • Effective team working are all in place. This report has been developed to enable the Maternity & Neonatal Safety Champions for the two trusts to report on and provide assurance to the relevant committees and the boards in respect of the above areas. Where required, the report will include risks & concerns requiring escalation as well as good practice, improvement and innovation.
Activities undertaken this month:
Activities undertaken in August and September have included the standard programme of walk rounds, service level meetings, and meetings with service leaders including the Group Director of Midwifery. • 15th August Maternity Support Workers Listening Event (NLAG) • 15th August Maternity & Neonatal Assurance Group • 16th August Maternity assurance visit (HUTH) • 19th August Meeting with Maternity & Neonatal Quad • 4th September Met with Recruitment, retention and pastoral midwife (HUTH) • 23rd September Introduction to Newly Qualified Midwives & Safety Champion Walkaround (HUTH) • 30th September Safety Champion Walkaround (NLAG) • 30th September Meeting with Maternity & Neonatal Quad

Positive News and Feedback

- Appointment to the Head of Midwifery role at HUTH
- Finance and investment paper for discussion at October Board and the Safety Champions note the importance of this investment to support safe maternity services.
- Patient approval on assurance visits
- Newly qualified midwives have commenced in post on all sites
- Increase in neonatal cots at HUTH now live to the network
- Increased group wide working and support in times of high-acuity
- Badgernet launch at NLAG
- Smoking cessation incentive scheme to be launched across the Group
- Roll-out of RSV vaccine has commenced at HUTH and due to launch at NLAG on October 7th.
- Successful Co-Production workshop with MNVP leads with plans in place to support successful co-production going forward.
- Maternity and Neonatal culture improvement plan now in place and was shared at Maternity and Neonatal Assurance Group in September. This work will need ongoing support and oversight.

Areas for Escalation

- Lack of a 24 hour triage at HUTH and early closures of triage
- Delays in induction of labour
- Burnout in maternity teams
- Theatre team resource when a second theatre is required has been highlighted in view of the recent never event.
- Resources for preceptorship support
- Need for QI resources to support maternity and neonatal improvements.
- Risk associated with ability to use agency staff following implementation of Badgernet
- Risk of further industrial action by Maternity Support Workers at DPOW.

Activities planned next month:
The following activities are planned during the month: **HUTH** • 11th October Safety Champion Walkaround • 15th October HNY LMNS Delivery Board • 17th October: Maternity & Neonatal Assurance Committee meeting • 28th October: Quad meeting **NLAG** • 31st October- Safety Champion Walkaround • 15th October HNY LMNS Delivery Board • 17th October: Maternity & Neonatal Assurance Committee meeting • 28th October: QUAD Meeting The Champions are keen to introduce a joint visit to further the opportunities available to the Group.

Stuart Hall
Non-Executive Director Maternity &
Neonatal Safety Champion (HUTH)
30th September 2024

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

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

Amanda Stanford, Group Chief Nurse

REFERENCES

Only PDFs are attached

BIC(24)188 - Maternity Neonatal Assurance Reports.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)188

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 10 October 2024**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	Maternity & Neonatal Assurance Reports – NLAG & HUTH
Executive Summary	**1. CNST / MIS Year 6:** Weekly meetings in place Bi-annual staffing report for Safety Action 5 for HUTH attached. Safety Action 2- risk of compliance with CQUIM at HUTH, plan in place to address UAD capacity remains a risk for delivery of Saving Babies Lives. Training is a risk with recovery plans in place to achieve compliance by 30th of November Consultant attendance audits reviewed at QSC Progress reports for each Trust attached. **2. Ultrasound Scan**: Snapshot review indicated overall good compliance. Risks managed when there are issues with capacity, **3. Neonatal Critical Care Services**: Identified areas of good practice and potential risks, such as a lack of out-of-hours neonatal surgical services. **4. Workforce*:*** Head of Midwifery at HUTH has been successfully recruited and will commence in post in November 2024. Paper outlining the additional staffing and funding requirements to maternity services across the group is presented to board today Gaps in recruitment to Clinical Leadership roles in maternity present a risk. Staffing remains very challenging at HUTH due to gaps in establishment, vacancy, sickness and maternity leave. 20.12 WTE and 11.2 WTE Newly qualified midwives commence in post in September at HUTH and NLAG respectively.
Background Information and/or Supporting Document(s) (if applicable)	**MIS Year 6 progress reports and associated appendices**
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review

	ü Assurance	☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report-

Northern Lincolnshire and Goole NHS Foundation Trust

Yvonne McGrath

August 2024

Contents

Item 1: Executive Summary

The Northern Lincolnshire and Goole NHS Foundation Trust's Maternity and Neonatal Safety Assurance Report for August 2024 provides an overview of the Trust's efforts to enhance safety and care quality in maternity and neonatal services.

Key highlights include the development of a Maternity and Neonatal Safety Improvement Plan (MatNeoSip), the progress in the CNST MIS Year 6: 10 Steps to Safety, and the implementation of the Saving Babies Lives Care Bundle (v3). Significant advancements have been made in improving staff training compliance, with the Trust on track to achieve the 90% compliance target by November 2024.

The report also highlights several challenges, such as variations in practice related to uterine artery Doppler (UAD) and ongoing workforce shortages, particularly in clinical leadership roles.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

Plans are developing to devise an overarching Maternity and Neonatal Safety Improvement Plan that will encompass actions and improvements driven by both local and national drivers. First actions will include the following:

Review of Three Year Delivery Plan for maternity and neonatal services recommendations and action plans

Review of ongoing Quality Improvement and Service Transformation projects and eventually the development of a Maternity & Neonatal Quality Improvement library to capture all projects.

Review of Ockendon actions

Workshop planned for September to agree co-production strategies and management of action plans with Maternity & Neonatal Voices Partnership

A draft MatNeoSip will be shared at Maternity and Neonatal Assurance Group in September

2.2 CNST MIS Year 6: 10 Steps to Safety

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					N/A
2 Maternity Services Data Set (MSDS)					None Identified for CNST. However, please note the MSDS will be disrupted whilst transitioning to BADGERNET. Support is being provided by the MITS project team across the group alongside collaboration with the Digital Midwife at HUTH.
3 Transitional Care Services					N/A
4 Clinical Workforce Planning					Unable to demonstrate progress made against action plans submitted in year 5 for compensatory rest and BAPM neonatal workforce requirements due to financial restrictions. Evidence of progress is required to allow the Trust to declare compliance. Currently being reviewed.
5 Midwifery Workforce Planning					N/A
6 SBLCB V3					There are variations in practice with regards to the timescales for uterine artery doppler (UAD). A capacity/demand review is being undertaken by the head of sonography
7 Service User Feedback / Co-produced Services					Evidence is to be provided by the LMNS on the NHS Futures Platform. They have advised they will start this in due course.
8 Training Plan					Compliance <90% for certain staff groups. Trajectory indicates targets will be met by 30th November 2024. Recovery plan in place.
9 Floor to Board					Safety champion arrangements to be agreed. Quad/Safety Champion meetings in place and walkarounds in progress. SCORE survey feedback sessions planned and Maternity & Neonatal Culture Improvement plan in development
10 MNSI / Early Notification Scheme					N/A
Total	**0**	**4**	**6**	**0**	

2.3 Saving Babies Lives Care Bundle (v3)

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24
Assurance review date	25 October 2023	18 December 2023	20 March 2024	10 June 2024
Element 1: Smoking in pregnancy	10%	70%	70%	70%
Element 2: Fetal growth restriction	55%	70%	90%	90%
Element 3: Reduced fetal movements	50%	100%	100%	100%
Element 4: Fetal monitoring in labour	40%	80%	80%	80%
Element 5: Preterm birth	48%	70%	81%	67%
Element 6: Diabetes	17%	67%	67%	83%
TOTAL	41%	71%	81%	77%

Following peer validation of evidence submitted for quarter 4 2023/24 by the LMNS, a grading of “significant assurance” was assigned with an overall compliance of 77% for all 6 elements. Submission of quarter 1 2024/25 data is on target for the September 2024 deadline.

The division continue to undertake multidisciplinary quality improvement and clinical audit work, with the aim in providing assurance for the partially compliant interventions.

2.5 Perinatal Quality Surveillance Model

Northern Lincolnshire and Goole NHS Foundation Trust

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

Maternity Support Programme	No

Data measure	June 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	6 eligible perinatal deaths in Q1 24/25 (3 neonatal death / 3 antepartum stillbirth). The following key themes identified from Q1 PMRT reviews were identified: The mother's risk status was not assessed at the onset / during the course of labour Mother's progress not monitored on a partogram Pre-term perinatal optimisation not sufficient.
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	N/A
Findings of review of all cases eligible for referral to MNSI	N/A
Compliance with duty of candour *(within 10 working days)*	0 incidents requiring DoC
Number of incidents graded as moderate or above and what action is being taken	0
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	100% - no gaps identified.

Service User Voice feedback	Please refer to body of report
Staff feedback from frontline champions and walk-abouts	16 open actions on the Safety Champion Improvement Plan – main themes relate to: Staffing Capacity & demand Estates
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 10	Please refer to body of report

Item 3: In month developments and updates

3.1 Maternity and Neonatal updates

Substantive Maternity Matron appointed at SGH
Acting up arrangements in place for the Head of Midwifery
Fundraising has begun with the HealthTree Foundation to renovate the active birth room/pool room at DPoW.
Triage task & finish group ongoing
ATAIN Quality Improvement Project launch event occurred on the 8th of August and project plans will emerge from this.
Ongoing work to deliver the RSV vaccine

3.2 Growth Scan Review audit

To provide assurance that growth ultrasound scans are being appropriately reviewed and action a 'snapshot' was undertaken. The challenges of providing ultrasound scans within 24 hours for reduced fetal movements is apparent in this audit.

As per Saving Babies Lives audit criteria – scans are not required if there has been a growth scan in the previous 2 weeks. NLAG comply with the SBL target as women are often on the serial scan pathway and are scanned regularly. These women are included in the figures of compliance.

Where women have not had a scan within 24 hours and there's no evidence of a previous scan, they are typically scanned within 48 – 72 hours and monitored via daily CTG until the scan takes place.

Diana, Princess of Wales Hospital

GESTATION	REASON FOR SCAN	REVIEWED APPROPRIATELY	COMMENTS
32+4	BMI 38	REVIEWED BY REGISTRAR IN ANC	35.3 CENTILE, NORMAL GROWTH VELOCITY, AFI AND DOPPLER NAD - REVIEW IN 4 WEEKS WITH FURTHER USS
28+2	BMI 43, NEW GDM	REVIEWED BY MIDWIFE IN ANC	71 CENTILE, NORMAL GROWTH VELOCITY, AFI AND DOPPLER - REVIEW IN 3/52 IN ANC

28+5	SMOKER	REVIEWED BY REGISTRAR IN ANC	65.7 CENTILE, NORMAL GROWTH AFI AND DOPPLER. SBLCB RECOMMENDS SERIAL GROWTH SCANS FROM 32/40 FOR SMOKING RISK FACTOR
35+5	SMOKER, BMI 36	REVIEWED BY REGISTRAR IN ADU	21.5 CENTILE, GROWTH VELOCITY SLOW, AFI AND DOPPLER NORMAL, NEW DIAGNOSIS OF PRE-ECLAMPSIA, PLAN FOR IOL 37/40 IF REMAIN STABLE, ANC 2/52
30+6	RFM x2 >28/40	REVIEWED BY REGISTRAR IN ADU	PRESSENTED WITH RFMS ON 6/8/24, USS NOT UNTIL 9/8/24,NORMAL GROWTH AFI AND DOPPLER 62.2 CENTILE
32+4	RFM X5	REVIEWED BY REGISTRAR IN ADU	PRESENTED WITH RFMS ON 18/7/24, USS NOT UNTIL 22/07/24, AFI AND DOPPLER ONLY AS PREVIOUS GROWTH SCAN ON 10/07/24, AFI AND DOPPLER NORMAL - PREVIOUS USS NAD, 62.9 CENTILE
28+1	TYPE 2 DIABETIC	REVIEWED BY REGISTRAR IN ANC	51.6 CENTILE, NORMAL GROWTH AND AFI, PLAN TO REPEAT USS IN ANC 3/52
37+1	SMOKER	REVIEWED BY REGISTRAR IN ANC	54.8 CENTILE, NORMAL GROWTH, AFI AND DOPPLER, PT HAS ANTI E AND ANTI CW ANTIBODIES SO REVIEW IN 2/52
34+0	GDM	REVIEWED BY REGISTRAR IN ANC	41.0 CENTILE, DOPPLER NORMAL, POLYHYDRAMNIOS 21.0CM SO SCAN REBOOKED FOR 1/52
28+4	GDM	REVIEWED BY REGISTRAR IN ANC	85.8 CENTILE, DOPLER, AFI, GROWTH - NORMAL. FOR REPEAT USS IN ANC 3/52

Scunthorpe General Hospital

GESTATION	REASON FOR SCAN	REVIEWED APPROPRIATELY	COMMENTS
26+0	HYPOTHYROIDISM, CARDIOMYOPATHY	REVIEWED BY REGISTRAR IN JANC	46.1 CENTILE, NORMAL GROWTH VELOCITY & AFI, REVIEW 2/52 USS & ADU, REVIEW JANC 4/52
27+3	EPILEPTIC, BMI 41.3	REVIEWED BY REGISTRAR IN JANC	11.1 CENTILE, NORMAL GROWTH VELOCITY & AFI, REVIEW 2/52 USS & JANC

36+6	? SLOW GROWTH SFH MEASUREMENT BY COMMUNITY MW	REVIEWED BY REGISTRAR IN ADU	36.7 CENTILE, NORMAL GROWTH VELOCITY, AFI & DOPPLERS NAD, REVIEW 2/52 USS & ADU CHECK TRAJECTORY
36+5	EPILEPTIC, PARVOVIRUS INFECTION CURRENT PREGNANCY	REVIEWED BY REGISTRAR IN JANC	59.1 CENTILE, NORMAL GROWTH VELOCITY, AFI& DOPPLERS NAD,DISCHARGE TO SHARED CARE WITH SAFETY NETTING ADVICE
31+6	LOW PAPP-A	REVIEWED BY REGISTRAR IN ANC	19.2 CENTILE, NORMAL GROWTH, AFI & DOPPLERS, SBLCB RECOMMENDS SERIAL SCANS FROM 32 WEEKS
36+4	REFERRED CMW ? BREECH, LOW BMI, DNA'D USS'S >20 WEEKS	REVIWED BY REGISTRAR IN ADU	14.2 CENTILE, BREECH PRESENTATION, REVIEW ANC 1/52 TO DETERMINE MODE OF DELIVERY, UNSURE AT TIME OF USS
37+0	SMOKER, PREVIOUS SGA BABIES	REVIEWED BY REGISTRAR IN ANC	40.0 CENTILE, NORMAL GROWTH VELOCITY, AFI & DOPPLERS, SBLCB RECOMMENDS SERIAL USS'S FROM 32/40, REVIEW 2/52 USS & ANC
35+4	GDM-DIET, RFM'S 3RD EPISODE	REVIEWED BY REGISTRAR IN JANC	22.4 CENTILE, NORMAL GROWTH VELOCITY, AFI & DOPPLERS, REVIEW USS & JANC 2/52, IOL 38-39 WEEKS
35+1	ALLO ANTI-D ANTIBODY LEVELS RISING, CMW REFERRAL	REVIEWED BY MW IN ADU	77.1 CENTILE, NORTMAL GROWTH VELOCITY, AFI & DOPPLERS, 18/8/24 ANC REVIEW, REVIEW USS AND ANC 2/52, REPEAT BLOODS
33+6	BMI 40.7, LGA, X2 EPISODES RFM'S	REVIEWED BY REGISTRAR IN ANC	26.7 CENTILE, NORMAL GROWTH VELOCITY, AFI & DOPPLERS, REVIEW USS & ANC 2/52, BOOKED FOR ELECTIVE LSCS 39/40

3.2 Neonatal updates

Item 4: Maternity dashboard

Trustwide Maternity Dashboard

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
Midwife to Birth Ratio	23.1	23.3	22.8	22.7	20.8	21.8		19.6				
Red Flags	2.0	7.0	14.0	3.0	14.0	9.0	7.0	8.0	18.0	10.0	6.0	7.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	0.0	0.0	3.0	1.0	3.0	1.0	1.0	1.0	3.0	2.0	1.0	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0	3.0	3.0	1.0	2.0	2.0	1.0	3.0	2.0	2.0	3.0	0.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	1.0	0.0	1.0	1.0	0.0	0.0	1.0	1.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	6.0
(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	0.0	1.0	1.0	1.0	0.0	1.0	0.0	0.0	1.0	1.0	0.0	0.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	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	1.0	0.0	2.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	2.0	2.0	5.0	0.0	8.0	3.0	5.0	2.0	7.0	1.0	2.0	1.0
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 %	94.2	92.8	94.5	93.9	98.5	94.3	96.9	101.0				
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	99.5	99.0	99.4	99.5	99.5	100.0	100.0	100.0	100.0	100.0

4.1 Training compliance

NLAG is on track to achieve the 90% compliance for MIS year six, all managers are informed of any non-attendance.

Safety action 8 (SA8) identifies that 90% attendance in each relevant staff group should attend:

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

NOTE: This is an annual rolling total and 90% must be achieved by 30th of November 2024.

Fetal Monitoring – JULY 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	100%	100%	100%
Other medical staff on obs rota	100%	80%	95%
Midwives	94%	97%	95%
TOTAL	**95%**		

PROMPT – JULY 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	63%	100%	80%
Other medical staff on obs rota	88%	80%	84%
Midwives	96%	94%	95%
Midwifery Support Workers	100%	79%	93%
Anaesthetic consultant	85%	92%	88%
Anaesthetic staff on Obs rota	100%	83%	91%
TOTAL	**93%**		

Neonatal Resuscitation – JULY 2024			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Neonatal/paediatric consultants / SAS grade doctors	78%	100%	88%
Neonatal/paediatric junior doctors	83%	96%	91%
Neonatal nursing staff / senior nurses	79%	95%	80%
Advanced neonatal nurse practitioners	-	-	100%
Midwives	94%	95%	94%
TOTAL	**92%**		

Item 5: Learning lessons

5.1 Maternity & Newborn Safety Investigation cases

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

5.2 Detail of incidents graded moderate or above and rapid reviews

Two rapid reviews in July (1 intrauterine death and 1 admission to ITU). One moderate or above in Julybe

Incident number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
325979-Significant bruising following forceps delivery	Obstetric	Moderate	Incident form not submitted contemporaneously- reviewed and taken to panel when identified for AAR to be completed. DoC completed.
325504-Fractured skull following forceps delivery	Neonatal	Moderate	DoC completed. Reviewed as a local incident as asymptomatic and no neurological deficit

Item 6: Workforce

6.1 Workforce

Vacancy Rate

Site	Midwives
DPOW	9.1 WTE 10%
SGH	8.5 WTE 12.9%

11.2 WTE newly qualified are due to commence in post in the Autumn which will leave a vacancy rate of 6.3 WTE cross-site.

The Bereavement Midwife is currently on long-term sick which leaves a gap in bereavement service provision- we are currently exploring options to cover this gap. Initial actions include additional education for the midwives on the PMRT process.

6.2 Clinical Leadership

Interviews for clinical leadership roles, (Clinical Directors and Clinical Leads) occurred on the 16th of August 2024, a Clinical Director for Neonates, pan-group was successfully appointed, unfortunately there were no applicants for Clinical Director for Maternity, (Pan-Group) and this is a significant risk for maternity services. The Quad is considering options to address this significant gap. Clinical Leads for Neonates and Maternity on the South Bank have been successfully appointed. Further interviews will occur at the beginning of September prior to the appointment of a North Bank Clinical Lead for Neonates.

Item 7: Triangulation of Themes

7.1 Triangulation of Claims Scorecard Q1 2024/25

Maternity Incentive Scheme – SA9

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

NHS Humber Health Partnership

Claims Scorecard April 2013 – March 2023 (55 claims)

Top injuries by volume:	**Top injuries by value:**
Unnecessary pain (9) Fatality (9) Stillborn (8) Unnecessary operation(s) (7) Psychological/psychiatric damage (3)	Bladder damage (2) Fatality (9) Stillborn (8) Psychological/psychiatric damage (3) Rupture (1)
Top causes by volume:	**Top causes by value:**
Failure / delayed treatment (13) Failure / delay in diagnosis (7) Failure to monitor 2nd stage of labour (4) Inappropriate treatment (3) Foreign body left in situ (3)	Inadequate nursing care (3) Intraoperative problems (3) Failure / delay in treatment (12) Failure / delay in diagnosis (7) Fail in antenatal screening (1)

Incidents Q1 24/25

Top 5 incident by volume:

- Delay in treatment or procedure - (Mat) **(22)**
- Post partum haemorrhage (PPH) >1500mls **(18)**
- Administrative / management policies **(16)**
- Communication failure between different teams **(15)**
- Documentation missing / not completed **(14)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **460**

Complaints Q1 24/25

There have been 4 complaints received:

- Communication / treatment (2)
- Care / treatment (2)

All 4 complaints are still open.

Learning Q1 24/25

Inutero transfer not considered for those attending triage at high risk of severe premature delivery.

Those with hypertension in a previous pregnancy should be offered uterine artery doppler and placed on the serial scan pathway.

Themes Q1 24/25

- Communication between women / birthing people and staff.
- New patient administration system introduced impacting on registering newborn babies at birth and communication amongst clinical teams.

Action Plan Q1 24/25 Not started | In progress | Complete

Aide memoire / training support guidance developed and available in all areas.	June 2024	
Patient feedback communicated to managers and specialist midwives at midwifery managers meeting for further dissemination to staff.	June 2024	
Safety bulletin disseminated to staff to raise awareness of the guidance around in-utero transfer criteria.	May 2024	
Uterine artery doppler referral form to be updated as only those who had experienced hypertension in a previous pregnancy who were medicated were for referral.	Aug 2024	

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Six

NLAG PROGRESS REPORT

October 2024

Yvonne McGrath – Group Director of Midwifery
Hayli Garrod – Maternity Audit and Compliance Manager

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

United by Compassion:
Driving for Excellence

Contents

Executive Summary

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

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

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

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

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

At present the Trust is on target to meet all 10 safety actions specified in the MIS and have started collating evidence. The table below provides an overview of the current position for each safety action and a brief description of the concerns. Further detail is provided in the body of the report for each safety action.

Safety Action		RAG	Comments / action taken
1	National Perinatal Mortality Review Tool		No evidence in Trust Board or Q&SCIC papers/minutes that Q3 and Q4 reports have been shared. Q1 report shared August 2024.
2	Maternity Services Data Set (MSDS)		No concerns – NHS England provisional publication demonstrates July MSDS submission passed.
3	Transitional care services		Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). MDT Launch event occurred on the 8th of August and project plan is under development.

Safety Action		RAG	Comments / action taken
4	Clinical Workforce Planning		Unable to demonstrate progress made against action plans submitted in year 5 for compensatory rest and BAPM neonatal workforce requirements due to financial restrictions. Narrative to be provided to inform NHSR of structure changes across the care group. Business case for 24/25 to be submitted as supporting evidence.
5	Midwifery Workforce Planning		Awaiting refreshed Birthrate plus report.
6	Saving Babies' Lives Care Bundle v3		There are variations in practice with regards to the timescales for uterine artery doppler (UAD). A capacity/demand review is being undertaken by the head of sonography. Q1 24/25 data submitted (self-assessed at 81% compliance), next quarterly review meeting to take place 19 September 2024. Theming and trending to be undertaken.
7	Listen to women, parents and families		Evidence is to be provided by the LMNS on the NHS Futures Platform. They have advised they will start this in due course.
8	Training Compliance		Compliance <90% for certain staff groups. Trajectory indicates targets will be met by 30th November 2024. Recovery plan in place with additional training sessions added throughout September and October.
9	Board Assurance		Evidence gathering in progress. Awaiting LMNS to provide evidence on NHS Futures Platform to support submission.
10	MNSI / Early Notification Scheme		N/A

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution **by 12 noon on 3 March 2025** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

  ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

  ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period.

  ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

External Verification Process

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c). NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

National Neonatal Research Database (NNRD), MNSI and NHS Resolution 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 time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Evidence will be scrutined by the Local Maternity and Neonatal System (LMNS) and will require sign off by the Integrated Care Partnership (ICP) Board following Trust Board approval.

Safety action 1:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 30 November 2024 to the required standard?
Lead: Natalie Jenkin

There have been 25 cases reported during MIS year 6 period (8 December 2023 onwards). 3 babies still alive (twin deliveries) and 5 were for notification only with no further action required. 17 cases are eligible for review and full assessment against CNST standards.

The table below provides an overview of current compliance against the standards for the 22 subjected to standard A (notification submission) and 17 perinatal deaths eligible for scrutiny against CNST standards however it should be noted that due to the time taken to complete the investigation process cases are at different stages with some deadlines not yet met.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process						
Standard	Threshold	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 Jul – Sep 24	Q3 Oct – Dec 24	Total
A) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	100%	7/7 (100%)	7/7 (100%)	**6/8 (75%)	-	-
**2 cases were notified to MBRRACE more than seven days after the date of the death (subject to notification only, not review). MBRRACE have advised that on these occasions the late notifications will not be included in the verification of Safety Action 1 and therefore will not impact compliance.						
Cases applicable for PMRT review are applicable to the following standards (n=17)						
B) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	6/6 (100%)	5/5 (100%) 1 not yet met as in process	2/2 (100%) 3 not yet met as in process	-	-
C) Multi-disciplinary reviews should be started within two months of the death.	95%	**5/6 (83%)	6/6 (100%)	2/2 (100%) 3 not yet met as in process	-	-
**Deadline breached by 1 day. Please note the review has been completed in its entirety three months before the expected deadline with no further delays in the review process identified. The breach has been notified to NHS Resolution for transparency.						
C) Multi-disciplinary reviews should be published within six months of the death.	60%	6/6 (100%)	3/3 (100%) 3 not yet met as in process	5 not yet met as in process	-	-
D) Quarterly reports should be submitted to the Trust Executive Board.	100%	1/1 (100%)	1/1 (100%)	Oct 24	-	-

****Update from NHS Resolution June 2024****

Change to the verification period - The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this wasn't announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024. Due to the change the non-compliant case detailed in Q4 standard C will not affect overall compliance due to the death occurring in March 2024.

Monitoring and Reporting

MBRRACE-UK provide a CNST MIS year six summary report to allow live monitoring of compliance and approaching deadlines. Compliance is monitored by the MIS Year 6 Delivery Group on a weekly basis. Quarterly PMRT reports are produced, detailing the findings of each review and subsequent actions taken to address any concerns identified and share learning.

Learning Points and Key Themes

Key themes identified from **Q2** cases PMRT or continued from previous quarterly reviews are as follows:

Paediatrician not called soon enough for delivery despite end of life care pathway plan in place.
Mother not referred for uterine artery doppler or serial scans despite previous hypertension.
Kleihauer bloods not tested
All Postnatal bloods and investigations not being taken.

The following key learning points from **Q2** PMRT reviews have been shared with staff via Safety Bulletins or PMRT Newsletter:

Paediatric attendance for all babies who are expected to be on end of life pathways.
Most up to date SBLV3 algorithm to be displayed in every clinic room and escalation on the Safety Bulletin to remind staff of the pathways criteria
All postnatal investigations required to gain full clinical picture
Discussion with Pathology that Kleihauer bloods are required to be tested following a stillbirth.

Risks: No evidence in Trust Board or Quality and Safety Committees in Common minutes that the quarter 3 or quarter 4 reports were discussed or uploaded as papers. Trust Board minutes refer to quarter 1 data but no evidence full PMRT report was submitted.

Mitigation: All quarterly PMRT reports to be shared with Trust Board in October 2024.

Safety action 2:
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Lead: Nicola Foster / Carrie-Louise Wilkie

Safety action 2 is focussed on data quality and completeness of the July 2024 submission to MSDS.

1. There is a need for 10 of the 11 Clinical Quality Improvement Metrics (CQIMs) to pass the associated data quality assurance checks criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series to be compliant.

The CQIMs data requirements are:

Babies who were born pre-term, Babies with a first feed of breastmilk,
Proportion of babies born at term with an Apgar score <7 at 5 minutes,
Women who had a postpartum haemorrhage of 1,500ml or more,
Women who were current smokers at booking, Women who were current smokers at delivery,
Women delivering vaginally who had a 3rd or 4th degree tear,
Women who gave birth to a single second baby vaginally ≥37 weeks after a previous caesarean
Caesarean section delivery rate in Robson group 1 women
Caesarean section delivery rate in Robson group 2 women
Caesarean section delivery rate in Robson group 5 women
Babies breastfed at 6-8 weeks
Babies readmitted to hospital <30 days after birth

2. The submissions should have a valid ethnic category recorded for at least 90% of women booked during July 2024.

Current Position: The "Clinical Negligence Scheme for Trusts: Scorecard", reported by NHS England, is published each month and can be accessed via the following link: NLaG Maternity Scorecard. The provisional scorecard demonstrates that NLAG have submitted the required data and passed all 11 CQIMs and documentation of ethnicity for July 2024. Further detail can be found in appendix A.

Risks: None Identified for CNST. However, please note the MSDS will be disrupted whilst transitioning to BADGERNET.

Safety action 3:
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?
Lead: Emma Spicer

Standard a requires the Trust to have Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice *Or*

Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.

Current Position: The Trust has a pathway in place and continues to work with the BAPM framework.

Multidisciplinary point prevalence auditing of Transitional Care babies born between 34+0-36+6 weeks gestation continues with quarterly reporting. The most recent report covered Q4 (23/24) and demonstrated good compliance against the recommendations detailed in the 'Neonates Admitted to Transitional Care' Guideline. Please refer to Appendix B for a breakdown of compliance.

The audit findings have been shared with the LMNS, Q2 24/25 results will be shared with the LMNS in November 2024.

Standard b states that Trusts should draw on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.

Current Position: Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). A group wide multidisciplinary face to face stakeholder event took place during August 2024 with attendance from the LMNS and MNVP Lead for NNEL. Further work is required to progress the project.

Confirmation of registration has been sent to the LMNS as per the technical guidance requirements. Progress is yet to be shared with the relevant safety champions.

Risks: None identified**.**

Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?
Lead: Preeti Gandhi / Lisa Pearce

Obstetric workforce

a)	1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility to undertake short-term locums.
	2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

The RCOG compliance and effectiveness tool was introduced for use during MIS year 5 which has allowed a retrospective audit trail and greater oversight for the clinical leads.

An audit has been completed for the six month period specified in the technical guidance (February and August 2024) to assess compliance of tier 2/3 (internal and external) short term locum bookings. A detailed group report is available to share with Trust Board in October 2024.

Breakdown of compliance – Short Term Doctors

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

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

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

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

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

Breakdown of compliance – Long Term Doctors

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

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

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

	3. Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. ***While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.***

The service is not able to declare compliance where consultants and senior Speciality and Specialist (SAS) doctors who are working as non-resident on-call out of hours are able to claim sufficient compensatory rest.

An action plan was submitted as per year 5 requirements and has been reviewed by the divisional Chief of Service. Additionally, a business case addressing the current risks to the operational delivery of the standards has been submitted as part of the 2024/25 annual business planning process.

A Standard Operating Procedure in line with RCOG recommendations has been ratified through divisional governance processes. Due to concerns raised by the workforce it was agreed this would be applicable to weekdays only.

Risks: Position on compensatory rest is unchanged due to the need of additional consultant workforce/financial investment.

Mitigation: Added to the divisional risk register as a significant risk. MIS Year 6 submission to include narrative around Group structure changes during the reporting period.

	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. When a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

A concurrent audit is undertaken at DPOW and SGH and reported as part of the Maternity Audit Dashboard by the Maternity Matrons.

100% compliance declared during the MIS period to date.

Trustwide Results						
	Jan-24	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**
Total No.	30	35	32	22	24	23
Consultant present at birth	30	35	32	22	24	23
% compliance	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

A detailed audit report for a spot check audit of June 2024 has also been completed across the Trust and has demonstrated 100% compliance in the consultant attending when requested. Results were shared with Trust Board in August 2024.

Anaesthetic medical workforce

b)	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

Confirmation received from obstetric anaesthetic consultant leads for SGH and DPOW declaring compliance. Spot check audits have been undertaken for August 2024 which demonstrated 100% compliance. Weekly rotas also evidence the appropriate staffing.

Overall Compliance – August 2024							
	Weekday (Consultant cover)		Weekday (Middle Grade cover)		Weekend (Middle Grade cover)		
Site	8am – 1pm	1pm – 6pm	6pm – 8.30pm	8.30pm – 9am	8.30am – 5.30pm	5.30pm – 9pm	8.30pm – 9am
SGH	22/22 (100%)	22/22 (100%)	22/22 (100%)	22/22 (100%)	9/9 (100%)	9/9 (100%)	9/9 (100%)
DPOW	22/22 (100%)	22/22 (100%)	22/22 (100%)	22/22 (100%)	9/9 (100%)	9/9 (100%)	9/9 (100%)
	88/88 (100%)		88/88 (100%)		54/54 (100%)		
Total Compliance: 230 / 230 (100%)							

*August bank holiday took place on the 26/08/24 and was covered by Middle Grade doctors at both SGH and DPOW in line with weekend cover. This cover was classed as compliant with the standard.

The Trust policy on Supervision and Appropriate Staffing Levels for Anaesthetic Staff working in Obstetrics (DCP271) also supports compliance.

Neonatal medical workforce

c)	The neonatal unit meets the relevant BAPM national standards of medical staffing. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

The Trust is not compliant with BAPM national standards. An action plan was developed and submitted for MIS year 5. This has been reviewed with the Clinical Lead and updated accordingly.

The action plan (Appendix C) will be shared was Trust Board in August 2024 and sent to the LMNS as per MIS requirements.

The table below provides an overview of BAPM requirements and Trust position.

LNU activity	Tier 1	Tier 2	Tier 3
>1000 Respiratory Care Days or >400 Intensive Care days	*>/= 1 resident, dedicated, 24/7 to ensure safety & quality*	*>/=1 resident, dedicated, 24/7 OR risk analysis if providing <24/7 separate cover*	Consultant neonatologists - Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist**.
DPOW Position:	Compliant	Compliant	Non-compliant dedicated cover is provided only between 0900-1300 at all other times there is only one consultant covering both neonates and paediatrics.
SGH Position:	Non-compliant Dedicated Tier 1 and Tier 2 cover 09:00-17:00. Tier 1 and Tier 2 shared cover for paediatrics and neonates 17:00-09:00.		

BAPM 2022 guidance states that all staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.

Risks: Position is unchanged from MIS year 5 due to the need of additional consultant workforce/financial investment.

Mitigation: MIS Year 6 submission to include narrative around Group structure changes during the reporting period.

Neonatal nursing workforce

d)	The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.

The Trust is not compliant with BAPM national standards. An action plan is in place and has been reviewed with the Nurse Director and Operational Matrons for Family Services Care Group. Further review of the action plan will be undertaken in November 2024 to reflect any further progress made.

Elements of non-compliance:

1. There must be a supernumerary Band 6 Shift lead 24/7

DPOW: establishment and funding in place at band 5 level to allow band 6 supernumerary. At present staffing vacancy position does not allow this to be a consistent feature of the rota.

SGH: The realignment of the WTE allows there to be 4 registered nurses on duty instead of 3.

Neither unit achieve 24/7 band 6 supernumerary status, however, both are consistently striving to achieve this when acuity and activity allows.

Action taken: Realigned establishment in agreement with Chief Nurse to ensure an equitable spread of nursing workforce across the neonatal units. The additional WTE allocated to the DPOW establishment remain vacant due to recruitment challenges. This will continue to be highlighted through Chief Nurse establishment.

2. Neonatal Nurse Educator

Additional funds have been received from the ODN to increase the Nurse Educator role with the expectation that there will be 2 x 0.6 WTE on each site at Band 7. The job evaluation process is currently underway.

Risks identified:

Unable to demonstrate progress made against action plans. Trust Board to approve action plan .

Safety action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Lead: Yvonne McGrath / Nicola Foster

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

NLaG Birthrate Plus report last received in July 2022 and remains in date to declare compliance.

A Birthrate Plus review is planned for HUTH and to align group processes a request has been made for Birthrate Plus to undertake a review for NLaG. This is due

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

Trust Board minutes need to evidence midwifery staffing budget reflects establishment as calculated in the Birthrate Plus report.

c) The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

Supernumerary co-ordinator status is reported on the Power BI Maternity Assurance Dashboard and included in the monthly Maternity and Neonatal Oversight Report to Trust Board. Compliance is also monitored by the Maternity Matrons via concurrent audit data collection with both sources reporting 100% compliance. Please refer to Appendix E for further information.

d) All women in active labour receive one-to-one midwifery care.

One to one care in labour is reported on the Power BI Maternity Assurance Dashboard and included in the monthly Maternity and Neonatal Oversight Report to Trust Board. In January 2024 compliance was reported below 100% due to data quality issues. This was investigated during MIS year five and confirmed as a data inputting error that could not be amended retrospectively.

As per the table below no further data quality issues have been identified.

One to One Care Labour Rates

	Apr	May	Jun	Jul	Grand Total
Grimsby Maternity Hospital					
Y	100%	100%	100%	100%	100%
N	0%	0%	0%	0%	0%
Scunthorpe and Goole Hospitals					
Y	100%	100%	100%	100%	100%
N	0%	0%	0%	0%	0%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

A monthly midwifery staffing oversight report that covered staffing/safety issues was co-produced by the division and Chief Nurse which incorporated the required information including a monthly breakdown of midwifery red flags (as per Appendix E). A bi-annual staffing report has been developed and will be shared with Trust Board in October 2024 covering the period of November 2023 to June 2024.

Risks: Traditional bi-annual staffing report not submitted due to previous reporting arrangements in MIS year 5.

Safety action 6:
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?
Lead: Linda Keech / Hayli Garrod

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

Implementation Progress

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four	Assessment five
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25
Assurance review date	25 October 2023	18 December 2023	20 March 2024	10 June 2024	19 September 2024
Element 1: Smoking in pregnancy	10%	70%	70%	70%	90%
Element 2: Fetal growth restriction	55%	70%	90%	90%	85%
Element 3: Reduced fetal movements	50%	100%	100%	100%	100%
Element 4: Fetal monitoring in labour	40%	80%	80%	80%	100%
Element 5: Preterm birth	48%	70%	81%	67%	74%
Element 6: Diabetes	17%	67%	67%	83%	83%
TOTAL	**41%**	**71%**	**81%**	**77%**	**83%**

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

However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.

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

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

The targets for March 2025 have been achieved for elements 1, 3 and 4.

Quality improvement activity continues for the elements that have not yet reached the target. It should be acknowledged that element 5 compliance fluctuates due to the circumstances around women presenting in pre-term labour and the small numbers involved.

Element 2 – Fetal growth restriction:

Uterine Artery Doppler process

There are variations in practice with regards to the timescales for uterine artery doppler (UAD) – the challenge is the number and availability of sonographers who are trained to undertake UAD and lack of clinician available at the Grimsby site. A meeting has been held with the head of sonography who is currently undertaking a capacity/demand review.

Mitigation required to demonstrate best endeavours have been made:

Escalation to MIS Year Six Delivery Group / Trust Board
Capacity and demand review evidence / outcome of discussions with AHP Care Group Director.
Evidence of women not referred for UAD have had surveillance through serial growth scans.

Management of Fetal Growth Restriction

NLaG has a higher rate of babies born over the 3rd centile before 39 weeks gestation where FGR is suspected in comparison to national reporting. A deep dive review has been undertaken to determine if women are being induced unnecessarily and results indicate that inductions are being carried out appropriately due to factors such as oligohydramnious or pre-eclampsia which are not captured in GROW 2.0.

The review also highlighted a data inputting error where suspected fetal growth restriction was recorded on GROW incorrectly. This equated to 25 cases from quarter 1 being incorrectly identified and has been fed back to the Perinatal Institute who have agreed to update our figures retrospectively for quarter 1 (reducing the rate from 8.6 to 5.5%), this remains slightly above the LMNS target of 5% but under the national average. Quarter 2 validation also highlighted the same issue and has been fed back to the Perinatal Institute who have agreed to amend the figures retrospectively but will not be reflected in the reporting until Q3. A meeting has been arranged in October 2024 with the Perinatal Institute. Posters have also been displayed in clinical areas about recording requirements for GROW and teaching for new starters on Care Camp will also address the importance.

There is also a higher percentage of babies <3rd birthweight centile born >37+6 weeks (to assess the effective detection and management of FGR) reported for quarter 1 (previously compliant). It was acknowledged by the LMNS that national averages have also increased above the target set of <48%.

Mitigation required to demonstrate best endeavours have been made:

Escalation to MIS Year Six Delivery Group / Trust Board
Deep dive evidence of investigation into data to be provided to the LMNS
Run charts to demonstrate potential tracking of increased national averages and common cause variation to be submitted in re-assessment November 2024.

Element 5 - Preterm birth:

Perinatal Optimisation

There has been a drop in the number of perinatal optimisation standards that have been met. This is often due to women presenting in advanced labour with no time to optimise care and focuses on small numbers for each quarter. However, as the pre-term birth rate is higher across the Trust when compared to national rates, a deep dive of preterm deliveries is underway to assess if any opportunities have been missed and to identify any learning. To date from cases reviewed preterm deliveries were due to maternal condition e.g. pre-eclampsia or abruption etc.

Pre-term Birth Team

Concerns also raised by the LMNS regarding the lack of a pre-term birth MDT team to address the issues identified.

Mitigation required to demonstrate best endeavours have been made:

Escalation to MIS Year Six Delivery Group / Trust Board
Paper to be submitted to Trust Board proposing introduction of Pre-term Birth Midwife
Demonstrate cohesive working on quality improvement measures amongst the pre-term birth individuals already identified.

Fetal Fibronectin

Unable to audit compliance for preterm birth assessment using quantative fetal fibronectin measurement across the LMNS due to the national shortage. All Trusts within the LMNS have declared partial compliance following local discussions and agreement.

No further mitigation required.

Pre-term Birth Discussions

To evidence antenatal discussion between the neonatal team and women who deliver preterm a discussion form has been rolled out for interim use during Q1 and stored in the mother's maternity notes. Audit results will be available for Q2 reporting. Discussions are underway regarding where this is captured on Badgernet for future recording.

Mitigation required to demonstrate best endeavours have been made:

Escalation to MIS Year Six Delivery Group / Trust Board
Evidence of audit outcomes following introduction of pre-term birth form.

Element 6 – Diabetes:

1 intervention outstanding relates to separation of pre-existing and gestational diabetes clinics. A proposal has been drafted but agreement has been delayed due to re-configuration of clinic time slots due to concerns about delivery quality care and thorough

discussions with newly diagnosed women. Discussions with the Clinical Lead, consultant leads and management team are taking place weekly to reach a resolution.

Mitigation required to demonstrate best endeavours have been made:

Escalation to MIS Year Six Delivery Group / Trust Board
Submission of clinic configuration proposal at time of November 2024 submission (or earlier if resolution reached).

Other evidence requirements:

Shared learning across the LMNS is demonstrated through the collaborative LMNS collaboration days (2 held during MIS reporting period), smoking in pregnancy LMNS wide meetings, perinatal forum, the neonatal ODN and informal collaboration/evidence sharing amongst Trusts within the LMNS.

Review of local themes and trends of the six elements was discussed at the Saving Babies Lives LMNS Collaboration Meeting and it was agreed quarterly PMRT reports, CLIP reporting and the triangulation of the claims scorecard reporting is acceptable as evidence.

Other identified risks:

Potential disruption to data submission / attainment rates due to the introduction of Badgernet in maternity (24 September 2024).

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

1) **Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:**

   a) Engagement and listening to families.

   b) Strategic influence and decision-making.

   c) Infrastructure.

The Maternity and Neonatal Voices Partnership (MNVP) is commissioned by the ICP and therefore work is undertaken jointly in order to provide the evidence to support this safety action.

a) Engagement and listening to families

For MIS year 6 the LMNS have advised that evidence gathering is currently being co-ordinated and will be available to access on the LMNS NHS Futures workspace where evidence will be accessible (including the LMNS Equity and Equality plan). The Trust will be informed when this becomes available.
https://future.nhs.uk/HCVCE/view?objectId=53690320

In addition, the MNVP lead for NL and NEL and a team of volunteers participated in cross site 15 steps events which provided the opportunity to look around the wards and feedback directly to the trust staff. The teams visited SGH in March 2024 and DPOW in June 2024, recommendations from the visits are being worked through with the Maternity Matrons.

The MNVP lead has shared future plans for gathering feedback from service users during quarter 2 2024/25:

New neonatal lead in post to start engagement with Neonatal families
Walk the patch events in antenatal areas and community midwife clinics
Visit to Goole Midwifery Led Unit
Visiting breastfeeding groups & local sling library
Further online surveys to be launched on webpage
Working with Ask a Midwife team (social media)
IOL AQUA work
Afterthoughts service improvements
Perinatal Pelvic Health Steering Group

Evidence of the MNVP Lead working with Trust bereavement leads is yet to be collated.

b) Strategic influence and decision-making

Terms of Reference for the following meetings have been updated to ensure the MNVP lead is a member.

Maternity Clinical Governance Meeting *(already listed as core member, invited to the meetings and regularly provides feedback on guidelines, leaflets and SOPs from a service user perspective).*
Neonatal Clinical Governance Meeting
Maternity and Neonatal Quality Improvement Meeting
Maternity and Neonatal Assurance Group

Minutes of the above meetings will be saved in the evidence folder throughout the year to demonstrate working towards MNVP being a quorate member of the meetings.

c) Infrastructure

Confirmation has been received from the LMHS Quality Lead that the following evidence will be available on the LMNS NHS Futures webpage in due course:

Job description for MNVP Lead
Contracts for service or grant agreements
Budgets with allocated funding
Local service user volunteer expenses policy.

Evidence is also available from MIS year five which includes the funding report from February 2023, reviewing the function and funding of the MNVP which resulted in a significant increase in funded time and resource.

The MNVP Lead has also provided a signed declaration to support her allotted hours and remuneration of expenses.

2) Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication, including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

The findings from the annual Maternity Survey have been reviewed and an action plan has been co-produced by the Head of Midwifery and the MNVP Lead (please see Appendix F).

Workshop to take place to develop the strategy and progress the actions from the survey.

Risks: None identified.

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

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

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

For competencies where compliance has been identified as below the expected standard, a site based recovery plan is instigated and staff have been booked onto the next available training session with additional sessions added in September and October. Attendance rates are monitored within the division on a monthly basis.

Fetal Monitoring – SEPTEMBER 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	71%	86%	79%
Other medical staff on obs rota	48%	81%	62%
Midwives	85%	90%	88%
TOTAL	**84%**		

PROMPT – SEPTEMBER 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	57%	100%	79%
Other medical staff on obs rota	71%	75%	73%
Midwives	92%	90%	91%
Midwifery Support Workers	100%	86%	95%
Anaesthetic consultant	92%	100%	96%
Anaesthetic staff on Obs rota	90%	100%	95%
TOTAL	**90%**		

Neonatal Resuscitation – SEPTEMBER 2024			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Neonatal/paediatric consultants / SAS grade doctors	78%	86%	81%
Neonatal/paediatric junior doctors	83%	68%	76%
Neonatal nursing staff / senior nurses	79%	90%	83%
Advanced neonatal nurse practitioners	-	-	100%
Midwives	92%	90%	91%
TOTAL	**88%**		

****Update from NHS Resolution July 2024****

In line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024) All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth must have reached a minimum of **'basic capability'** as described in the BAPM Neonatal Airway Capability Framework.

No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability.

Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.

Requirement around NLS Certification:

A minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations unsupervised should have been trained and assessed in line with the guidance above.

Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised by year 7 of MIS and ongoing. Whilst Trusts are encouraged to continue to work towards the BAPM guidance where possible regarding first responders at births <34 weeks, this will not form part of the MIS requirements for compliance.

Current position for NLAG & HuTH

A Group MDT meeting took place following the update and a plan is in place to cover the requirements on the CNST/neonatal update NLS session. For basic airway training - already covering all materials and taking a register, however, not all formal documentation within the BAPM appendix is completed.

ACTION:

- Implement the competency sign off paperwork within training
- Explore a way to electronically capture this information retrospectively
- CNST requirement for unsupervised first responders, from a medical perspective, will be signed off at induction. this will require the competency sign off documentation and recording
- Meet with Neonatal Educators at NLAG to review NLS trainers (only 1 currently available at present).

Standard airway training – not currently covering as part of training programme.

ACTION: plan to implement for neonatal nurses alongside the NLS update session including the competency sign off paperwork from July 2024 across the Group.

Technical guidance also specifies that registered Resus Council trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. Assurance has been provided by the Neonatal Educators that this requirement is met, certificates to evidence this are currently being collated.

Core Competency Framework

For year 5 submission a three year Training Needs Analysis (TNA) / Training Plan was populated with training rates and plans for developments. Whilst this is no longer a mandatory requirement for year 6, NLaG continue to work towards delivery of this. To monitor progress, quarterly review meetings are taking with training facilitators to review the contents of the training packages, discuss attendee feedback, progress in achieving stretch targets and to ensure training sessions reflect best practice.

Risks: Non-attendance at scheduled training sessions.

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

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

Evidence requirements / progress update:

A non-executive director (NED) is in place as Board level safety champion who works with the perinatal leadership team 'Quad' to undertake safety champion walkabouts. This provides insight into floor level safety concerns.
Review of maternity and neonatal quality and safety is undertaken by the Trust Board via the monthly Maternity and Neonatal Oversight Reports. The PQSM Dashboard is also shared with the Trust Board on a monthly basis (Appendix G).

Thematic learning informed by PSIRF is detailed in the claims scorecard triangulation, Maternity Safety Bulletins, PMRT quarterly report and in the Trust's CLIP report (submitted to Trust Board quarterly).

Collaboration / sharing learning with the LMNS/ICB lead is undertaken in line with the PQSM and is evidenced by reports into the LMNS Perinatal Quality Surveillance Group. These are accessible on the LMNS NHS Futures platform and have been saved in the evidence folders.

Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions is shared at the Maternity Improvement Group visible to both maternity and neonatal staff and reflects progress made on identified concerns raised by staff and service users.

Regular staff engagement sessions take place through safety champions walk rounds and shout out Wednesday. A Safety Champion Improvement Plan logs issues raised and is monitored at the Maternity and Neonatal Assurance Group Meeting. Safety bulletins are shared with staff on a regular basis.

The Trust's claims scorecard has been triangulated with incident, complaints and theming data for quarter 1 2024/25. This has been shared at the Clinical Governance Meeting in July 2024 and is to be shared at the next Quality and Safety Committee meeting (on behalf of the Board). The scorecard is published annually (expected August 2024), triangulation for Q2 will be undertaken in October 2024 and shared with Trust Board in December 2024.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Evidence requirements / progress update:

Evidence is required in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly. Monthly meetings have occurred since July 2024 .
Maternity and Neonatal Culture Improvement Plan was included in the Maternity and Neonatal Assurance Group in September 2024. It will be an agenda item at the Maternity and Neonatal Assurance Group going forward.
Feedback sessions have now been planned as part of the SCORE survey feedback.

Risks: None identified.

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

a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.

The division has a clear standard operating procedure in place that is followed for reporting qualifying cases to MNSI. To date, there has been **1** case (MI-036753) that met the reporting criteria in January 2024. Verbal duty of candour (DoC) was completed but the written DoC was not completed as the case was declined from MNSI within 10 working days.

b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024.

The division works closely with the Claims team to ensure qualifying early notification cases are reported to has a clear standard operating procedure in place that is followed for reporting qualifying cases to MNSI. To date, there have been 0 cases that have met the reporting criteria.

c For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that:

- **i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and**
- **ii. ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.**

Compliance with statutory duty of candour section has been added to Maternity and Neonatal Oversight Report to ensure Trust Board are sighted. The central Governance team have also added a section to cover this in their incident Board reporting and is reported as part of the Integrated Performance Report (IPR).

Both requirements have also been added to the PQSM dashboard (appendix G) from July 2024 onwards which is included within the Maternity and Neonatal Assurance Report.

Meeting Papers	Board papers include qualifying cases	Board papers include DoC Compliance	Board papers include Families informed
Site	**NLAG**	**NLAG**	**NLAG**
December 2023	Trust Board before reporting period of 8th December 2024		
February 2024	Yes	Yes	Yes
April 2024	Yes - but no cases	Yes (IPR) - but no cases	No – but no cases
June 2024	Yes - but no cases	Yes (IPR) - but no cases	Yes for Group - no NLAG cases
August 2024	Yes - but no cases	Yes - but no cases	Yes - but no cases

Appendix A: MSDS Maternity Scorecard

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 6: Safety Action 2

The table below summarises the number of criteria met by each maternity service provider, by month. For Y6, there are two criteria to meet on MSDS data submission. This scorecard will be updated and published each month.

The final assessment will be based on the final data for **July 2024** for which the submission deadline is **30th September 2024**.

Organisation Name

NORTHERN LINCOLNSHIRE AND GOOLE ...

Notes:

All figures are Final except for the most recent month. All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

As of April 2024, this summary has been updated to reflect the two criteria for CNST year 6. This has been updated for all the time series data.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Provisional

Organisation Name	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	2	2	2	2	2	2

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

United by Compassion:
Driving for Excellence

Organisation Name

NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRU...

Reporting Period

July 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	290			Passed
CQIMDQ14	315	305	103.3		Passed
CQIMDQ15	315	315	100.0		Passed
CQIMDQ16	295	315	93.7		Passed
CQIMDQ24	290	295	98.3		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	180	300	60.0	Passed
CQIMDQ08	300	320	93.8	Passed
CQIMDQ09	315	305	103.3	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	315	305	103.3		Passed
CQIMDQ11	110	315	34.9		Passed
CQIMDQ12	10	315	3.2		Passed
CQIMPPH	5	315			Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	315	305	103.3		Passed
CQIMDQ22	315	315	100.0		Passed
CQIMDQ23	295	315	93.7		Passed
CQIMPreterm	20	310		61	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	315	305	103.3		Passed
CQIMDQ15	315	315	100.0		Passed
CQIMDQ16	295	315	93.7		Passed
CQIMDQ18	225	315	71.4		Passed
CQIMDQ20	5	215	2.3		Passed
CQIMTears	5	215			Passed

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	315	305	103.3	Passed
CQIMDQ15	315	315	100.0	Passed
CQIMDQ16	295	315	93.7	Passed
CQIMDQ18	225	315	71.4	Passed
CQIMDQ26	315	315	100.0	Passed
CQIMDQ27	310	310	100.0	Passed
CQIMDQ28	140	310	45.2	Passed
CQIMVBAC	5	10	50.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	315	305	103.3	Passed
CQIMDQ31	320	320	100.0	Passed
CQIMDQ32	295	320	92.2	Passed
CQIMDQ33	320	320	100.0	Passed
CQIMDQ34	225	320	70.3	Passed
CQIMDQ36	315	315	100.0	Passed
CQIMDQ37	155	315	49.2	Passed
CQIMDQ38	320	320	100.0	Passed
CQIMDQ39	315	315	100.0	Passed
CQIMRobson01	0	50	0.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	45	95	47.4	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	15	25	60.0	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	310	305	101.6	Passed
CQIMDQ04	305	310	98.4	Passed
CQIMDQ05	40	305	13.1	Passed
CQIMSmokingBooking	40	305	13.1	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	315	315	100.0	Passed
CQIMSmokingDelivery	40	315	12.7	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	305	310	98.4	Passed

Appendix B: Transitional Care Audit Compliance (Q1 2024/25)

Trust wide Point Prevalence Audit			Quarter 1	
No	**Target**	**Standard**	**SGH**	**DPOW**
1.	100%	Babies should be receiving the appropriate level of care in accordance with their clinical need (in line with traffic light system).	36/36 (100%)	46/46 (100%)
2.	100%	Babies should be admitted within 1 hour of being identified as requiring TC.	5/5 (100%)	5/5 (100%)
3.	100%	The correct documentation should be used in accordance with the level of care provided at the time of the audit (point prevalence) • Normal midwifery care (purple book) • Enhanced Midwifery care / TC (blue book) • Neonatal collab document.	36/36 (100%)	46/46 (100%)
4.	100%	The documentation should be fully completed and accurate in all cases.	8/8 (100%)	13/13 (100%)
5.	100%	In 100% of cases the care plan is completed and updated each shift.	27/27 (100%)	6/6 (100%)
6.	100%	there should be clear transfer from & to the babies' postnatal notes.	3/3 (100%)	13/13 (100%)
7.	100%	There should be evidence of the shared care model.	2/2 (100%)	6/6 (100%)
8.	100%	Babies should be seen by a Paediatrician within 24hrs of admission to Transitional Care.	5/5 (100%)	5/7 (71%)
9.	100%	Babies should be updated on CMIS for Transitional Care or EMC.	8/8 (100%)	14/14 (100%)
10.	100%	There should be an allocated Transitional Care Midwife or ATAIN HCA on duty on the day of the audit.	2/36 (6%)	32/46 (70%)

Appendix C: BAPM Neonatal Medical Workforce Action Plan

CNST MIS Year Six - Neonatal Medical Workforce Action Plan

Requirements for Safety Action 4:

1. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations.

<table>
<tr><th>BAPM standard requirement</th><th>MIS Year 6 status</th><th>Action Required</th><th>Lead</th><th>Timescale</th><th>Status</th><th>Evidence</th></tr>
<tr><td>BAPM junior medical staffing guidance for Local Neonatal Units:

<table>
<tr><th>LNU activity</th><th>Tier 1</th><th>Tier 2</th></tr>
<tr><td>>1000 Respiratory Care Days or >400 Intensive Care days</td><td>>/= 1 resident, dedicated, 24/7 to ensure safety & quality</td><td>>/=1 resident, dedicated, 24/7 OR risk analysis if providing <24/7 separate cover</td></tr>
<tr><td colspan="3">Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff*.</td></tr>
<tr><td colspan="3">Tier 2: EWTD compliant rota with a minimum of 8 WTE staff*.</td></tr>
<tr><td colspan="3">**All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.</td></tr>
</table>
</td><td>DPOW:
No action required - dedicated Tier 1 and Tier 2 24/7 cover for paediatrics and neonates.

SGH:
Dedicated Tier 1 and Tier 2 cover 09:00-17:00.

Tier 1 and Tier 2 shared cover for paediatrics and neonates 17:00-09:00.</td><td>Seek confirmation of future local neonatal care model through Humber Acute Services Review (this will dictate the need for increased workforce at SGH).</td><td>Miss Gandhi / Lisa Pearce / Dr Hebbar</td><td>To be confirmed</td><td>Currently on hold decision to decouple made by the ICB, awaiting further clarification.</td><td></td></tr>
<tr><td></td><td></td><td>Alignment of medical workforce with future local neonatal care model to ensure BAPM compliance</td><td>Miss Gandhi / Lisa Pearce / Dr Hebbar</td><td>To be confirmed</td><td>Awaiting outcome of business case submitted as part of 2024/25 business planning.</td><td></td></tr>
</table>

<table>
<tr><th>BAPM standard requirement</th><th>MIS Year 6 status</th><th>Action Required</th><th>Lead</th><th>Timescale</th><th>Status</th><th>Evidence</th></tr>
<tr><td colspan="7">BAPM consultant medical staffing guidance for Local Neonatal Units:</td></tr>
<tr><td>
<table>
<tr><th>LNU activity</th><th>Tier 3</th></tr>
<tr><td>>1000 Respiratory Care Days or >400 Intensive Care days</td><td>Consultant neonatologists - Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist**.</td></tr>
<tr><td colspan="2">**All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.</td></tr>
</table>

It is recommended that all NICUs implement consultant presence on the unit for at least 12 hours per day (generally expected to include two ward rounds / handovers), or more as resources allow and depending on patient numbers and intensity.

Source: The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf</td><td>8.75 x WTE at DPOW /
8 x WTE at SGH

Dedicated Tier 3 neonatal cover between 09:00-13:00.

Tier 3 shared cover for paediatrics and neonates 13:00 – 09:00.</td><td>Update to be sought on the outcome of the business case submitted as part of 2024/25 business planning.

Confirm local requirements with Chief of Service in line with updated BAPM 2022 guidance.</td><td>Miss Gandhi / Lisa Pearce / Dr Hebbar</td><td>01 August 2024</td><td>In progress</td><td>Medical staffing establishment</td></tr>
<tr><td>Minimum of 1 consultant with a designated lead interest in neonatology.</td><td>2 x consultants with a designated lead interest in neonatology in place.</td><td>-</td><td>Dr Hebbar</td><td>-</td><td>Compliant</td><td>Job plans / written confirmation from Clinical Lead</td></tr>
</table>

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
BAPM consultant medical staffing guidance for Local Neonatal Units:						
Tier 3 consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification / substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN.	2 x consultant neonatal leads have substantial exposure to tertiary neonatal practice (evidence required).	N/A	Dr Hebbar / Dr Oba / Dr Majuran	N/A	Compliant	Written confirmation from Clinical Lead
All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).	Information to be requested	Evidence to be gathered from Neonatal Consultants	Dr Hebbar / Dr Oba / Dr Majuran	01 September 2024	In progress	Training records / job plans / attendance at meetings

Sources:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Optimal Arrangements for Neonatal Intensive Care Units in the UK: A BAPM Framework for Practice (2021) https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021

Staffing Request as per Business Case:
The Proposal to implement the BAPM recommendations will ensure dedicated resident doctor cover 24/7 for neonates both Tier1 and Tier2 level. The dedicated consultant cover form neonates will be extended for busy periods until 21.00 hours, and one consultant covering both paediatrics and neonates at night. The change in staffing and rota needs to happen only at one site as the recommendations is for one site to be a Level 2 unit (LNU) and the other site to be Level1 (SCU) as per the recommendations of the Y&H Neonatal Operational delivery network and HASR.

This proposal was based on BAPM Framework for Practice 2018:

LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs.https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/64/LNU_doc_Nov_2018.pdf

Appendix D: BAPM Neonatal Nursing Workforce Action Plan

CNST MIS Year Six - Neonatal Nursing Workforce Action Plan

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
Both Neonatal Unit Managers (1WTE each Site) are required to be supernumerary 100% of the roster period	Establishment reviews implemented August 2022 to meet standard requirement	No action required	Deborah Bray, Emma Spicer / Jennifer Copley	-	Complete	Rosters
There should be a 1WTE Band 7 Lead nurse for Transitional Care Services who are Supernumerary 100% of the roster period	Due to Band 7 Lead Nurse for the LNU's being supernumerary the oversight of the Transitional Care Service is incorporated into their role and responsibilities – ODN supported this position	No further action required.	Deborah Bray, Emma Spicer / Jennifer Copley	-	Complete	Rosters
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant	Neonatal Matrons in post and works closely with the lead consultant neonatologists.	No further action required.	Deborah Bray	-	Complete	Job descriptions

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
There must be a supernumerary Band 6 Shift lead 24/7	To fully comply each neonatal unit needs to recruit 5.14wte Band 5 RN's per site to achieve 1 supernumerary Band 6 to be released to provide overall leadership of the shift. DPOW: establishment and funding in place at band 5 level to allow band 6 supernumerary. At present staffing vacancy position does not allow this to be a consistent feature of the rota. SGH: The realignment of the WTE allows the SGH neonatal unit to have 4 registered nurses on duty instead of 3. Neither unit achieve 24/7 band 6 supernumerary status, however, consistently strive to achieve this when acuity and activity allows.	Action taken: Realigned establishment in agreement with Chief Nurse to ensure an equitable spread of nursing workforce across the neonatal units. The additional WTE allocated to the DPOW establishment remain vacant due to recruitment challenges. This will continue to be highlighted through Chief Nurse establishment. The recruitment to the realignment for the WTE to the SGH neonatal unit has been completed and new starters are awaiting employment checks. (Sept 24).	Deborah Bray, Emma Spicer / Jennifer Copley	Continuous review through Chief Nurse establishment review process	In progress	Chief Nurse Establishment Review
1 WTE Band 7 Nurse Educator required to work cross site	Current position – 2 x 0.63 WTE Band 6 Neonatal Nurse Educators in place (1 at each site). The ODN expectation is that the Neonatal Educators are Band 7 and have created a network job description for hospitals to work to. Additional funds have been received from the ODN to increase the Nurse Educator role with the expectation that there will be 2 x 0.6 WTE on each site at Band 7.	Complete the job evaluation process for the Nurse Educator role. Delay due to amendments required to job description to achieve Band 7 at AFC panel (Sept 24).	Natalie Jenkin	01 August 2024	In progress	Job Description e-Roster

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC:1 RN 2 HD:1 RN 4 SC:1 RN 4 TC:1 RN	Staffing levels and cot capacity/acuity data is entered in to BadgerNet on a daily basis for both sites and risk mitigated accordingly.	Continued submission to demonstrate compliance.	Emma Spicer & Jennifer Copley Matrons	-	Ongoing monitoring	Workforce Toolkit / BadgerNet data
		Additional resource to be found if acuity levels exceed workforce numbers.	Emma Spicer & Jennifer Copley Matrons	-	Ongoing monitoring	Rosters /Bank reports /Agency spend reports Escalation policy
	Workforce tools provided to Chief Nurse to inform establishment review process. Chief Nurse submitted overarching nursing and midwifery workforce review paper to the executive team - awaiting outcome.	Workforce toolkit reports to be reviewed and incorporated into Chief Nurse review and BC Planning around establishments. No new reports available as of Sept 24. The neonatal establishment as part of the Chief Nurse review process.	Emma Spicer & Jennifer Copley Neonatal / Paediatric Matrons	01 Aug 2024	In progress	Scunthorpe BAPM Q2 23 24.xlsx Grimsby BAPM Workforce Q2 23 24
70% of the workforce should be Registered Nurses	Current staffing status is compliant as follows: DPOW: 71.7% (23/24) SGH: 62.5% (23/24)	Review recruitment plans to ensure they support standard requirements. SGH currently recruiting to vacancies to increase compliance. Continue to review quarterly.	Emma Spicer & Jennifer Copley	31 March 2024	Complete	Rosters
30% of the workforce should be non-registered.	DPOW: 28.2% (23/24) SGH: 37.5% (23/24)					

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
80% of registered nurse workforce should be QIS 70% compliance with QIS standard to be maintained 100% of the time.	DPOW: 68% (rolling training programme in place due to number of new starters). SGH: 69.5% (rolling training programme in place due to number of new starters during 2023 From September 2024 DPOW and SGH will be fully staffed. Currently waiting for non-qualified nurses to start. Due to acuity the shift lead may not always be supernumerary but should be able to have the lowest workload to do both. An incident form will be completed to evidence how often this occurs and the impact this has.	Current position at DPOW: 1 nurse awaiting her results at the end of September. 2 nurses starting QIS in September and potentially 2/3 starting next September 2025 (Sept 24). There is a training plan in place to support appropriate staff to access the relevant training and educations modules to achieve the QIS.	Emma Spicer & Jennifer Copley	Review 30 September 2024	Ongoing	Training compliance rates
Non-registered workforce should complete a minimum of NVQ level 3 training in neonatal care.	DPOW: 100% / SGH: 93% Training plan in place to support the new starters to ensure the non-registered workforce are supported to complete the required academic and practical training.	Continue to monitor training rates to ensure that 100% of the non-registered workforce complete the required training within 1 year of employment.	Emma Spicer & Jennifer Copley	31 December 2024	Ongoing monitoring	Training compliance
Neonatal Outreach must be available 7 days a week.	SGH and DPOW have a 5 day service but work flexibly to facilitate discharge.	N/A	Deborah Bray	-	-	-

Appendix E: Maternity Assurance Dashboard

Trustwide Maternity Dashboard

Indicator	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024
Midwife to Birth Ratio	21.8		19.6					
Red Flags	9.0	7.0	8.0	18.0	10.0	6.0	7.0	6.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	1.0	1.0	1.0	3.0	2.0	1.0	0.0	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	2.0	1.0	3.0	2.0	2.0	3.0	0.0	1.0
(c) Missed medication during an admission to hospital	1.0	0.0	0.0	2.0	0.0	0.0	0.0	1.0
(d) Delay of more than 30 minutes in providing pain relief	1.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	1.0	1.0	0.0	0.0	6.0	4.0
(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
(g) Delay of 2 hours or more between admission for induction and beginning of process	1.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	1.0	0.0	2.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	3.0	5.0	2.0	7.0	1.0	2.0	1.0	0.0
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
Actual v Planned Staffing %	94.3	96.9	101.0					
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	99.5	99.5	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	28.4	22.8	22.5	21.1	26.1	25.6	26.1	2.8
Vacancies - Registered	22.4	16.9	16.9	17.8	16.5	15.2	17.0	2.1
Vacancies - Unregistered	5.9	5.9	5.5	3.3	9.6	10.4	9.1	0.7
Serious Incidents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Complaints	0.0	2.0	2.0	2.0	2.0	1.0	1.0	1.0
PALS	3.0	6.0	2.0	8.0	4.0	5.0	4.0	7.0
Sickness Absence (Division) %	5.7	5.7	4.8	4.6	5.0	5.0	5.1	5.3

Appendix F: Maternity Survey (Picker) Action Plan 2024

Co-produced by Nicola Foster Head of Midwifery and Kimberley Boyd Maternity and Neonatal Voice Partnership (MNVP) Lead.

Identifier	Area for Improvement	Action Required	Action by Date	Person Responsible	Action Status
D6	Found partner was able to stay with them as long as they wanted (in hospital after birth) Trust 35% Picker average 57%.	Revisit partners staying overnight at SGH (scope possibility of partitions) Review guidance re communication for partners.	31/8/204	Claire Brothwell (Maternity Matron SGH) Vicki Booth (Maternity Matron DPOW)	In progress
F19	Felt GP talked enough about physical health during postnatal check-up Trust 58% Picker average 70%.	Add to agenda at Northern Lincolnshire Women and Children's Board.	31/8/2024	Nicola Foster (Head of Midwifery)	In progress
F20	Felt GP talked enough about mental health during postnatal check-up Trust 60% Picker average 72%.	Add to agenda at Northern Lincolnshire Women and Children's Board.	31/8/2024	Nicola Foster (Head of Midwifery)	In progress
B3	Offered a choice of where to have baby Trust 65% Picker average 76%.	Highlight to community midwifery teams re antenatal discussions including choice of where to have baby.	31/8/2024	Michelle Smith (SGH community midwifery manager) Christine Page-Patrick (DPOW community midwifery manager)	In progress
C9	Partner / companion involved (during labour and birth) Trust 88% Picker average 94%.	Discussion at Team Leaders meeting Antenatal education and communication to include and highlight involvement.	31/8/2024	Nicola Foster (Head of Midwifery) Michelle Smith (SGH community midwifery manager) Christine Page-Patrick (DPOW community midwifery manager)	8/5/24 Discussed at Team Leaders meeting (NF)

Appendix G: Perinatal Quality Surveillance Model (PQSM Dashboard – June 2024)

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

Maternity Support Programme	No

Data Measure	May 24	Jun 24	Jul 24
Findings of review of all perinatal deaths using the real time data monitoring tool	4 eligible perinatal deaths in Q4 23/24 (1 neonatal death / 1 antepartum stillbirth / 2 unspecified stillbirths). *Learning points included in main body of report.*	6 eligible perinatal deaths in Q1 24/25 (3 neonatal death / 3 antepartum stillbirth). *Learning points included in main body of report.*	To date there have been 4 perinatal deaths in Q2, all 4 have been notified to MBRRACE and are currently in the review process. *Learning points for Q1 are included in main body of report.*
Number of cases referred to MNSI/ENS	0	0	0
Family's informed of referral to MNSI/ENSR	N/A	N/A	N/A
Findings of review of all cases eligible for referral to MNSI	N/A	N/A	N/A
Compliance with duty of candour *(within 10 working days)*	0 incidents requiring DoC	0 incidents requiring DoC	1 (100%)
Number of incidents graded as moderate or above and what action is being taken	0	0	1
Training compliance for all staff groups in maternity related to the core competency framework:			
Fetal Monitoring (including K2)	95%	95%	91%
PROMPT	93%	93%	90%
Neonatal Resuscitation	93%	94%	92%

Data Measure	May 24	Jun 24	Jul 24
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively			
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively. Reviewed daily and plans put in place to mitigate risk e.g. DPI, use of mutual aid across the group.			
Midwifery staffing (Registered Nurses and Midwives & Care Staff)	Total Planned Hours	Total Actual Hours	Fill Rate %
	16,504.4	14,503.3	87.7%
Neonatal staffing (Registered Nurses and Midwives & Care Staff)	Total Planned Hours	Total Actual Hours	Fill Rate %
	8,556.0	7,200.3	84.2%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	No gaps identified	No gaps identified	No gaps identified
Service User Voice feedback - Friends and Family Test	**NICU Trustwide:** 13 responses – 92% positive / 8% neutral **Maternity Trustwide:** 66 responses **–** 100% positive	**NICU Trustwide:** 8 responses – 100% positive **Maternity Trustwide: 72** responses **–** 97% positive	**NICU Trustwide:** 13 responses – 100% positive **Maternity Trustwide: 84** responses **–** 97% positive
Staff feedback from frontline champions and walk-abouts	16 open actions on the Safety Champion Improvement Plan – main themes relate to: Staffing Capacity & demand Estates	16 open actions on the Safety Champion Improvement Plan – main themes relate to: Staffing Capacity & demand Estates	Listening events continue Ongoing work on Maternity Safety Champion Culture Improvement Plan Score survey feedback events for Quad and staff now planned. Ongoing work to develop action plan from staff survey findings.
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No	No	No
Coroner Reg 28 made directly to the Trust	0	0	0
Progress in ATAIN Actions	On target	On target	On target
Progress in Implementation of Saving Babies Lives Care Bundle Version 3	On target – 77% implementation progress (Q4 2023/24)	On target – 77% implementation progress (Q4 2023/24)	On target – 81% implementation progress (Q1 2024/25)
Progress in achievement of CNST 10 – Year 6	On target (please see body of report)	On target (see body of report)	Please refer to body of report

Appendix H: Triangulation of Claims Scorecard Q1 2024/25

Maternity Incentive Scheme – SA9

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

NHS Humber Health Partnership

Claims Scorecard April 2013 – March 2023 (55 claims)

Top injuries by volume: Unnecessary pain (9) Fatality (9) Stillborn (8) Unnecessary operation(s) (7) Psychological/psychiatric damage (3)	**Top injuries by value:** Bladder damage (2) Fatality (9) Stillborn (8) Psychological/psychiatric damage (3) Rupture (1)
Top causes by volume: Failure / delayed treatment (13) Failure / delay in diagnosis (7) Failure to monitor 2nd stage of labour (4) Inappropriate treatment (3) Foreign body left in situ (3)	**Top causes by value:** Inadequate nursing care (3) Intraoperative problems (3) Failure / delay in treatment (12) Failure / delay in diagnosis (7) Fail in antenatal screening (1)

Incidents Q1 24/25

Top 5 incident by volume:

- Delay in treatment or procedure - (Mat) **(22)**
- Post partum haemorrhage (PPH) >1500mls **(18)**
- Administrative / management policies **(16)**
- Communication failure between different teams **(15)**
- Documentation missing / not completed **(14)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **460**

Complaints Q1 24/25

There have been 4 complaints received:

- Communication / treatment (2)
- Care / treatment (2)

All 4 complaints are still open.

Learning Q1 24/25

Inutero transfer not considered for those attending triage at high risk of severe premature delivery.

Those with hypertension in a previous pregnancy should be offered uterine artery doppler and placed on the serial scan pathway.

Themes Q1 24/25

- Communication between women / birthing people and staff.
- New patient administration system introduced impacting on registering newborn babies at birth and communication amongst clinical teams.

Action Plan Q1 24/25 Not started | In progress | Complete

Aide memoire / training support guidance developed and available in all areas.	June 2024	
Patient feedback communicated to managers and specialist midwives at midwifery managers meeting for further dissemination to staff.	June 2024	
Safety bulletin disseminated to staff to raise awareness of the guidance around in-utero transfer criteria.	May 2024	
Uterine artery doppler referral form to be updated as only those who had experienced hypertension in a previous pregnancy who were medicated were for referral.	Aug 2024	

Appendix I: Maternity Group Culture Improvement Plan

No.	Recommendation	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress
1	Student support	Awareness of support available to students whilst on clinical placement. PLF in post 1.0 WTE for midwifery students. R&R and Pastoral Lead available to students to access, maintaining visibility on daily walk arounds and attending UoH for teaching sessions such as Neonatal Life Support. PLF and R&R lead working together to run half day student forums within clinical hours to maintain visibility and discuss topics such as PMA, compassionate conversations, active bystanders and F2SU. Students have requested a "mini-PROMPT" to practice skills and drills in safe environment with education lead	Students will feel supported in their clinical environment and know where to go if they need support in addition to clinical staff		Ongoing	Daily walkarounds by R+R lead, introducing self to students and checking in on wellbeing. Focussed conversations around Kings Fund ABC framework and ensuring students are able to raise concerns where necessary. SLEC framework launched in February 2024 guiding PLF work. Rosters available in advance on eroster to ensure work/life balance and continuation with supervisors
2	International midwives	Demonstrate awareness of support for IRMs both in the Trust and the community. Provide with preceptor and manager and regular check-in's from pastoral lead. Encourage welcoming and safe environment. Enhance staff knowledge on cultural diversity, unconscious bias and how our behaviours impact others.	12 international midwives now employed by the Trust. They will feel welcome and supported to adapt to their new place of work and home life.		Ongoing	Daily walkaround by R+R Lead to check-in on wellbeing and preceptorship/clinical competencies as acting as link for pastoral support since starting role in January. All individual midwives assigned their own preceptor to discuss progress and concerns as well as a manager. NHSE funding one place for PMA course in January. Awaiting EOI up to 16th August and PMA will appoint. Agreed by DoM that one midwife will be released for this training in January to ensure our workforce is represented by our PMA team.

						Previous HoM was holding monthly TEAMS calls but these have ceased as HoM now left Trust. R+R Lead has achieved Cultural Competency Certificate from Trust and other managers encouraged but not undertaken. R+R Lead attends MOST study day and TEAM days to raise awareness of pastoral issues for international midwives at each session - promoting empathy and encouraging staff support. Arranged for IRM's to have swimming lessons, supported to book coastal holidays, introduced to local amenities and supported with arranging childcare. Tickets arranged for IRM's to attend "NHSE Celebration event" in Leeds. One IRM sent on leadership course.
3	Leadership		Staff will feel well-led, psychologically safe, inspired and held by the senior management team but also each other. Staff being promoted into new bands will be well supported by a buddy to learn and flourish in their new roles. All staff will feel that the impact of the Safer Learning Environment Charter framework.		Ongoing	Matrons meeting with Organisational Development Lead every Monday morning to encourage cohesive working and a psychologically safe environment for expressing concerns. Regular drop-ins held by Director of Midwifery, Chief Nurse (North and South Bank) and F2SU Guardian. Private and closed Facebook group commenced 15th July for all staff to receive updates, praise, support and share positive stories - now has 200 members. R+R and Pastoral Lead attending MOST training and team days to discuss compassionate and courageous conversations, active bystanders and self-care in line with Capital Midwife Civility Toolkit. Midwives offered the opportunity to become "Preceptorship Champions" - teaching clinical skills to newly

						qualified midwives to offer investment, value recognition and show the investment in them that they are requesting.
4	Professional Midwifery Advocates	Raise awareness of PMA team to staff. Ensure cohesive PMA team with members appearing as representatives of workforce. To align with colleagues in NLaG joining forces with PNA teams and sharing strategy. Team need a Lead PMA to drive and grow service.	Staff will be familiar with members of the PMA team and have access to a PMA Monday to Friday 8am - 4pm via email and mobile phone. Staff will have a choice about which PMA they use and are not obligated to access PMA at any time. Staff to understand benefits of A-EQUIP model delivered by PMA team.		Ongoing	PMA register maintained by R+R Lead midwife currently. Weekly message with photograph featuring the PMA who is holding the phone and email on a rostered basis. PMA's providing support in their own time, in addition to their substantive posts. Three PMA's used more than others and not all team members contributing to workload currently. QR code used to capture activity then reported monthly to Jodie McVie to feedback to NHSE. Data previously collected by RM Sue Cooper who was given 7.5 hours Band 6 per week, in addition to community substantive post, but this contract ended 3rd June. 12 midwives on waiting list wishing to start the course. One place held for January 25 for an International Midwife - expressions of interest to be handed in to PMA team by 16th August. Team to determine appropriate selection process for midwives wishing to train to be a PMA based on qualities and values.

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FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 6, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 1 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

July 2024

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

United by Compassion:
Driving for Excellence

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Trust Board and Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

Late fetal losses – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

Stillbirths – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.

Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

Terminations of pregnancy: terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

The following deaths should be reviewed to meet safety action one standards:

All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
All stillbirths (from 24+0 weeks' gestation)
Neonatal death (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) (up to 28 days after birth)

2. STANDARDS

A report has been received by the Trust Executive Board each quarter from XX that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**Standard**
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**60%**
d) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in MIS Year Six (Appendix A)

There has been a total of 12 incidents reported to MBRRACE-UK via the PMRT during MIS year six. 5 in Quarter 4 (01 January – 31 March 2024) in 7 in Quarter 1 (01 April – 30 June 2024). 5 cases were reported to MBRRACE but were for notification only and therefore not eligible for further measurement against CNST standards or review.

0 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

No concerns have been raised with the notification submission and the current reporting process is to continue.

3.2 Summary of all incidents reviewed through PMRT in Quarter 1 2024/25 (Appendix B)

There have been 5 incident reviewed through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during January and March 2024 due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

0 cases had no issues identified that would have had an impact on the outcome.
3 cases had issues identified that would have had no impact on the outcome
2 cases had issues that may have had a difference to the outcome.

<u>Grading of care provided to the mother after the death of the baby</u>

2 cases had no issues identified that would have had an impact on the outcome
3 cases had issues identified that would not have had an impact on the outcome

3.3 CNST Compliance as per MIS Year 6 Standards (Appendix C)

12/12 (100%) are currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

Identification and management of fetal growth restriction (FGR) was a relevant issue

Issues associated with reduced fetal movement (RFM) management

Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor

The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of all Eligible Incidents Reported in MIS Year 6 (n=12)

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q1	93831	Neonatal death	29+0	17/06/24	17/06/24	2100	Unbooked	DPOW	DPOW	Yet to be sought	No	Yes	Yes	N/A – post qualifying date
	93830	Antepartum stillbirth	29+2	19/06/24	19/06/24	560	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	N/A – post qualifying date
	93399	Neonatal death	36+2	20/05/24	29/05/24	2300	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	Not yet met
	92981	Antepartum stillbirth	30+0	23/04/24	23/04/24	1900	Unbooked	DPOW	DPOW	Yet to be sought	No	Yes	Yes	Not yet met
	92872	Antepartum stillbirth	25+2	17/04/24	17/04/24	1290	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet met
	92871	Neonatal death	23+3	17/04/24	17/04/24	532	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet met
	92608	Antepartum stillbirth	39+4	30/03/24	30/03/24	3112	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92515	Neonatal death	27+4	21/03/24	21/03/24	1230	SGH	SGH	SGH	Yes	No	Yes	No	Met
	92441	Antepartum stillbirth	22+3	19/03/24	19/03/24	558	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	91639	Antepartum stillbirth	25+0	30/01/24	30/01/24	1790	SGH	SGH	SGH	Yes	No	Yes	Yes	Met

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q1	91196	Neonatal death	26+4	04/01/24	04/01/24	910	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	91144	Neonatal death	22+5	01/01/24	01/01/24	510	SGH	SGH	SGH	Yes	No	Yes	Yes	Met

Appendix B – Summary of all incidents reviewed in Q1 of 2024/2025

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91639 Antepartum stillbirth 25 weeks	Complex cardiac anomaly, ventriculomegaly. Contributory factor of pre-eclampsia, possible marginal abruption.	The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	Mother had poor/no English and arrangements other than an interpreter were made during her labour and birth. Chromosome analysis of the baby was not carried out. Infection screening of the mother and baby was not carried out. This mother only had partial investigations for underlying metabolic and/or haematological Abnormalities.	For discussion of this case at Coordinators meeting about appropriate allocation and support for agency midwives. For discussion at managers meeting, quarterly PMRT meeting and for inclusion on PMRT Newsletter.
91144 Neonatal death 22+5 weeks	Extreme prematurity.	Up to birth: the review group identified care issues which they considered may have made a difference to the outcome for the baby. From birth to death: the review group identified care issues which they considered may have made a difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	This mother was in preterm labour/threatened preterm labour but was not offered: antenatal steroids when indicated. antibiotics when indicated. magnesium sulphate for fetal neuroprotection when indicated. This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately. Senior staff were needed at the time this mother was giving birth, they were called but didn't arrive. The fetal heart monitoring in established labour was not carried out correctly.	Conflict of Opinion Guideline to be redistributed and communicated to staff. Neonatal Lead to provide further training and roles/responsibilities regarding care of extreme prematurity. Further training to be given with regards DCG303 Care of the Extreme Premature Neonate. Care of the Extreme Premature Neonate Guideline to be updated. Learning to be included on the PMRT Newsletter. Spot checks for completion of equipment checklists.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91144 Neonatal death 22+5 weeks			The interpretation of the fetal heart rate monitoring in established labour was not correct. Neonatal staff were predicted to be required but all staff of an appropriate seniority did not attend. During the resuscitation of the baby positive pressure respiratory support was required but it was not administered appropriately. The notes relating to the resuscitation of the baby were inadequate and so it is not possible to fully assess the quality of the resuscitation. Positive pressure respiratory support ir oxygen was required but a saturation monitor was not used to assess the baby's oxygen saturation. It is not possible to assess from the notes whether surfactant was indicated and given appropriately during the resuscitation of the baby. It is not possible to assess from the notes whether chest compressions were indicated and administered appropriately during the resuscitation of the baby. During the stabilisation of the baby the stabilisation/support was not carried out appropriately. The baby should have been admitted to the neonatal unit sooner.	

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91144 Neonatal death 22+5 weeks			The respiratory management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate. The management of pain and sedation of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate. The decision to offer re-orientation of care for the baby could have been considered sooner. It is not possible to assess from the notes whether appropriately trained staff were involved in moving the baby to the neonatal unit. Not all the equipment needed to move the baby to the neonatal unit was available. Although indicated this mother was not offered further postnatal investigations for herself and/or her baby. It is not possible to tell from the notes if the parents were provided with written support information around emotional issue before they left hospital.	

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91196 Neonatal death 26 weeks	Extreme prematurity, RDS bilateral IVH, traumatic birth with associated bruising.	Up to birth: the review group identified care issues which they considered may have made a difference to the outcome for the baby. From birth to death: the review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group concluded there were no issues with care identified for the mother following the death of her baby.	This mother had preterm labour or had preterm pre-labour rupture of membranes during her pregnancy which was not managed according to national or local guidelines. This mother's risk status during labour was not assessed during her labour. This mother had pregnancy complications but they were not recognised as requiring specific birth planning advice. This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs. This mother was in preterm labour/threatened preterm labour but was not offered: antenatal steroids when indicated. antibiotics when indicated. magnesium sulphate for fetal neuroprotection when indicated. Type of fetal monitoring in labour was not appropriate. The fetal heart monitoring in the latent phase of labour was not carried out correctly. It was not possible to tell from the documentation if the interpretation of the fetal heart rate monitoring in the latent phase of labour was correct. The interpretation of the fetal heart rate monitoring in established labour was not correct.	For presentation at PMRT Quarterly and Safety Bulletin to focus on IUT criteria. All triage documentation, Antenatal CTG and PROM Guidelines to be updated to include need for CTG from 26 weeks gestation. For inclusion on the PMRT Newsletter.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91196 Neonatal death 26 weeks			During this mothers' labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out. This mother's progress in labour was not monitored on a partogram.	
92441 Antepartum stillbirth 37 weeks	Acute hypoxic ischaemic mode of demise, secondary to pathological small placenta	The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	There is no evidence in the notes that this mother was asked about domestic abuse at booking. Although indicated this mother was not offered a Kleihauer test.	Statistics to be shared at the Managers meeting and Community meetings. For inclusion on this week's huddle and for discussion with coordinators at each shift.
92515 Neonatal death 27 weeks	Anencephaly	Up to birth: the review group identified care issues which they considered may have made no difference to the outcome for the baby. From birth to death: the review group that there were no issues with care identified from birth up to the point that the baby died. The review group concluded there were no issues with care identified for the mother following the death of her baby.	This mother lives with family members who smoke but they were not offered referral to smoking cessation services. Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons. This mother had had a caesarean section previously but her birth options for this pregnancy were not discussed with her during the antenatal period. This mother had an operative delivery but this was not carried out with appropriate urgency.	For inclusion on the PMRT newsletter and to explore inclusion on Badgernet for the future. For discussion at the quarterly PMRT meeting. Update the Neonatal Death Cherished Pathway.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
92515 Neonatal death 27 weeks			It is not possible to assess from the notes whether options for organ donation were considered and discussed with the parents as part of the end of life care for their baby.	

Appendix C – Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	100%	6/6 (100%)	6/6 (100%)	-	-	
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	6/6 (100%)	2/2 (100%) 4 – not yet met (in process)	-	-	
Multi-disciplinary reviews should be started within two months of the death.	95%	*5/6 (83%)	6/6 (100%)	-	-	
Multi-disciplinary reviews should be published within six months of the death.	60%	6/6 (100%)	6 – not yet met (first deadline 17/10/24)	-	-	
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted May 2024	Submitted August 2024	-	-	

NHS Resolution - change to the verification period

The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this was not announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

*Due to the above change the non-compliant case detailed in Q4 will not affect overall compliance due to the death occurring in March 2024.

Appendix D: Learning Points and Key Themes:

The following key learning points from **Q4** PMRT reviews have been shared with staff via safety bulletins:

Risk assessments must be completed and documented during antenatal, intrapartum and postnatal periods.
Please follow the cherished pathways to ensure all the investigations are completed. These are necessary to aid with identifying potential causes of IUD.
It is important to document that information regarding RFM has been given. Without this, we cannot be certain this has happened.
All those who have an IUD, regardless of blood group should be offered a Kleihauer test. This aids the investigations to determine potential causes for IUD.
CO monitoring should always be completed and documented at each antenatal appointment.
Assessment for aspirin should be completed for all pregnant people.
When on a scan pathway, scans should be performed 3-4 weekly and this should not be exceeded.
Maternal observations and the partogram should always be completed.
Neonatal alerts should be sent for those on nerve pain medications.
Cherished Care Pathways should always be completed to know exactly what care has been provided.

Key themes identified from **Q1** cases PMRT reviews are as follows:

The mother's risk status was not assessed at the onset / during the course of labour
Mother's progress not monitored on a partogram
Pre-term perinatal optimisation not sufficient.

Action to be taken in response to the issues identified are detailed in appendix C.

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/4 (25%)	0/5 (0%)	-	-	**1/9 (11%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/4 (25%)	0/5 (0%)	-	-	**1/9 (11%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/4 (0%)	0/5 (0%)	-	-	**0/9 (0%)**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/4 (0%)	2/5 (40%)	-	-	**2/9 (22%)**

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Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 6, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 2 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

October 2024

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

United by Compassion:
Driving for Excellence

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Trust Board and Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

Late fetal losses – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

Stillbirths – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.

Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

Terminations of pregnancy: terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

The following deaths should be reviewed to meet safety action one standards:

All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
All stillbirths (from 24+0 weeks' gestation)
Neonatal death (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) (up to 28 days after birth)

2. STANDARDS

A report has been produced for the Trust Executive Board each quarter from December 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**Standard**
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**60%**
d) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in MIS Year Six (Appendix A)

There has been a total of 25 incidents reported to MBRRACE-UK via the PMRT during MIS year six:

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
Q4 (01 Jan – 31 Mar 24)	6	1	1
Q1 (01 Apr – 30 Jun 24)	6	1	1
Q2 (01 Jul – 30 Sept 24)	5	3	1
Total	**17**	**5**	**3**

17 cases are eligible for review and full assessment against CNST standards. 3 babies were still alive (twin of a reportable case), 5 cases were reported to MBRRACE but were for notification only (terminations for fetal anomaly) and therefore not eligible for full assessment against CNST standards or review. Of these, 3 were notified to MBRRACE within seven days and 2 were reported late (11 and 16 days after the date of the death).

MBRRACE have advised that on these occasions the late notifications will not be included in the verification of Safety Action 1, which MBRRACE-UK/PMRT will be carrying out. However, any future late notifications which are for deaths occurring more than two weeks after the date of this email will be included in the verification and may result in the Trust failing to meet the standards required for Safety Action 1.

0 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

3.2 Summary of all incidents reviewed through PMRT in Quarter 2 2024/25 (Appendix B)

There have been 4 incidents reviewed through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during April, May and June 2024 due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

2 cases had no issues identified that would have had an impact on the outcome.
1 case had issues identified that would have had no impact on the outcome
1 case had issues that may have had a difference to the outcome.

Grading of care provided to the mother after the death of the baby

2 cases had no issues identified that would have had an impact on the outcome

2 cases had issues identified that would not have had an impact on the outcome

3.3 CNST Compliance as per MIS Year 6 Standards (Appendix C)

Following updated guidance from NHS Resolution and communications from MBRRACE-UK the Trust is on target to achieve full compliance. Please refer to Appendix C for further breakdown.

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

Identification and management of fetal growth restriction (FGR) was a relevant issue

Issues associated with reduced fetal movement (RFM) management

Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor

The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of all eligible incidents (for review) reported in MIS year 6 (n=17)

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q2	95387	Antepartum stillbirth	37+6	29/09/24	30/09/24	2380	SGH	SGH	SGH	Yet to be sought	No	Yes	Not yet met	N/A – post qualifying date
	95343	Antepartum stillbirth	28+5	26/09/24	26/09/24	2100	DPOW	DPOW	DPOW	Yes	No	Yes	Not yet met	N/A – post qualifying date
	94938	Neonatal death	23+5	26/08/24	26/08/24	650	SGH	SGH	SGH	Yes	No	Yes	Yes	N/A – post qualifying date
	94853	Antepartum stillbirth	24+6	21/08/24	21/08/24	592	Jessops	SGH	SGH	Yet to be sought	No	Yes	Yes	N/A – post qualifying date
	94427	Antepartum stillbirth	35+2	20/07/24	20/07/24	2042	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	N/A – post qualifying date
Q1	93831	Neonatal death	29+0	17/06/24	17/06/24	2100	Unbooked	DPOW	DPOW	Yet to be sought	No	Yes	Yes	N/A – post qualifying date
	93830	Antepartum stillbirth	29+2	19/06/24	19/06/24	560	SGH	SGH	SGH	Yes	No	Yes	Yes	N/A – post qualifying date
	93399	Neonatal death	36+2	20/05/24	20/05/24	2300	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	Not yet met
	92981	Antepartum stillbirth	30+0	23/04/24	23/04/24	1900	Unbooked	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92872	Antepartum stillbirth	25+2	17/04/24	17/04/24	1290	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92871	Neonatal death	23+3	17/04/24	17/04/24	532	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q4	92608	Antepartum stillbirth	39+4	30/03/24	30/03/24	3112	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92515	Neonatal death	27+4	21/03/24	21/03/24	1230	SGH	SGH	SGH	Yes	No	Yes	No	Met
	92441	Antepartum stillbirth	22+3	19/03/24	19/03/24	558	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	91639	Antepartum stillbirth	25+0	30/01/24	30/01/24	1790	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	91196	Neonatal death	26+4	04/01/24	04/01/24	910	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	91144	Neonatal death	22+5	01/01/24	01/01/24	510	SGH	SGH	SGH	Yes	No	Yes	Yes	Met

Appendix B – Summary of all incidents reviewed through PMRT in Q2 of 2024/2025

Case	Cause of Death	Grading of Care	Issues Identified	Actions
92608 Antepartum stillbirth 39+4 weeks	Terminal acute hypoxic ischaemic event occurred on the background of chronic intrauterine hypoxia and associated fetal anaemia	The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth of the baby, but serial scans were not planned. This mother had a history of pregnancy induced hypertension and her antenatal care was not appropriate given this history. Although indicated this mother was not offered a Kleihauer test.	Ensure the most up to date SBLV3 algorithm is in every clinic room and escalate on the Safety Bulletin. Investigate the requesting and reporting process for the Kleihauer test.
92871 Neonatal death 23+3 weeks	Respiratory arrest secondary to extreme prematurity. Possible acute chorioamnionitis.	The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	Neonatal staff were predicted to be required when the baby was born but were not called soon enough. Although indicated this mother was not offered a coagulation screen and fibrinogen for DIC and repeated as appropriate. Although indicated this mother was not offered infection screening for herself and her baby.	Communication to all maternity and obstetric staff of the legal requirement for paediatric attendance for all babies who are expected to be on end of life pathways. Reminder of the importance of investigations to gain a full clinical picture.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
92872 Antepartum stillbirth 25+2 weeks	Parvovirus infection	The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died. The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.	No actions identified relating to issues identified as directly relevant to the death of this baby. No actions identified relating to issues identified as not directly relevant to the death of this baby.	No Actions required.
92981 Antepartum stillbirth 30+0 weeks	Following the review which considered the results of the placental histology and other investigation the cause of death of the baby was undetermined. Having made this determination the review panel noted that the results of a post-mortem were needed to be certain about the cause of death.	The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died. The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.	This mother was unbooked at delivery. Are there any organisational issues to consider in relation to her not booking?	Patient was unaware of pregnancy and admitted to A&E with abdominal pain. Following delivery patient later divulged that she was aware of the pregnancy but believed to be in early pregnancy. Multiple social and physical factors identified. Appropriate referrals made for social/wellbeing support. Named safeguarding midwives and social care supporting.

Appendix C – Summary of CNST Compliance as per MIS Year 6 Standards (N=22)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	100%	7/7 (100%)	7/7 (100%)	**6/8 (75%)	-	-
Cases applicable for PMRT review are applicable to the following standards (n=17)						
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	6/6 (100%)	5/5 (100%) 1 not yet met as in process	2/2 (100%) 3 not yet met as in process	-	-
Multi-disciplinary reviews should be started within two months of the death.	95%	*5/6 (83%)	6/6 (100%)	2/2 (100%) 3 not yet met as in process	-	-
Multi-disciplinary reviews should be published within six months of the death.	60%	6/6 (100%)	3/3 (100%) 3 not yet met as in process.	5 not yet met as in process.	-	-
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted May 2024	Submitted August 2024	Submission October 2024	-	-

NHS Resolution - change to the verification period

The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this was not announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

*Due to the above change the non-compliant case detailed in Q4 will not affect overall compliance due to the death occurring in March 2024.

**2 cases were notified to MBRRACE more than seven days after the date of the death (subject to notification only, not review). MBRRACE have advised that on these occasions the late notifications will not be included in the verification of Safety Action 1 and therefore will not impact compliance.

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q2** cases PMRT or continued from previous quarterly reviews are as follows:

Paediatrician not called soon enough for delivery despite end of life care pathway plan in place.
Mother not referred for uterine artery doppler or serial scans despite previous hypertension.
Kleihauer bloods not tested
All Postnatal bloods and investigations not being taken.

The following key learning points from **Q2** PMRT reviews have been shared with staff via Safety Bulletins or PMRT Newsletter:

Paediatric attendance for all babies who are expected to be on end of life pathways.
Most up to date SBLV3 algorithm to be displayed in every clinic room and escalation on the Safety Bulletin to remind staff of the pathways criteria
All postnatal investigations required to gain full clinical picture
Discussion with Pathology that Kleihauer bloods are required to be tested following a stillbirth.

Action to be taken in response to the issues identified are detailed in appendix C.

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/4 (25%)	0/5 (0%)	1/4 (20%)	-	**2/13 (15%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/4 (25%)	0/5 (0%)	0/4 (0%)	-	**1/13 (8%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/4 (0%)	0/5 (0%)	0/4 (0%)	-	**0/13 (0%)**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/4 (0%)	2/5 (40%)	0/4 (0%)	-	**2/13 (15%)**

Northern Lincolnshire and Goole NHS Foundation Trust

FAMILY SERVICES DIVISION

TRUST BOARD BRIEFING REPORT

THE CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) INCENTIVE SCHEME

SAFETY ACTION 1: NATIONAL PERINATAL MORTALITY REVIEW TOOL

NICOLA FOSTER
HEAD OF MIDWIFERY, GYNAECOLOGY AND BREAST

APRIL 2024

Purpose of the report
The purpose of this report is to provide assurance to the Trust Board that the national Perinatal Review Tool is being completed by a multidisciplinary team to the standard required by the Clinical Negligence Scheme for Trusts (CNST).

Introduction
'Safer Maternity Care' published in 2016 set out a vision for making NHS maternity services some of the safest in the world, by achieving a national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030.

There are several initiatives supporting the delivery of safer maternity care. These include work by:

- The respective Royal Colleges (Obstetricians and Gynaecologists, and Midwives)
- MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths).
- NHS Resolution: Contributed significantly by reviewing maternity mortality and morbidity cases, recommending where and how services and the wider system can focus efforts for improvement and raising national awareness about these.

A collaboration led by MBRRACE-UK was appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT), designed with user and parent involvement to support high quality standardised perinatal reviews. The fundamental aim of the PMRT is to support local reviews of care when babies die. This is to provide answers for bereaved parents and their families about whether the care that they and their baby received was appropriately safe and personalised or whether different care may have changed the outcome. The second, but nonetheless important, aim is to ensure local learning results from review findings to improve care, reduce safety-related adverse events, and prevent future baby deaths.

The PMRT is designed to support the systematic, multidisciplinary, high quality review of the circumstances and care leading up to and surrounding each stillbirth (from 22 weeks' gestation onwards) or neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

The CNST Incentive Scheme (Year Five) Requirements
As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST). This is administered by NHS Resolution (formerly the NHS Litigation Authority). NHS resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The scheme applies to all Acute NHS Trusts that deliver maternity care and incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all 10 of the safety actions will recover the element of their contribution to the CNST MIS fund.

To comply with safety action 1 of the MIS the Trust must demonstrate that the national Perinatal Mortality Review Tool (PMRT) is being used to review perinatal deaths to the required standard, within the specified timescales for cases meeting the review criteria. The PMRT places at its core the fundamental aim of supporting objective, robust and standardised review to provide answers for bereaved parents and their families about why their baby died. A second, but nonetheless important, aim is to ensure local and national learning occurs as a consequence of review findings in order to improve care and ultimately prevent future baby deaths.

The standards specified in CNST safety action 1 are detailed below:

a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary 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 30 May 2023. Minimum evidential requirement for Trust Board Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT.

Compliance is been triangulated with data submitted to MBRRACE-UK, reports can be accessed via the following link: Perinatal cases (ox.ac.uk)

Deaths that must be reported and eligible for PMRT are:

- late fetal losses: a baby delivered between 22+0- and 23+6-weeks gestational age showing no signs of life, irrespective of when the death occurred.
- stillbirths: a baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.
- neonatal deaths: a liveborn baby (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available), who died before 28 completed days after birth.

Saving babies' lives version three: a care bundle for reducing perinatal mortality
To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

Identification and management of fetal growth restriction (FGR) was a relevant issue

Issues associated with reduced fetal movement (RFM) management

Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor

The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix A.

Perinatal Mortality Review Tool
The aim of the PMRT is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports:

Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.

A structured process of review, learning, reporting and actions to improve future care.

Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided.

Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.

Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable.

Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

At the conclusion of the multidisciplinary review the team agree the grading of care, the categories are as follows:

<u>Prior to the confirmation of the baby's death:</u>

A – The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.

<u>Following the confirmation of the baby's death:</u>

A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother.

Overview of Deaths Reviewed using PMRT
During quarter 4 of 2023/24 (January – March 2024), a total of 4 cases have been reviewed using the Perinatal Morality Review Tool. An overview for each case is provided below.

MBRRACE ID:	**88695**		
Stillbirth/Neonatal Death:	Unspecified Stillbirth	**Date of death:**	31/07/2023
Weeks of gestation:	28+1	**PMRT commenced:**	30/08/2023
PMRT Completed:	22/01/2024	**Grading:**	B,B
Actions:			
Actions relating to issues identified as directly relevant to the death of this baby:	No actions identified as directly relevant to the death of this baby.		
Actions relating to issues identified as not directly relevant to the death of this baby:	No actions identified relating to issues identified as not directly relevant to the death of this baby.		
Cause of death:	Undetermined. Contributory factors: Prematurity Premature pre labour rupture of membranes Possible chorioamnionitis.		

Compliant with CNST standards?	
Notified to MBRRACE-UK within seven working days?	**P**
Surveillance information completed within one month?	**P**
Parents perspectives of care and any questions sought?	**P**
Multi-disciplinary review started within 2 months?	**x**
Multi-disciplinary review completed to the draft report stage within four months?	**x**
Multi-disciplinary review published within six months?	**P**

If non-compliance declared, please specify the reason:

Communication issue with outside trust involved in care needs. Surveillance was assigned to another trust for completion as they provided the mother's antenatal care. An email was sent asking them to also complete the factual questions, which they agreed to do; however this was never completed.

Although an MDT meeting was planned within the four-month deadline period, this had to be cancelled as there was no representation from the outside trust. The meeting was rescheduled, and the representative attended, therefore the case was closed on the 22/01/2024.

Reported as part of MIS year 5 submission, mitigation submitted and accepted by NHS Resolution.

MBRRACE ID:	90049		
Stillbirth/Neonatal Death:	Antepartum stillbirth	**Date of death:**	27/10/2023
Weeks of gestation:	24+5	**PMRT commenced:**	21/11/2023
PMRT Completed:	05/02/2024	**Grading:**	B, B
Actions:			
Actions relating to issues identified as directly relevant to the death of this baby:	No actions identified as directly relevant to the death of this baby.		
Actions relating to issues identified as not directly relevant to the death of this baby:	**This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements.** Action: Reminder to be sent to all staff on the PMRT newsletter to remind staff about providing written documentation. **At first presentation with reduced fetal movements this mother was not appropriately risk assessed.** Action: Education on how to complete the new triage paperwork (including discussion on study day). Discussion with the individual midwife. **This mother's risk status was not assessed during the course of her labour.** Action: Reminder to be sent to all staff on the PMRT newsletter regarding undertaking risk assessments in labour. **Although indicated this mother was not offered a coagulation screen and fibrinogen for DIC and repeated as appropriate.** Action: Reminder to all staff on the PMRT newsletter regarding following the cherish pathway pro forma for investigations.		
Cause of death:	Undetermined. **Contributory factors:** Global fetal vascular malperfusion of high grade. **Other post-mortem findings included:** The costochondral junction of the rib was unusual - the growth plate was not linear, which may be suggestive of maternal vitamin D deficiency. There was a subchorionic haematoma (minor) and marginal haematoma. Fetal squames were present in lungs suggestive of stress in utero. Organs topographically and morphologically normal.		

Compliant with CNST standards?	
Notified to MBRRACE-UK within seven working days?	**P**
Surveillance information completed within one month?	**P**
Parents perspectives of care and any questions sought?	**P**
Multi-disciplinary review started within 2 months?	**P**
Multi-disciplinary review completed to the draft report stage within four months?	**P**
Multi-disciplinary review published within six months?	**P**

MBRRACE ID:	**90251**		
Stillbirth/Neonatal Death:	Unspecified stillbirth	**Date of death:**	05/11/2023
Weeks of gestation:	unknown	**PMRT commenced:**	29/11/2023
PMRT Completed:	09/02/2024	**Grading:**	B, B
Actions:			
Actions relating to issues identified as directly relevant to the death of this baby:	No actions identified as directly relevant to the death of this baby.		
Actions relating to issues identified as not directly relevant to the death of this baby:	**Although indicated, this mother was not offered a Kleihauer test.** Action: For inclusion on the PMRT newsletter. **This mother only had partial investigations for underlying metabolic and/or haematological abnormalities as per the local but not national guideline – why does the local not meet the national guideline?** Action: To update the cherish pathway to include the HbA1c checklist. **It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home.** Action: For inclusion on the mandatory study day regarding fully completing the cherish pathway. **A completed bereavement checklist was not in the notes.** Action: For inclusion on the mandatory study day regarding fully completing the cherish pathway. **This mother was un-booked at delivery. Are there any organisational issues to consider in relation to her not booking?** Action: For escalation to the ED governance lead for training purposes.		
Cause of death:	Undetermined. **Contributory factor**: Acute chorioamnionitis.		

Compliant with CNST standards?	
Notified to MBRRACE-UK within seven working days?	**P**
Surveillance information completed within one month?	**P**
Parents perspectives of care and any questions sought?	**P**
Multi-disciplinary review started within 2 months?	**P**
Multi-disciplinary review completed to the draft report stage within four months?	**P**
Multi-disciplinary review published within six months?	**P**

MBRRACE ID:	90521		
Stillbirth/Neonatal Death:	Neonatal death	**Date of death:**	23/11/2023
Weeks of gestation:	37+3	**PMRT commenced:**	12/12/2023
PMRT Completed:	22/03/2024	**Grading:**	B, B
Actions:			
Actions relating to issues identified as directly relevant to the death of this baby:	**No actions identified as directly relevant to the death of this baby**		
Actions relating to issues identified as not directly relevant to the death of this baby:	**NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened.** Action: PMRT newsletter to remind staff to carry out CO monitoring at booking. **This mother was not assessed for the need for aspirin.** Action: PMRT newsletter to remind staff to assess mothers for aspirin. **This mother had a risk factor for having a growth restricted baby but serial scans were not performed at the correct times/intervals.** Action: To be included on the PMRT newsletter to remind staff that when fetal growth restriction is identified on the scan, time intervals between the scan should be more frequent than 4 weekly. **Estimated fetal weights from scans had not been plotted on a chart.** Action: To be included on the PMRT newsletter to remind staff that when fetal growth restriction is identified on the scan, time intervals between the scan should be more frequent than 4 weekly. **There were concerns about the baby's growth rate, but these were not investigated and acted upon appropriately.** Action: To be included on the PMRT newsletter to remind staff that when fetal growth restriction is identified on the scan, time intervals between the scan should be more frequent than 4 weekly. **The baby was small for gestational age at birth and had been identified as IUGR prenatally, but the management was not appropriate.** Action: To be included on the PMRT newsletter to remind staff that when fetal growth restriction is identified on the scan, time intervals between the scan should be more frequent than 4 weekly. **This mother had a growth restricted baby during her pregnancy which was not managed according to the national or local guidelines.** Action: To be included on the PMRT newsletter to remind staff that when fetal growth restriction is identified on the scan, time intervals between the scan should be more frequent than 4 weekly. **During this mother's maternal observations, commensurate with her level of risk and national guidelines, were not carried out.** Action: To be included on the PMRT newsletter to remind staff of the importance of ongoing maternal observations in labour.		

	This mothers progress in labour was monitored on a partogram but the partogram was only partially completed. Action: PMRT newsletter to remind staff to fully complete the partogram with observations, fetal heart, and contractions.
Cause of death:	Bilateral Renal Agenesis; Lung Hypoplasia.

Compliant with CNST standards?	
Notified to MBRRACE-UK within seven working days?	**P**
Surveillance information completed within one month?	**P**
Parents perspectives of care and any questions sought?	**P**
Multi-disciplinary review started within 2 months?	**P**
Multi-disciplinary review completed to the draft report stage within four months?	**P**
Multi-disciplinary review published within six months?	**P**

Conclusion
During Q4 the multidisciplinary team completed the perinatal mortality review tool to review 4 eligible deaths. This included 2 unspecified stillbirths, 1 neonatal death and 2 antepartum stillbirths.

0 cases met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI).

The required CNST standards were met in 3 of the 4 cases reviewed. Non-compliance was declared for standard c in case 8895 as the MDT reviewed was delayed due to representative issues from the outside trust, impacting the timeliness of the MDT review meeting taking place. This case was declared as part of the MIS year 5 submission with a request for mitigating circumstances to be considered.

No themes were identified during quarter 4.

Appendix A: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q1	Q2	Q3	Q4	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/1 (0%)	0/5 (0%)	1/9 (11%)	1/4 (25%)	**2/19 (11%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/1 (0%)	1/5 (20%)	0/9 (0%)	1/4 (25%)	**2/19 (11%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/1 (0%)	0/5 (0%)	0/9 (0%)	0/4 (0%)	**0/19 (0%)**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/1 (0%)	0/5 (0%)	0/9 (0%)	0/4 (0%)	**0/19 (0%)**

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

Yvonne McGrath
Group Director of Midwifery
September 2024

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

1. Background

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

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

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

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

2. Birthrate Plus Workforce Planning

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

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

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

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

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

3. Results

Birthrate Plus Results 2021	Total WTE Current Funded	Recommended Birthrate Plus Clinical wte	Variance wte	Current Budget
DPOW	99.14	93.72	5.42	?
SGH	73.00	73.30	-0.30	?
Additional Specialist and Management wte	15.80	18.37	-2.57	?
Total clinical, specialist and management wte	**187.94**	**185.39**	**2.55**	?

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

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

4. Specialist Midwives

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

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

5. Current Midwifery staffing Issues and Risks

Recruitment and retention progress

Our current budget for all midwives is 187.94 WTE. Only a small proportion of our workforce work full time. We have two Band 5/6 midwives starting in July and nine newly qualified (Band 5) midwives joining the Trust in October.

Attrition

Between February and May 2024 only two midwives left (retirements). Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed.

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

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

Maternity Leave position

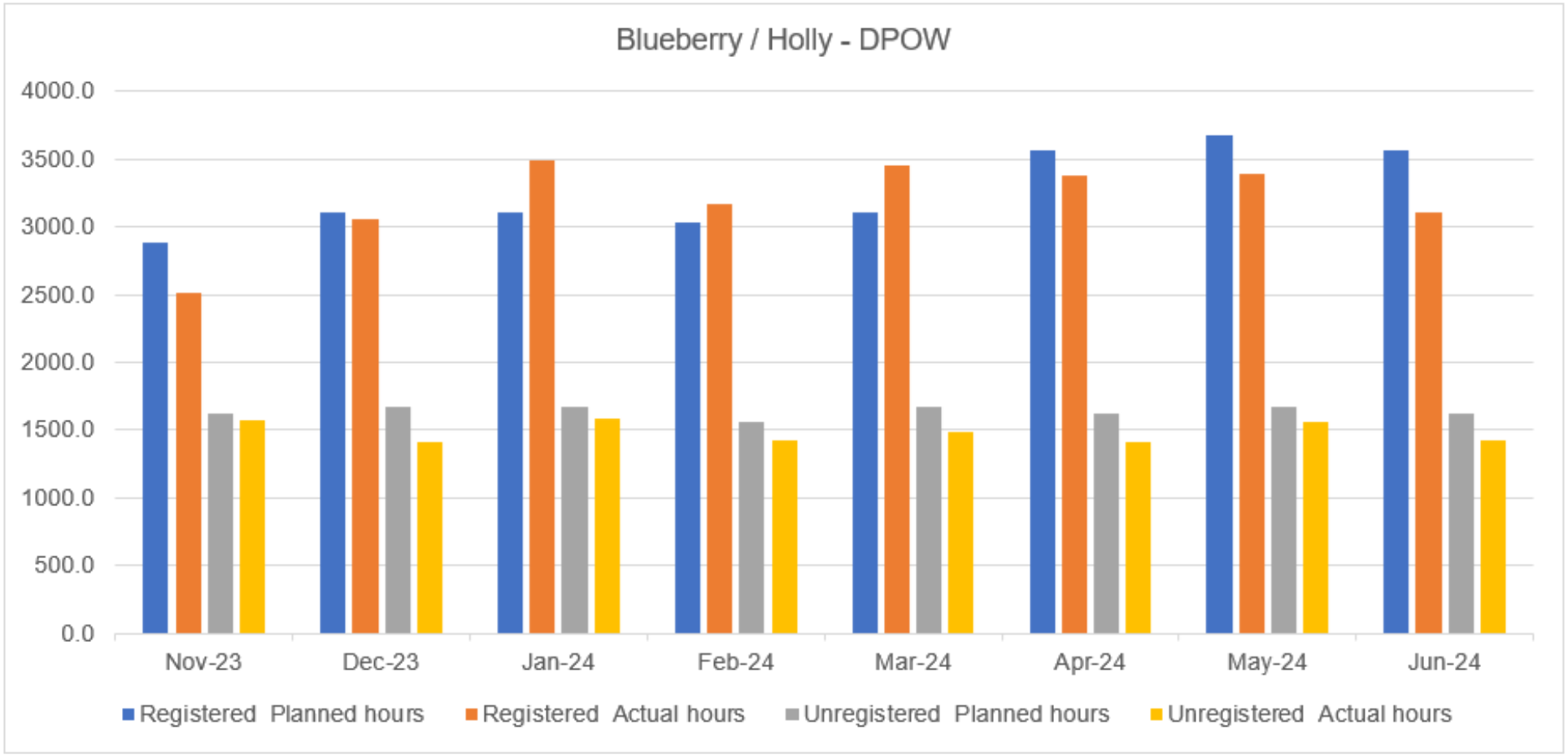
In June 2024 the maternity leave rate was at 2.36% of our whole midwifery workforce.

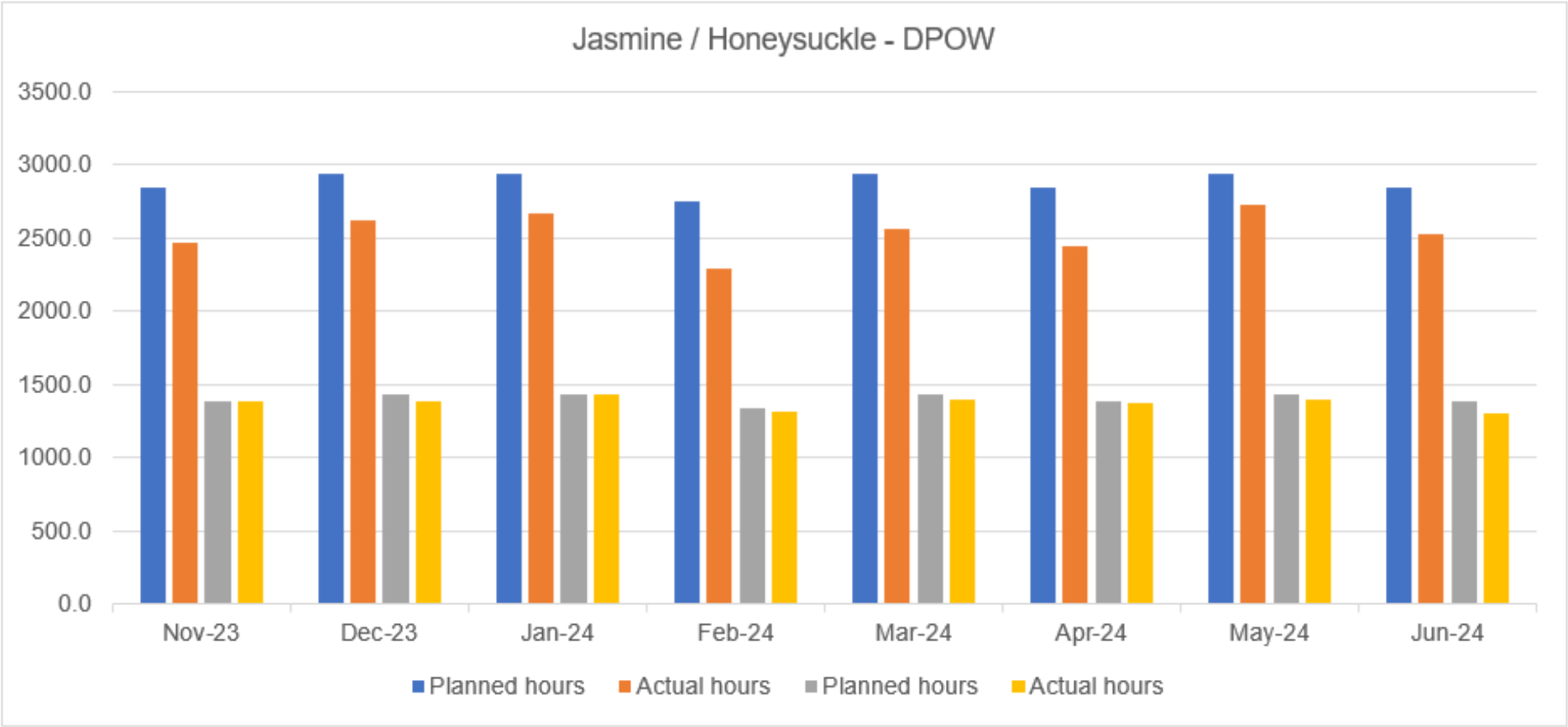
Sickness absence rates November 2023 to June 2024:

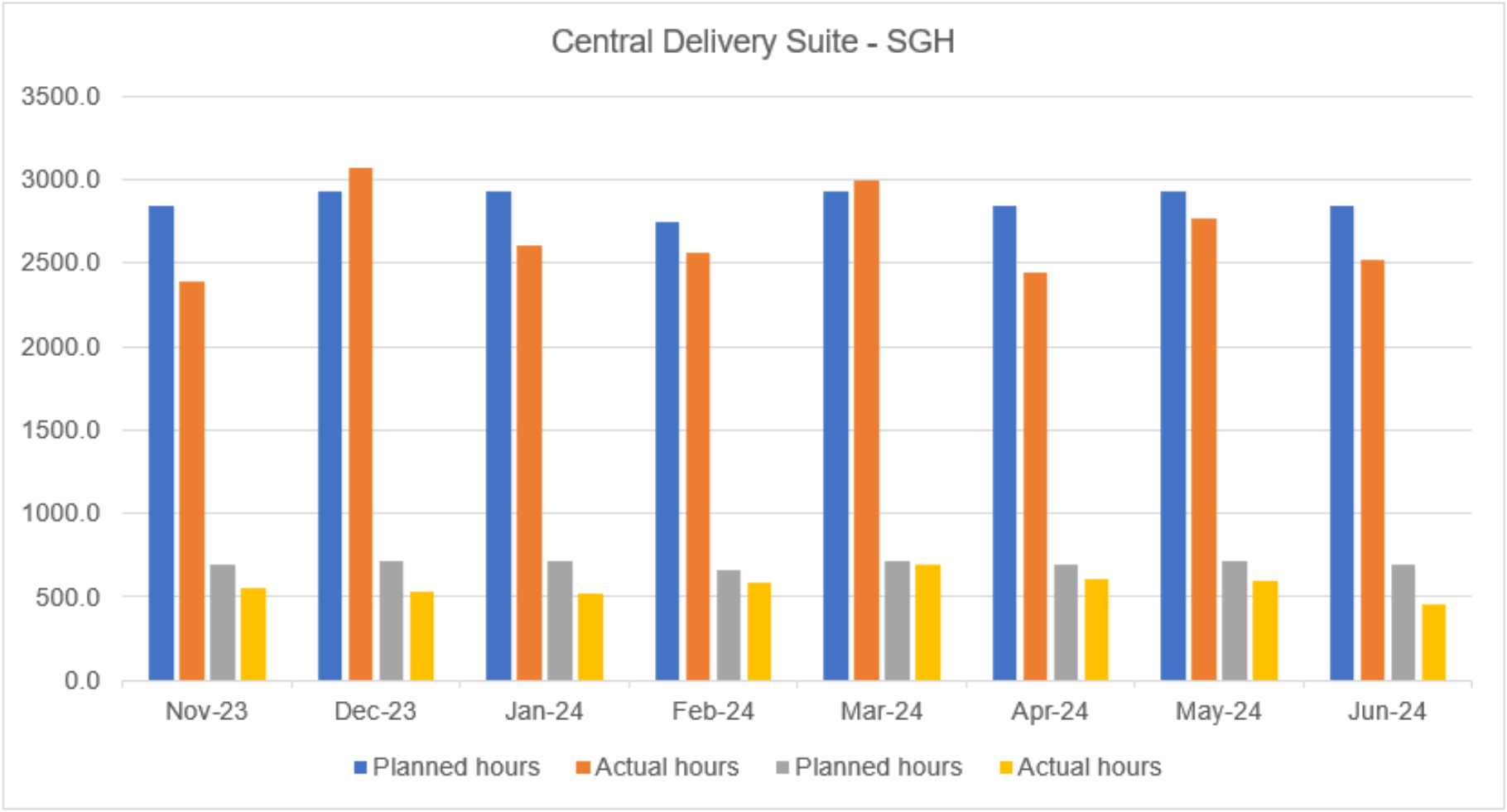
Sickness levels for Nursing and Midwifery Registered staff (short-term and long-term) are slowly declining:

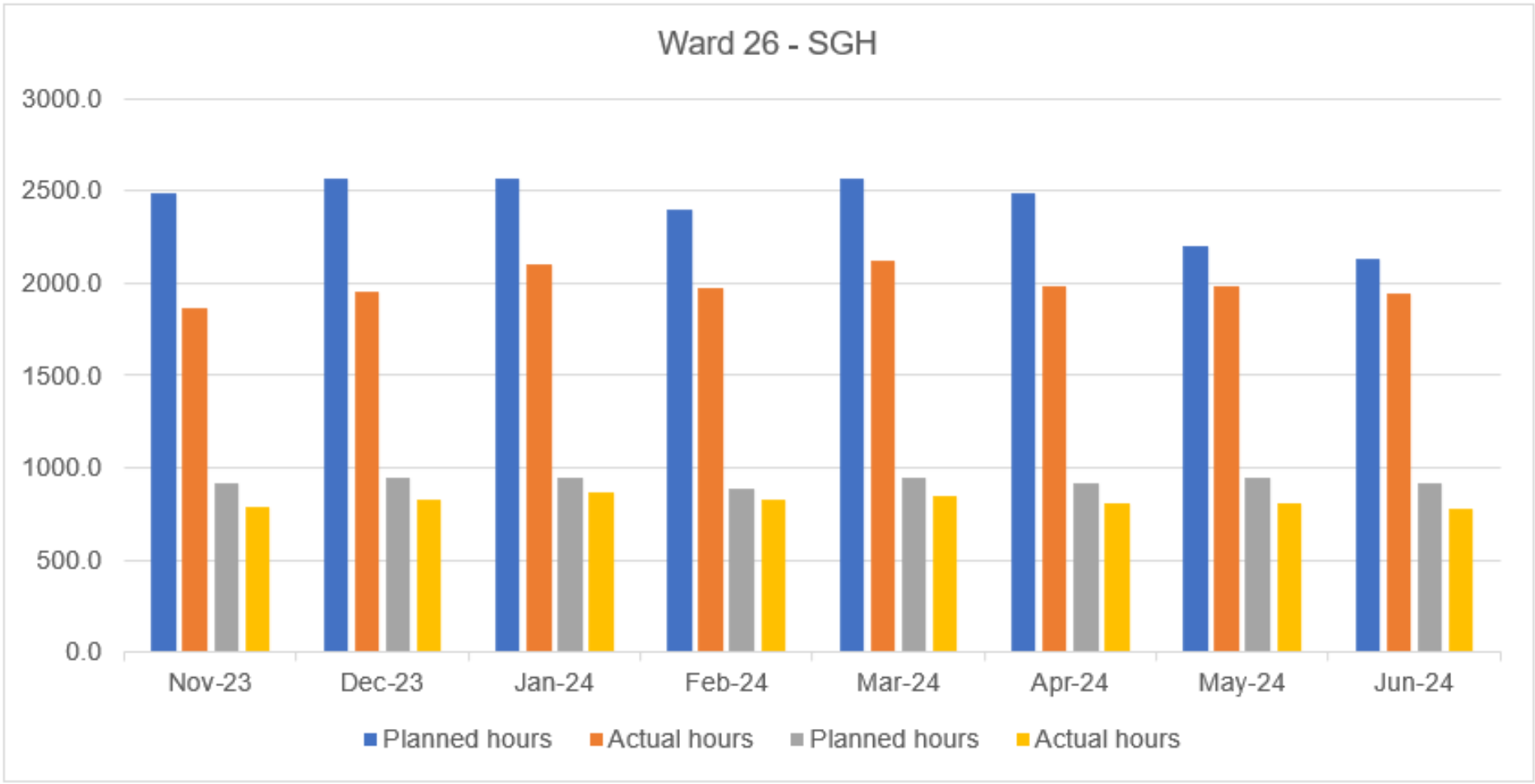
Month	November 23	December 23	January 24	February 24	March 24	April 24	May 24	June 24
% of all midwives	6.82%	7.05%	8.62%	7.10%	6.38%	6.85%	5.14%	6.30%

6. Planned Versus Actual Midwifery Staffing Levels (Inpatient Areas)


Blueberry / Holly - DPOW
4000.0
3500.0
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Jasmine / Honeysuckle - DPOW
3500.0
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Planned hours
Actual hours
Planned hours
Actual hours


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



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

7. Birth Rate Plus Acuity Tool

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

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

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

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

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

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

Supernumerary Labour Ward Co-ordinator

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

The following chart outlines the compliance by month:

There have been 0 recorded incidents in these 8 months where the labour ward co-ordinator is not supernumerary.

8. One to One in Established Labour

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

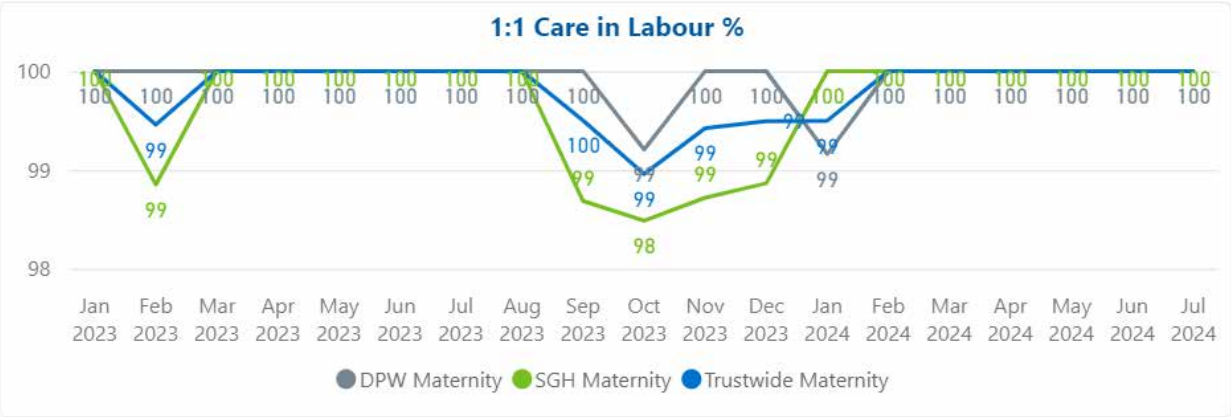
If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

	Number of days per month	Number of shifts per month	Compliance
November 23	30	60	100%
December 23	31	62	100%
January 24	30	60	100%

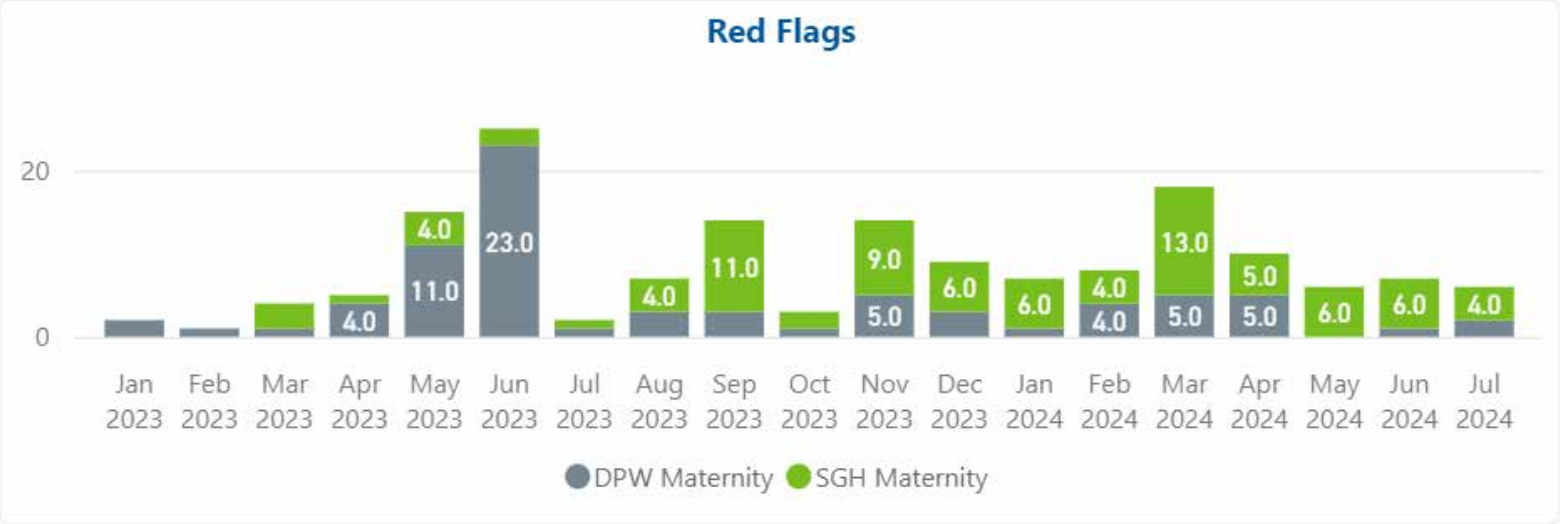
February 24	31	62	100%
March 24	31	62	100%
April 24	29	58	100%
May 24	31	62	100%
June 24	30	60	100%

There have been 0 recorded incidents in these 8 months where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour. However, it should be noted that 1:1 care in labour figures may be reported less than 100% due to inputting errors onto CMIS This is exampled in the chart below as per Power BI reporting. A prospective audit is undertaken and reported by the Maternity Matrons on the Maternity Audit Dashboard. Figures of compliance demonstrate a rate of 100% over the last 8 months.



Red Flag Incidents

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



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

Trustwide Maternity Dashboard

Indicator	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
Midwife to Birth Ratio	20.8 ↘	21.8 ↗		19.6				
Red Flags	14.0 ↗	9.0 ↘	7.0 ↘	8.0 ↗	18.0 ↗	10.0 ↘	6.0 ↘	7.0 ↗
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	3.0 ↗	1.0 ↘	1.0	1.0	3.0 ↗	2.0 ↘	1.0 ↘	0.0 ↘
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	2.0 ↗	2.0	1.0 ↘	3.0 ↗	2.0 ↘	2.0	3.0 ↗	0.0 ↘
(c) Missed medication during an admission to hospital	0.0	1.0 ↗	0.0 ↘	0.0	2.0 ↗	0.0 ↘	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	1.0 ↗	1.0	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	6.0 ↗
(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
(g) Delay of 2 hours or more between admission for induction and beginning of process	0.0 ↘	1.0 ↗	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	0.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	1.0 ↗	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	1.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘	0.0
(j) Community staff have been called in to work on the unit.	8.0 ↗	3.0 ↘	5.0 ↗	2.0 ↘	7.0 ↗	1.0 ↘	2.0 ↗	1.0 ↘
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
Actual v Planned Staffing %	98.5 ↗	94.3 ↘	96.9 ↗	101.0 ↗				
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1:1 Care in Labour %	99.4 ↗	99.5 ↗	99.5 ↗	100.0 ↗	100.0	100.0	100.0	100.0
Vacancies	29.4 ↗	28.4 ↘	22.8 ↘	22.5 ↘	21.1 ↘	26.1 ↗	25.6 ↘	26.1 ↗
Vacancies - Registered	23.0 ↘	22.4 ↘	16.9 ↘	16.9 ↗	17.8 ↗	16.5 ↘	15.2 ↘	17.0 ↗
Vacancies - Unregistered	6.4 ↗	5.9 ↘	5.9 ↘	5.5 ↘	3.3 ↘	9.6 ↗	10.4 ↗	9.1 ↘
Serious Incidents	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Complaints	1.0 ↗	0.0 ↘	2.0 ↗	2.0	2.0	2.0	1.0 ↘	1.0
PALS	3.0 ↘	3.0	6.0 ↗	2.0 ↘	8.0 ↗	4.0 ↘	5.0 ↗	4.0 ↘
Sickness Absence (Division) %	5.4 ↘	5.7 ↗	5.7 ↘	4.8 ↘	4.6 ↘	5.0 ↗	5.0 ↗	5.1 ↗

9. Recommendations

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

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

Maternity & Neonatal Safety Assurance Report- Hull University Teaching Hospitals

Yvonne McGrath

August 2024

Contents

Contents

Item 1: Executive Summary

The Maternity & Neonatal Safety Assurance Report for Hull University Teaching Hospitals (HUTH) outlines the ongoing efforts and progress made in improving the safety and quality of maternity and neonatal services. The report highlights key initiatives, including the planned development of a comprehensive Maternity and Neonatal Safety Improvement Plan (MatNeoSip), participation in the Maternity Safety Support Programme, and compliance with the CNST Maternity Incentive Scheme's 10 Steps to Safety.

The report also details a recent review of neonatal critical care services, identifying both areas of good practice and potential risks, such as the lack of out-of-hours neonatal surgical services and delays in neonatal follow-up appointments. Staffing issues persist, with a 7.8% vacancy rate for midwives, although efforts to recruit and retain staff are ongoing.

The report emphasizes the importance of continued vigilance and improvement, with a focus on listening to both staff and service users to drive further enhancements in safety and care quality.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

Plans are developing to devise an overarching Maternity and Neonatal Safety Improvement Plan that will encompass actions and improvements driven by both local and national drivers. First actions will include the following:

Review of Three Year Delivery Plan for maternity and neonatal services recommendations and action plans
Review of ongoing Quality Improvement and Service Transformation projects and eventually the development of a Maternity & Neonatal Quality Improvement library to capture all projects.
Review of Ockendon actions
Workshop planned for September to agree co-production strategies and management of action plans with Maternity & Neonatal Voices Partnership

2.2 Maternity Safety Support Programme

Draft Diagnostic Report received in June. Exit criteria from the MSSP will be agreed once report finalised.
Concerns raised about bereaved mothers not receiving 1:1 care in labour. Immediate action for this to be monitored as a red flag. It is noted that there are low numbers of DATIX submitted regarding red flags and it is proposed that HUTH adopt the NLAG trigger list to aid submission. Utilising the bereavement team in hours to support 1:1 care has also been discussed.
Terms of Reference for review of Community Services Pan-group are currently being agreed.

2.3 CNST MIS Year 6: 10 Steps to Safety

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					N/A
2 Maternity Services Data Set (MSDS)					Due to the implementation of BadgerNet there has been a risk raised by the digital team regarding the data quality of the external submission for MSDS. The LMNS on the Trust's behalf wrote to NHS Resolution 22 April to explain the concerns with the data quality when implementing BadgerNet. Following discussion with NHSR and Digital colleagues a decision has been taking to manually input data to correct the issues with CQUIM compliance.
3 Transitional Care Services					N/A
4 Clinical Workforce Planning					N/A
5 Midwifery Workforce Planning					Issues identified with daily co-ordinator supernumerary status. Midwifery funded establishment does not match BR+ recommendations
6 SBLCB V3					Quality improvement work continues to address areas of non-compliance. Progress made throughout quarter 4 2023/24.
7 Service User Feedback / Co-produced Services					Evidence is to be provided by the LMNS on the NHS Futures Platform. They have advised they will start this in due course.
8 Training					Compliance <90% for certain staff groups. Trajectory indicates targets will be met by 30th November 2024. Recovery plan in place.
9 Floor to Board					Safety champion arrangements to be agreed. Culture improvement work continues to be undertaken.
10 MNSI / Early Notification Scheme					N/A
Total	**1**	**4**	**5**	**0**	

2.4 Saving Babies Lives Care Bundle (v3)

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24
Assurance review date	13 October 2023	18 December 2023	19 March 2024	10 June 2024
Element 1: Smoking in pregnancy	30%	40%	50%	60%
Element 2: Fetal growth restriction	45%	50%	90%	95%
Element 3: Reduced fetal movements	0%	50%	50%	50%
Element 4: Fetal monitoring in labour	0%	20%	20%	20%
Element 5: Preterm birth	41%	48%	67%	70%
Element 6: Diabetes	17%	17%	83%	83%
TOTAL	34%	43%	69%	73%

Following peer validation of evidence submitted for quarter 4 2023/24 by the LMNS, the overall compliance against all six elements was 73%. Where Elements 3 and 4 remain at 50% and 20%, it was acknowledged that progress has been made on updating guidance and establishing the audits needed to meet the requirements within each of those elements. A discussion highlighted that engagement with the Digital Midwife and monitoring of the transition to BadgerNet is required to ensure data retrieved from the system can be relied upon for audit data accuracy.

Submission of quarter 1 2024/25 data is on target for the September 2024 deadline.

2.5 Perinatal Quality Surveillance Model

Hull Royal Infirmary

CQC Maternity Ratings	Safe	Well Led	Overall
HRI	Inadequate	Inadequate	Inadequate

Data measure	June 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	8 eligible perinatal deaths in Q1. Key points for Learning from PMRT are: Sepsis pathway started but not completed Induction of labour was not performed in a timely manor Smoking cessation referrals were not completed Routine enquiry not asked at every contact The mother's risk status was not assessed at the onset / during the course of labour Pre-term perinatal optimisation not sufficient Reduced fetal movements guideline not followed
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	N/A
Findings of review of all cases eligible for referral to MNSI	N/A
Number of incidents graded as moderate or above and what action is being taken	4 Action taken: Initial Incident Reponse, After Action Reviews, PMRT, ATAIN reviews
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	To be collated
Service User Voice feedback	Please refer to body of report
Staff feedback from frontline champions and walk-abouts	

MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	Yes
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 10	Please refer to body of report

2.6 Maternity and Neonatal Dashboard

Date Metric name	01/01/24	01/02/24	01/03/24	01/04/24	01/05/24	01/06/24	01/07/24
Number of Births per month	405	385	402	376	400	372	385
Number of Bookings per month	488	421	425	465	462	422	425
Booking before 10 weeks	88.0%	69.9%	71.3%	73.3%	85.0%	77.9%	79.4%
Booking over 12 weeks	12.0%	12.5%	11.3%	7.8%	0.5%	3.0%	2.0%
Caesarean Section	40.1%	44.0%	40.3%	45.7%	47.0%	45.2%	50.5%
Elective Caesarean Section (grade3 +4)	19.4%	21.4%	19.4%	18.6%	20.8%	16.7%	28.6%
Emergency Caesarean Section (grade 1 +2)	20.7%	23.0%	20.2%	27.2%	26.3%	28.5%	21.0%
knife to skin outside criteria							
Instrumental Birth	6.5%	50.0%	7.5%	5.3%	7.8%	5.9%	33.0%
Normal Birth		56.0%	49.5%	49.2%	46.5%	49.7%	44.5%
BBA	0	2	5	5	3	4	7
Home Birth	0.7%	0.5%	1.8%	1.3%	0.3%	0.3%	0.3%
Induction of Labour	27.2%	29.4%	28.6%	37.8%	37.7%	35.5%	34.5%
Epidural	33.0%	32.0%	48.5%	47.1%	67.8%	64.0%	73.7%

Work continues to develop the dashboard and updates will be shared in future meetings.

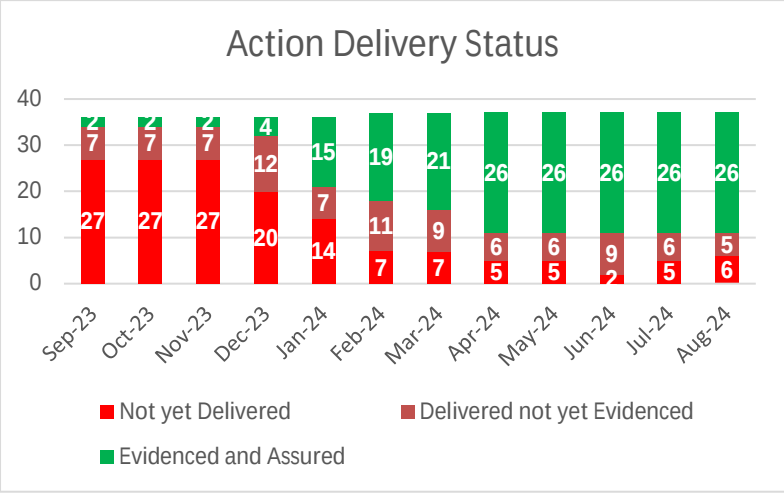
Item 3: In month developments and updates

3.1 CQC/Section 31

The purpose of this section is to demonstrate the status of CQC action plans for Maternity services at HUTH, illustrating progression and risks to delivery of the CQC compliance improvement plans across the Group. This plan follows the CQC Maternity inspection in March and April 2023.

The Group Chief Nurse undertook and assurance review of all open CQC action plans within the Core Services. The Maternity CQC action plan was reviewed with the Group Chief Nurse, Director of Midwifery, Director of Quality Governance, Associate Director of Quality Governance as well as the Head of Compliance. As part of this review, it was agreed to remove the use of the Reverse Rag Rating and implement to revised BRAG rating status and action plan template.

For the eleven actions against the CQC plan that remain not fully complete, revised delivery dates were discussed at the most recent delivery group that were considered deliverable. These range between September 2024 (for those remaining actions not requiring additional investment in staff) to December 2024 where additional investment is required to be secured to embed the progress made (e.g., triage) on a sustainable basis without utilising budgeted establishment across other areas. December 2024 delivery would require an imminent decision on priority areas of funding, ahead of revised Birthrate+ assessments.



3.2 Maternity updates

Head of Midwifery appointed- expected start date November 2024
Triage task & finish group ongoing
ATAIN Quality Improvement Project launch event occurred on the 8th of August and project plans will emerge from this.
Ongoing work to deliver the RSV vaccine
Listening event held with Maternity Safety Champion and Non-Executive Director Sue Liburd in view to concerns raised by Maternity Support Workers at August board and several actions have been generated.

3.2 Growth Scan Review audit

To provide assurance that growth ultrasound scans are being appropriately reviewed and action a 'snapshot' was undertaken. All reviewed appropriately with the exception of one scan that was reviewed by a Doctor and could have had a midwifery review.

Scan Concern	Reviewed by	Medical review required	Was the plan appropriate	Did the plan follow the SOP ? (If appropriate)
Previous scan crossed centile. Normal scan and features today	Consultant	Yes - external factors not relating to scan	Yes	N/A
Growth below the 10th centile at 38/40	Midwife	Yes and completed by consultant	Yes	Yes obstetric review completed
Growth above the 90th centile at 31/40	Midwife	No	Yes	Yes able to be reviewed by midwife and plan implemented

DCDA twins, growth below the 3rd and 10th cenitle abnormal PI's, polyhydraminos MCAD normal	Midwife	Yes and completed by specialist F/M consultant	Yes	N/A
Growth above the 90th centile and Breech.	Registar	No required but completed by Registrar	Yes	No, scan could have been reviewd by Midwife
DCDA twins, slowed growth of both and growth below the 3rd for T2, polyhydraminos T1	Midwife	Yes and completed by specialist Twin consultant	Yes	N/A
Growth below the 10th centile at 36/40	Midwife	No	Yes	Yes reviewed and plan implemented by midwife.
Growth below the 10th centile at 32/40	Midwife	No	Yes	Yes reviewed and plan implemented by midwife.
Polyhydraminos at 31/40	Midwife	No	Yes	Yes reviewed and plan implemented by midwife.
Growth above the 90th centile at 32/40	Midwife	No	Yes	Yes reviewed and plan implemented by midwife.

3.3 Neonatal updates

Neonatal Critical Care-Summary of outcomes following a quality compliance review

Introduction
Over recent months the Yorkshire and Humber (YH) senior management team (SMT) and the YH neonatal operational delivery network (ODN) has seen an increasing number of issues in the delivery of neonatal services, specifically neonatal intensive care units (NICUs). Whilst at this stage this is not of sufficient concern, the specialised commissioning quality team has been asked to undertake a quality compliance review of the NICUs across the YH region to provide a picture of the respective services and highlight any gaps or challenges that the services are facing.

Methodology
The quality compliance review was collected using an excel spreadsheet containing 33 quality indicators drawn from the neonatal critical care service specification, review of MBRRACE data and input from the YH ODN. Included with the self-declaration was an oversight of collated outcome data, for ease of reference for the teams.

Of the 33 quality indicators, seven were classified as not applicable and did not require compliance, however, were included as a fact finding exercise. It was the intention to capture the opinions of staff members working within neonatal services as to their opinions around why patient outcomes were as reported and to gain a more in-depth wider understanding at service level.

The quality compliance review has been carried out at three of the four NICUs across the YH region namely at Hull University Teaching Hospitals NHS Trust (HuTH), Sheffield Teaching Hospitals NHS Foundation Trust (STH) and Leeds Teaching Hospitals NHS Trust (LTHT). The fourth NICU commissioned in YH is based at Bradford Teaching Hospitals NHS Foundation Trust (BTH), however, has recently undergone an assurance commissioning visit and therefore were excluded from this exercise. Jayne Wilson Quality Manager June 2024

On receipt of the completed excel spreadsheet, the quality team reviewed the self-declaration and made comment where clarity was required. The document was then returned to the service for final completion. On completion of the self-declaration, the service noted themselves compliant with 20 out of the 26 compliance quality indicators and non-compliant against six. Following analysis by the quality team, out of the 26 compliance quality indicators, the service was compliant with 19 with seven non-compliances.
The seven non-compliances are:

- Lack of lead for family centre care and bereavement
- Speech and language therapist not yet in post
- Lack of out of hours surgery
- Bliss baby charter audit not yet completed
- Lack of a research strategy
- Unclear whether patient information is available in different languages
- Core service activity levels not achieved

Good practice
Following review of the self-declaration and supplementary evidence, the quality team has identified the following good practice:

- Robust governance structure and processes
- Neonatal guidelines group, governance, management and oversight
- Embedded non-executive director safety champion

Potential risks
Following review of the non-compliances, the quality team has identified the following potential risks:

- The neonatal surgical centre provision is limited to 9am to 5pm on working days only due to a lack of neonatal anaesthetic provision out of the normal working hours. Babies requiring neonatal specialist surgical care are transferred to another hospital, with transfer facilitated by Embrace. In addition, there is no sustainable plan in place if Embrace are unable to facilitate the transfer. This surgical pathway could potentially impact on the critical management of a surgical neonate during transfer, as well as, on a mothers separation if they are not discharged from the maternity service. The number of neonates transferred out of the unit for surgical care is unknown, however, this will significantly impact on the capacity of the receiving hospital. Furthermore, the transfer of neonates for surgery to a different hospital is significantly impacting on the transfer service and resources required to accompany the neonate for surgery to a different hospital is significantly impacting on the transfer service and resources required to accompany the neonates

There are challenges in neonatal follow up provision with waiting lists for first appointments post discharge, on average, between six and nine months. This is out with NCCR / NNAP recommendations. Issues identified at early age ensure appropriate intervention, therefore this could potentially compromise a babies outcome.

Item 4: Maternity dashboard

Date Metric / name	01/01/24	01/02/24	01/03/24	01/04/24	01/05/24	01/06/24
Number of Births per month	405	385	402	376	400	372
Number of Bookings per month	488	421	425	465	462	422
Booking before 10 weeks	88.0%	69.9%	71.3%	73.3%	85.0%	77.9%
Booking over 12 weeks	12.0%	12.5%	11.3%	7.8%	0.5%	3.0%
Caesarean Section	40.1%	44.0%	40.3%	45.7%	47.0%	45.2%
Elective Caesarean Section (grade3 +4)	19.4%	21.4%	19.4%	18.6%	20.8%	16.7%
Emergency Caesarean Section (grade 1 +2)	20.7%	23.0%	20.2%	27.2%	26.3%	28.5%
knife to skin outside criteria						
Instrumental Birth	6.5%	50.0%	7.5%	5.3%	7.8%	5.9%
Normal Birth		56.0%	49.5%	49.2%	46.5%	49.7%
BBA	0	2	5	5	3	4
Home Birth	0.7%	0.5%	1.8%	1.3%	0.3%	0.3%
Induction of Labour	27.2%	29.4%	28.6%	37.8%	37.7%	35.5%
Epidural	33.0%	32.0%	48.5%	47.1%	67.8%	64.0%

4.1 Training compliance

HUTH are on track to achieve the 90% compliance for MIS year six, all managers are informed of any non-attendance and staff cannot be cancelled without the Medical Director being informed (at HUTH).

Safety action 9 (SA8) identifies that 90% attendance in each relevant staff group should attend:

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

NOTE: This is an annual rolling total and 90% must be achieved by 30th of November 2024. Current performance is based on all staff compliance. However, following guidance from NHS Resolution those on maternity leave or long term sickness will be excluded from the denominator of the calculation. This will be reflected in August reporting.

Obstetric medical staff	86%
Midwives	89%
TOTAL	**88%**

PROMPT – JULY 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.	
Staff Group	**HUTHT**
Obstetric medical staff	82%
Midwives & Midwifery Support Workers	88%
Anaesthetic consultant	88%
TOTAL	**86%**

Neonatal Resuscitation – JULY 2024	
Staff Group	**HUTHT**
Neonatal/paediatric medical staff	69%
Neonatal nursing staff / senior nurses	80%
Advanced neonatal nurse practitioners	50%
Midwives	87%
TOTAL	**72%**

Item 5: Learning lessons

5.1 Maternity & Newborn Safety Investigation cases (ongoing)

MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
MI-036865	Yes	Yes	Yes	Family Factual Accuracy Check

5.2 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
W314616- IUD at 38+5 while awaiting IOL for reduced fetal movements.	Obstetric	Fatal	Referred to MNSI (21/08/2024), Verbal DOC completed. For WPSS and MIRM review and PMRT process.
W313915- IUD at 34+1 attended with first episode of RFMs	Obstetric	Severe Harm	DOC completed. For WPSS and MIRM review and PMRT process.
W311944- Bladder injury at Cat 1 Caesarean Section for abruption. Superficial bladder injury repaired by Obstetrician. Urology attended, no harm, follow-up in place.	Obstetric	Moderate	Reviewed at WPSS- appropriate consent provided, appropriate escalation and care given. DoC completed. No further action required.
W331030—Limited sensation to pass urine following forceps and multiple failed TWOCs.	Obstetric	Moderate	For AAR to be completed. Arrangements ongoing.
W311884- Term skull fracture following unassisted vaginal delivery.	Obstetric/Neonatal	Moderate	Reviewed at WPSS- no intrapartum concerns. Rare complication. Baby recovering well. DoC completed.
W311846-21+5 NVD born alive following MTOP	Obstetric	Moderate	Reviewed at WPSS- Mbrrace notification completed. No further action required. DoC completed.

Item 6: Workforce

6.1 Midwifery Workforce-Vacancy

	Midwives
HRI	15.4 WTE 7.8%

15.4 WTE vacancy rate including maternity leave and long-term sickness; over the next quarter several midwives return from maternity leave and 20.12 WTE newly qualified midwives will commence at the Trust in September, however as the triage service remains unfunded and draws on existing established and newly qualified midwives will be supernumerary until November, there will continue to be significant staffing deficits.

6.2 Clinical Leadership

Interviews for clinical leadership roles, (Clinical Directors and Clinical Leads) occurred on the 16th of August 2024, a Clinical Director for Neonates, pan-group was successfully appointed, unfortunately there were no applicants for Clinical Director for Maternity, (Pan-Group) and this is a significant risk for maternity services. The Quad is considering options to address this significant gap. Clinical Leads for Neonates and Maternity on the South Bank have been successfully appointed. Further interviews will occur at the beginning of September prior to the appointment of a North Bank Clinical Lead for Neonates.

Item 7: Triangulation of Themes

7.1 Triangulation of Claims Scorecard Q1 2024/25

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9)

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

NHS Humber Health Partnership

Claims Scorecard April 2012 – June 2023 (87 claims)

Top injuries by volume:	Top injuries by value:
Stillborn Cardiac arrest Bowel damage / dysfunction Admission / unnecessary operation(s) Fatality	Cerebral Palsy Brain damage Developmental delay Hypoxia Not specified
Top causes by volume:	**Top causes by value:**
Failure to recognise a complication Failure / delay in treatment Failure / delay in diagnosis Failure to warn / informed consent Failure to perform tests	Failure / delay in treatment Fall / delay in diagnosis Failure to monitor the first stage of labour Failure to act on abnormal test results

Incidents Q1 24/25

Top 5 incident by volume:

- Term NNU admissions **(23)**
- Post partum haemorrhage (PPH) >1500mls **(8)**
- Transfer out **(8)**
- Missed aspirin **(5)**
- Documentation missing / IT concerns **(5)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **396**

Complaints Q1 24/25

There have been 10 complaints received:

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

All 10 complaints are still open.

Learning Q1 24/25

- Ensure smoking cessation is offered to all Family members
- Ensure CO monitoring is undertaken at ever contact
- Reminder to all staff to use Amnisure when SROM is suspected to aid confirmation
- Ensure women are offered adequate pain relief in labour regardless of the stage of labour
- Escalation of underreporting on DATIX.

Themes Q1 24/25

- Communication and risk assessment
- Clinical assessment
- Guidance and escalation

Action Plan Q1 24/25 Not started | In progress | Complete

Develop guideline for Extreme Preterm SROM antibiotic therapy/repeating steroids pathway	July 2024	
Remind staff that any woman reporting reduced fetal movements in the community should be provided with consistent advice and referred to antenatal triage	June 2024	
Reduced fetal movement to be made available on BadgerNet	June 2024	

Humber Health Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Six

HUTH PROGRESS REPORT

September 2024

Yvonne McGrath – Group Director of Midwifery
Eloise Sims – Maternity Audit and Compliance Manager

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

United by Compassion:
Driving for Excellence

Contents

Executive Summary

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

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

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

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

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

Main concern with safety actions at present is regarding Midwifery Workforce Planning, otherwise the Trust is on target to meet the other safety actions specified in the MIS and have started collating evidence. The table below provides an overview of the current position for each safety action and a brief description of the concerns. Further detail is provided in the body of the report for each safety action.

Safety Action		RAG	Comments / action taken
1	National Perinatal Mortality Review Tool		Q3 and Q4 Board report did not contain the level of detail required for MIS Y6. Further investigation required as limited detail noted in meeting minutes to quantify PMRT discussions.
2	Maternity Services Data Set (MSDS)		The MSDS was disrupted whilst transitioning to BADGERNET. Information has been added retrospectively for births between July-September for the next data submission.
3	Transitional care services		Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements).

Safety Action		RAG	Comments / action taken
4	Clinical Workforce Planning		Action plans in place where not compliant with neonatal workforce.
5	Midwifery Workforce Planning		Maternity Budget does not reflect the staffing recommendations from BirthRate +, and no documentary evidence of an agreed plan. Red flag data for coordinator supernumerary status and 1:1 care in labour.
6	Saving Babies' Lives Care Bundle v3		Following peer validation of evidence submitted for Q2 2024/25 by the LMNS, with an overall compliance of 74% for all 6 elements. Re-submission of two audits 27/09. Theming and trending to be undertaken.
7	Listen to women, parents and families		Evidence is to be provided by the LMNS on the NHS Futures Platform. They have advised they will start this in due course.
8	Training Compliance		Fetal monitoring and PROMPT not compliant at present. Emails sent to staff who are not booked onto fetal monitoring before deadline. Awaiting information regarding number staff dated before deadline for PROMPT.
9	Board Assurance		Evidence gathering in progress. Awaiting LMNS to provide evidence on NHS Futures Platform to support submission.
10	MNSI / Early Notification Scheme		To collate evidence of Trust board sight of MNSI and evidence of DOC and families have information regarding the MNSI and NHS Resolution's EN Scheme.

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution **by 12 noon on 3 March 2025** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

  ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

  ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period.

  ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

External Verification Process

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c). NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

National Neonatal Research Database (NNRD), MNSI and NHS Resolution 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 time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Evidence will be scrutinised by the Local Maternity and Neonatal System (LMNS) and will require sign off by the Integrated Care Partnership (ICP) Board following Trust Board approval.

Safety action 1:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 30 November 2024 to the required standard?
Lead: Rebecca Julian

There has been a total of 22 incidents reported to MBRRACE-UK via the PMRT during MIS year six.

Quarter	**Eligible for full CNST assessment**	**Eligible for notification only**	**Total per Quarter**
Q3 (15 Dec – 31 Dec 23)	1	1+2	**2**
Q4 (01 Jan – 31 Mar 24)	2	2+5	**4**
Q1 (01 Apr – 30 Jun 24)	7	2+6	**9**
Q2 (01 Jul – 30 Sept 24)	2	5+5	**7**
Total	**12**	**10+18**	**22**

10 cases were reported to MBRRACE so far in MIS year 6 but were for notification only due to joint case or MNSI cases. 18 cases were reported to MBRRACE so far in MIS year 6 but were for notification only due to termination of pregnancy and therefore not eligible for further measurement against CNST standards or review. 2 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI) during Quarter 2.

The table below provides an overview of current compliance against the standards for the 13 perinatal deaths eligible for scrutiny against CNST standards however it should be noted that due to the time taken to complete the investigation process cases are at different stages with some deadlines not yet met.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**	2/2 (100%)	8/8 (100%)	3/3 (100%)	-	**13/13 (100%)**
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**	2/2 (100%)	8/8 (100%)	3/3 (100%)	-	**13/13 (100%)**
Multi-disciplinary reviews should be started within two months of the death.	**95%**	2/2 (100%)	8/8 (100%)	3 – not yet reviewed but within dates	-	**10/10 (100%)**
Multi-disciplinary reviews should be published within six months of the death.	**60%**	2/2 (100%)	8/8 (100%)	3 – not yet reviewed but within dates	-	**10/10 (100%)**
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted April 2024	Submitted July 2024	Submitted October 2024	-	**3/3 (100%)**

****Update from NHS Resolution June 2024****

Change to the verification period - The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this wasn't announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

Monitoring and Reporting

The Perinatal Mortality Review Tool (PMRT) and process is embedded. MBRRACE-UK provide a CNST MIS year six summary report to allow live monitoring of compliance and approaching deadlines. Compliance is monitored by the MIS Year 6 Delivery Group on a weekly basis.

Separate quarterly PMRT reports are produced, detailing the findings of each review and subsequent actions taken to address any concerns identified and share learning.

Quarter 2 (24/25) PMRT report will be reported to Trust Board in October 2024. The following key themes identified were:

Induction of labour was not performed in a timely manor
The mother's risk status was not assessed at the onset / during labour
Reduced fetal movements guideline not followed
1 to 1 care not met in labour
Ongoing aspirin accessibility and education issues
DNA policy not followed
Interpreter and/or language line not utilised in pregnancy and labour

Risks: Q3 and Q4 Board report did not contain the level of detail required for MIS Y6 as reporting period between 8th Dec 23 and 30th Nov 24. This has been reformatted to comply with the requirements in Q1 and Q2. Further investigation required as limited detail noted in meeting minutes to quantify PMRT discussions have been held with Trust Maternity Safety & Board level safety champions.

Mitigation: Quarterly PMRT reports to be shared with Trust Board in October 2024.

Safety action 2:
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Lead: Mike Collins

Safety action 2 is focussed on data quality and completeness of the July 2024 submission to MSDS.

1. There is a need for 10 of the 11 Clinical Quality Improvement Metrics (CQIMs) to pass the associated data quality assurance checks criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series to be compliant.

The CQIMs data requirements are:

Babies who were born pre-term, Babies with a first feed of breastmilk,
Proportion of babies born at term with an Apgar score <7 at 5 minutes,
Women who had a postpartum haemorrhage of 1,500ml or more,
Women who were current smokers at booking, Women who were current smokers at delivery,
Women delivering vaginally who had a 3rd or 4th degree tear,
Women who gave birth to a single second baby vaginally ≥37 weeks after a previous caesarean
Caesarean section delivery rate in Robson group 1 women
Caesarean section delivery rate in Robson group 2 women
Caesarean section delivery rate in Robson group 5 women
Babies breastfed at 6-8 weeks
Babies readmitted to hospital <30 days after birth

2. The submissions should have a valid ethnic category recorded for at least 90% of women booked during July 2024.

Current Position: The "Clinical Negligence Scheme for Trusts: Scorecard", reported by NHS England, is published each month and can be accessed via the following link: HUTH Maternity Scorecard.

Due to the transition from Lorenzo to BadgerNet, there has been missing data for CQIMDQ37 and MSDS has been disrupted (see Appendix A). Manual data entry of previous pregnancies onto BadgerNet has been undertaken for the next data submission. NHS Resolutions agreed a second opportunity and later submission due to the identified DQ issues. There has also been discussion regarding requesting an exemption, providing HUTH demonstrate the system will capture the right data in the future. The reporting window for final data for July 2024 was the 30th September 2024 – all reasonable endeavours have been made to be compliant.

Risks: Due to BadgerNet transition, one criterion passed only and not compliant with this safety action in previous months.

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

Standard a requires the Trust to have Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice *Or*

Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.

Current Position: The Trust has a pathway in place and continues to work with the BAPM framework.

The last quarterly Transitional Care report covered Q1 and Q2 2024, with ongoing data surveillance now embedded. The data captures babies between 34+0 to 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemented oxygen was not delivered. See appendix B. Further audit to be completed by lead for Q3.

Standard b states that Trusts should draw on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.

Current Position: Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). A group wide multidisciplinary face to face stakeholder event took place during August 2024 with attendance from the LMNS and MNVP Lead for NNEL. Further work is required to progress the project.

Confirmation of registration has been sent to the LMNS as per the technical guidance requirements. Progress is yet to be shared with the relevant safety champions.

Risks: None identified**.**

Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?
Lead: Uma Rajesh

Obstetric workforce

a)	1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility to undertake short-term locums.
	2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

HuTH Breakdown of compliance

During the audit period 0 locums were used to cover tier 2 or 3 rota shifts in Obstetrics and Gynaecology were covered by 4 locum doctors on a short term basis (<2 weeks). The table below details the split between internal and external locum cover.

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

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

Standard Compliance			
INERNAL - Short term locum staffing (<2 weeks)			
Site	**Currently work in their unit on the tier 2 or 3 rota**	**Have worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)**	**Hold a certificate of eligibility (CEL) to undertake short term locums**
HuTH (n=0)	N/A	N/A	N/A
Achievement: N/A			

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

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

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

Long Term Doctors

There is an SOP for induction of new locums and management team uses an on boarding checklist and departmental induction including shadowing with senior clinicians for the first 2 weeks of the locum post is already embedded in place. The Trust Board and Trust Board level safety champions have been kept updated of the progress to this document via minutes of the MTAC (Maternity Transformation Assurance Committee) meetings and in the Bi-Annual Staffing Reports.

	3. Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. ***While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.***

The service is compliant with RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and the rota coordinators ensure this is built into the rota plans. All Consultant job plans are built in line with this RCOG recommendation and standards and signed off by the RCOG before appointments are made. HUTH have rotas that can display this but are awaiting completion of a Standard Operating Procedure. Following discussion with NHS Future's, no additional SOP would be required for the purposes of MIS alone, however it would be best practice to incorporate reference to how this compliance is maintained into an existing obstetric workforce SOP.

	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. When a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

A snapshot audit was completed and found 100% compliance with consultant attendance. This was sent to QSC for information purposes. A final version will be shared with Trust Board in December.

Anaesthetic medical workforce

b)	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

As per technical guidance, weekly rotas have evidenced the appropriate staffing, compliant with the ACSA standard 1.7.2.1. In January, the bi-annual Staffing report also confirmed 100% compliance.

	May	June	July	August	September	October
% compliance	100%	100%	100%	100%	100%	100%

Neonatal medical workforce

c)	The neonatal unit meets the relevant BAPM national standards of medical staffing. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Current position – compliant with BAPM standards. Please see appendix C for the benchmarking for BAPM standards and the compliance at HUTH as per clinical lead.

Neonatal nursing workforce

d)	The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.

The Trust is not compliant with BAPM national standards. An action plan (appendix D) is in place and has been reviewed with the Nurse Director and Operational Matrons for Family Services Care Group. Further review of the action plan will be undertaken in November 2024 to reflect any further progress made.

<u>Elements of non-compliance:</u>

1. A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS). Due to new recruits in Spring, this dipped to 44.6% (cot side workforce). Training proposal and trajectories included in appendix.

2. No Nurse/Midwife with clinical leadership. Surgical Link Team in place with 1 x Band 6 senior nurse who has completed the specialist surgical course.

3. Neonatal units providing surgical services have at least one nurse/ midwife with neonatal surgical experience who has responsibility for co-ordinating transfer and discharge of babies pre- and post- surgery, liaising with primary and community services, and supporting parents and referring teams.

4. 75% compliant - There should be an appropriately resourced clinical education team to support the training and education requirements of the cot side workforce. This team should consist of Nurse Educators at both band 6 and band 7 and have a WTE resource that provides 1 WTE educator per 50 staff members.

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

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years. HUTH maternity services undertook a full Birthrate Plus (BR+) assessment in 2021 and received the final report in February 2022.There was also a Birthrate Plus Refresh report received in November 2023 which considered the implementation of the new maternity triage. Therefore, these reports remain in date to declare compliance. Midwifery included in Bi-Annual Staffing Report complete in January 2024 and Midwifery specific staffing report written in August 24 resulting in compliance for 5.1 and 5.2.

A Birthrate Plus review is planned for HUTH and to align group processes a request has been made for Birthrate Plus to undertake a review for NLaG.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

Trust Board minutes need to evidence midwifery staffing budget reflects establishment as calculated in the Birthrate Plus report.

Risk: Maternity Budget does not reflect the staffing recommendations from BirthRate+. Addressing the immediate quality and safety risks within Maternity Services and associated Midwifery staffing requirements paper is presented to the board this month (October 2024) and the recommendation that this funding is agreed would ensure that compliance with Maternity Incentive Scheme Year 6 was secured and the paper details the proposed recruitment timeline. The table below reconciles the differences between the Birthrate+ tabletop recommendations and the requested investment in the midwifery staffing requirements paper.

Birthrate+ table top summer 2022 gap	22.35
Additional headroom training requirement not built into Birthrate+ assumption which used 21%	2.98
Matron / Ward management leadership roles not factored into original Birthrate+ table top assumptions	5.5
Additional roles flagged by Three Year Delivery Plan / other national initiative post Birthrate+	7.22
Total	38.05

c) The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

Supernumerary co-ordinator status is reported on the Power BI Maternity Assurance Dashboard/live acuity tool and included in the Maternity and Neonatal Oversight Report to Trust Board. Red flag reports highlight where compliance has not been met.

There were 19 occasions from 1/1/2024 – 31/5/2024 when the labour ward coordinator was not supernumerary and not providing 1:1 care and 5 times when they were not supernumerary but providing 1:1 care.

RF10	Labour Ward Coordinator not supernumerary – Providing 1:1 Care for a woman Anytime when the coordinator is caring for a woman who requires 1:1 care and not able to maintain supernumerary status- the woman may be in labour (Cat I-V) or a high risk AN (A2) or PN (PD1) woman requiring 1:1 care due to her condition.	5	10%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care Any time when the coordinator is caring for a woman & not able to maintain supernumerary status- the women are not in labour & do not required 1:1 care- for example A1,PD2,PN,X.	14	29%

It is noted that the wording of this states ‘at the start of the shift’ and technical guidance states that a coordinator must start each shift with a protected supernumerary status. ‘It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity’ and if there is evidence of local escalation policy and this is not a recurrent daily event, trusts may declare compliance with this standard.

An action plan has been developed, see appendix E.

Risk: Live acuity tool does not state specifically the start of the shift.

Mitigate: Consider evidence of rosters or audit to consider if supernumerary coordinator at start of shift.

d) All women in active labour receive one-to-one midwifery care.

One to one care in labour is reported on the Power BI Maternity Assurance Dashboard and live acuity tool. It has also included in the bi-annual maternity staffing report that was shared with QSC as a sub-committee of the board.

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

	Number of days per month	Number of shifts per month	Compliance
November	30	60	100%
December	31	62	100%
January	31	62	100%
February	29	58	100%
March	31	62	100%
April	30	60	100%

There have been 0 recorded incidents in these 6 months where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

A Bi-annual midwifery, medical and neonatal staffing report was submitted January 2024 followed by a Midwifery Staffing oversight report in August 2024 to QSC as a sub-committee of the board covering the period of November 2023 to June 2024, including a monthly breakdown of midwifery red flags.

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

Following peer validation of evidence submitted for Q2 2024/25 by the LMNS, with an overall compliance of 74% for all 6 elements. Following re-submission of 2 additional audits, this increased to 76%.

Implementation Progress

% of Interventions Fully Implemented (LMNS Validated)

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Review Quarter		Q2 23/24	Q3 23/24	Q4 23/24	Q1 24-25	Q2 24-25
Assurance Review Date		13/10/23	18/12/23	19/03/24	10/06/24	18/09/24
Element 1		30%	40%	50%	60%	70%
Element 2		45%	50%	90%	95%	100%
Element 3		0%	50%	50%	50%	50%
Element 4		0%	20%	20%	20%	40%
Element 5		41%	48%	67%	70%	67%
Element 6		17%	17%	83%	83%	83%
TOTAL		34%	43%	69%	73%	76%

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

However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.

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

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

Evidence of progress against the agreed improvement trajectory was discussed and areas of sustained improvement where high levels of reliability have been achieved were identified. The targets for elements 1, 2 and 6 are on track for March 2025. Quality improvement activity continues for the elements that have not yet reached the target.

Element 3 – Raising awareness of Reduced Fetal Movements

Improvements have been seen in audit results for 3.2 although minimum standards that confirm full implementation are yet to be achieved, therefore progress remains at 50% and is off track against the improvement trajectory for element 3.

There are 4 interventions required for 3.2 so all interventions must be successfully implemented in order to be compliant.

- 3.2a Standards for cCTG monitoring are being maintained. Compliant
- 3.2b Proportion of women who attend with recurrent reduced fetal movements who had an ultrasound scan by the next working day to assess growth. Upward trajectory.
- 3.2c Percentage of stillbirth which had issues associated with reduced fetal movements management identified using PMRT. Compliant
- 3.2d Rate of induction of labour when reduced fetal movement is the only indication before 39 weeks gestation. Audit currently being completed. Action plan created and development of infographic and presentation to doctors.

Element 4 – Effective fetal monitoring in labour

All audits are now in place to enable regular monitoring of standards, analysis of non-compliant cases and action planning. There has been discussion regarding the fetal monitoring team moving to a labour ward office to increase visibility and embed change. Audit results for risk assessment in labour has met minimum standards in both Q4 and Q1 and this intervention is now fully implemented. There has been improved standards in both quarters for interventions 4.3 (hourly reviews) and 4.4 (hourly buddy system), although minimum standards that confirm full implementation are yet to be achieved. Therefore progress is at 40% this quarter which is off track against the improvement trajectory for element 4.

Quarter	Documented Hourly reviews
Q1	64.30
Q4	55%
Q3	50%

Quarter	Documented buddy system
Q1	73.8%
Q4	75%
Q3	46%

Mitigation required to demonstrate best endeavours have been made: To demonstrate direction of travel with run charts. Continue to complete monthly audit and action plan.

Element 5 – Reducing Pre-term birth

HUTH have maintained standards for a number of interventions and have maintained compliance for 3 of the BAPM9 interventions – thermoregulation, VTV and caffeine.

Minimum standards have not been met for 6 of the BAPM9 interventions suggesting that further QI work is required to embed the PeriPrem passport. This has resulted in a slight drop in overall progress for Element 5 which is off track against the improvement trajectory for element 5. It should be acknowledged that element 5 compliance fluctuates due to the circumstances around women presenting in pre-term labour and the small numbers involved.

Pre-term Birth Team

Concerns also raised by the LMNS regarding the lack of a pre-term birth MDT team to address the issues identified. No formal positions within Midwifery and Neonates with agreed job descriptions. Workforce paper has been submitted to the Trust Board and Escalation to MIS Year Six Delivery Group.

Mitigation required to demonstrate best endeavours have been made: Funding to support appointment of a Pre-term Lead Midwife is included in the paper presented to the Board in October 2024. Demonstrate cohesive working on quality improvement measures amongst the pre-term birth individuals already identified.

Perinatal Optimisation

There has been a drop in the number of perinatal optimisation standards that have been met. This is often due to women presenting in advanced labour with no time to optimise care and focuses on small numbers for each quarter. With a pre-term birth team, conducting QI projects and deep dive audits would consider factors, as the numbers are so small, percentages can change significantly. Regarding mother's milk, Rachael Dunhill is conducting an audit on seasonal variations over the last 3 years and SBL Midwife is conducting trolley walk to promote these elements and understand any barriers.

Fetal Fibronectin

Unable to audit compliance for preterm birth assessment using quantitative fetal fibronectin measurement across the LMNS due to the national shortage. All Trusts within the LMNS have declared partial compliance following local discussions and agreement. No further mitigation required.

Pre-term Birth Discussions

Discussion regarding auditing and/or investigating where conversations are documented when the neonatal team discuss care options. NLAG discussed how they have rolled out a new form for interim use during Q1 and stored in the mother's maternity notes. Previous documentation at HUTH on paper, but discussions are underway regarding where or whether this could be captured on BadgerNet for future recording.

Mitigation required to demonstrate best endeavours have been made: Escalation to MIS Year Six Delivery Group / Trust Board.

Safety action 7:
Listen to women, parents and families using maternity and neonatal services and co-produce services with users.
Lead: Yvonne McGarth

1) Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

a) Engagement and listening to families.

b) Strategic influence and decision-making.

c) Infrastructure.

The Maternity and Neonatal Voices Partnership (MNVP) is commissioned by the ICP and therefore work is undertaken jointly in order to provide the evidence to support this safety action.

a) Engagement and listening to families

For MIS year 6 the LMNS have advised that evidence gathering is currently being co-ordinated and will be available to access on the LMNS NHS Futures workspace where evidence will be accessible (including the LMNS Equity and Equality plan). The Trust will be informed when this becomes available.
https://future.nhs.uk/HCVCE/view?objectId=53690320

At the Hull MNVP meeting on the 10th July, it was acknowledged that the 15-steps visit should have been undertaken in March 2024, but it was delayed due to changes in HUTHT's senior staff and new appointments just starting. Some progress has been made on the previous action plan; a co-production workshop was held in September 2024 and actions include development of strengthened coproduction strategies going forward.

b) Strategic influence and decision-making

Terms of Reference for the following meetings have been updated to ensure the MNVP lead is a member.

Maternity Clinical Governance Meeting *(already listed as core member, invited to the meetings and regularly provides feedback on guidelines, leaflets and SOPs from a service user perspective).*
Neonatal Clinical Governance Meeting
Maternity and Neonatal Assurance Group.

Minutes of the above meetings will be saved in the evidence folder throughout the year to demonstrate working towards MNVP being a quorate member of the meetings. The MNVP lead will require adding to the Terms of Reference when devised.

c) Infrastructure

Confirmation has been received from the LMHS Quality Lead that the following evidence will be available on the LMNS NHS Futures webpage in due course:

Job description for MNVP Lead
Contracts for service or grant agreements
Budgets with allocated funding
Local service user volunteer expenses policy.

Evidence is also available from MIS year five which includes the funding report from February 2023, reviewing the function and funding of the MNVP which resulted in a significant increase in funded time and resource.

The MNVP Lead has also provided a signed declaration to support her allotted hours and remuneration of expenses.

2) Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication, including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

A co-production workshop was held in September 2024 and actions include development of strengthened coproduction strategies going forward

Risks: None identified.

Safety action 8:
Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?
Lead: Nichola Riggs

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

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

Attendance rates are monitored within the division monthly and there is ongoing monitoring. See below for the reports from 23rd September 2024.

Fetal monitoring training:

86.9%				ACTUAL IN MONTH COMPLIANCE			Excluding Mat Leave / LTS etc		
Fetal Monitoring	Total No. Staff require learning	Number required to achieve 90%	diff	Non-compliance required to meet 90%	23.09.24	% compliance	YES	ALL	%
Obstetric Specialist Nurses	15	15		0	15	100.0%	14	14	100.0%
Maple & Rowan Wards	43	39		2	37	86.0%	35	39	89.7%
Community Midwifery	46	42		0	43	93.5%	39	41	95.1%
Labour Ward and Delivery	55	50		2	48	87.3%	48	53	90.6%
ANC/ADU	26	24		1	23	88.5%	23	24	95.8%
Midwifery Led Unit	23	21		2	19	82.6%	18	20	90.0%
Obstetric Rotational Staff	17	16		0	17	100.0%	16	16	100.0%
Obs & Gynae Medical Staff	48	44		9	35	72.9%	34	45	75.6%
Parental Education	1	1		0	1	100.0%	1	1	100.0%
Grand Total	**274**	**252**		**16**	**238**		228	253	90.1%

There are 25 members of staff identified as non-compliant - 18 have dates prior to end November, the remaining 7 have been contacted individually via email.

97.0%					ACTUAL IN MONTH COMPLIANCE	
K2	Total No. Staff require learning	Number required to achieve 90%	diff	Non-compliance required to meet 90%	23.09.24	% compliance
Obs Consultant	19	18		0	19	100.0%
Obs ST1 -7	21	19		0	20	95.2%
Midwives	226	204		0	219	96.9%
Grand Total	**266**	**241**		**0**	**258**	

Please note that with the current medics, having had a rotation recently, there are some who haven't yet transferred their K2 accounts so these figures won't reflect every staff member.

Multi-professional maternity emergencies training

86.7%				ACTUAL IN MONTH COMPLIANCE			Excluding Mat Leave / LTS etc		
PROMPT (23/24)	Total No. Staff require learning	Number required to achieve 90%	diff	Non-compliance required to meet 90%	23.09.24	% compliance	YES	ALL	%
Obstetric Specialist Nurses	15	15		1	14	93.3%	14	14	100.0%
Maple & Rowan Wards	64	58		4	54	84.4%	51	60	85.0%
Community Midwifery	54	49		0	50	92.6%	48	49	98.0%
Labour Ward and Delivery	66	60		0	65	98.5%	63	64	98.4%
ANC/ADU	34	31		0	31	91.2%	31	32	96.9%
Midwifery Led Unit	43	39		1	38	88.4%	36	38	94.7%
Obstetric Rotational Staff	17	16		0	17	100.0%	16	16	100.0%
Obs & Gynae Medical Staff	52	47		17	30	57.7%	30	51	58.8%
Parental Education	1	1		0	1	100.0%	1	1	100.0%
Grand Total	**346**	**316**		**23**	**300**		290	325	89.2%

There are 10 staff booked onto PROMPT training before the end of October 2024. The remaining 11 Midwives and 13 Medical Staff members have been contacted to book on to the training immediately.

Neonatal Life Support Training

93.4%				ACTUAL IN MONTH COMPLIANCE			Excluding Mat Leave / LTS etc		
Newborn Life Support (Neonatal Resus)	Total No. Staff require learning	Number required to achieve 90%	diff	Non-compliance required to meet 90%	23.09.24	% compliance	YES	ALL	%
Obstetric Specialist Nurses	15	14		0	15	100.0%	14	14	100.0%
Maple & Rowan Wards	43	39		0	40	93.0%	38	39	97.4%
Community Midwifery	46	42		0	43	93.5%	39	41	95.1%
Labour Ward and Delivery	55	50		0	54	98.2%	52	53	98.1%
ANC/ADU	26	24		2	22	84.6%	22	24	91.7%
Obstetric Rotational Staff	23	21		2	19	82.6%	18	20	90.0%
Midwifery Led Unit	17	16		0	17	100.0%	16	16	100.0%
Parental Education	1	1		0	1	100.0%	1	1	100.0%
Grand Total	**226**	**207**		**4**	**211**		200	208	96.2%

Compliant at present.

Work also continues to mobilise the dedicated pre-booked block training weeks for face-to-face training for each member of staff to commence in 2025, with changes to the establishment proposed to enable teams to access the required level of training sustainably. This is expected to positively affect significantly on training compliance, as there will be better controls in terms of managing attendance rates and DNAs.

****Update from NHS Resolution July 2024****

In line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024) All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth must have reached a minimum of **'basic capability'** as described in the BAPM Neonatal Airway Capability Framework.

No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability. Staff that attend births with supervision at all

times will not need to complete this assessment process for the purpose of MIS compliance.

Requirement around NLS Certification:

A minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations unsupervised should have been trained and assessed in line with the guidance above.

Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised by year 7 of MIS and ongoing. Whilst Trusts are encouraged to continue to work towards the BAPM guidance where possible regarding first responders at births <34 weeks, this will not form part of the MIS requirements for compliance.

Current position for NLAG & HuTH

A Group MDT meeting took place following the update and a plan is in place to cover the requirements on the CNST/neonatal update NLS session. For basic airway training - already covering all materials and taking a register, however, not all formal documentation within the BAPM appendix is completed.

ACTION:

Implement the competency sign off paperwork within training
Explore a way to electronically capture this information retrospectively
CNST requirement for unsupervised first responders, from a medical perspective, will be signed off at induction. this will require the competency sign off documentation and recording
Meet with Neonatal Educators at NLAG to review NLS trainers (only 1 currently available at present).

Standard airway training – not currently covering as part of training programme.

Action: plan to implement for neonatal nurses alongside the NLS update session including the competency sign off paperwork from July 2024 across the Group.

Technical guidance also specifies that registered Resus Council trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. Assurance has been provided by the Neonatal Educators that this requirement is met, certificates to evidence this are currently being collated.

Risks: Non-attendance at scheduled training sessions.

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

a) All Trust requirements of the PQSM must be fully embedded.

Evidence is required in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly. Monthly meetings have occurred since July 2024 .

Maternity and Neonatal Culture Improvement Plan was included in the Maternity and Neonatal Assurance Group in September 2024. It will be an agenda item at the Maternity and Neonatal Assurance Group going forward.
Feedback sessions have now been planned as part of the SCORE survey feedback.

Risks: None identified.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

Evidence requirements / progress update:

A non-executive director (NED) is in place as Board level safety champion who works with the perinatal leadership team 'Quad' to undertake safety champion walkabouts. This provides insight into floor level safety concerns.

Review of maternity and neonatal quality and safety is undertaken by the Trust Board via the monthly Maternity and Neonatal Oversight Reports. The PQSM Dashboard is also shared with the Trust Board on a monthly basis (Appendix G).

Thematic learning informed by PSIRF is detailed in the claims scorecard triangulation, Maternity Safety Bulletins, PMRT quarterly report and in the Trust's CLIP report (submitted to Trust Board quarterly).

Collaboration / sharing learning with the LMNS/ICB lead is undertaken in line with the PQSAG and is evidenced by reports into the LMNS Perinatal Quality

Surveillance Group. **Evidence to be uploaded to the NHSFutures platform by the LMNS.**

Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions is shared at the Maternity and Neonatal Assurance Group visible to both maternity and neonatal staff and reflects progress made on identified concerns raised by staff and service users.

Regular staff engagement sessions take place through safety champions walk rounds and shout out Wednesday. A Safety Champion Improvement Plan logs issues raised and is monitored at the Maternity and Neonatal Improvement and Monitoring Meeting. Safety bulletins are shared with staff on a regular basis.

The Trust's claims scorecard has been triangulated with incident, complaints and theming data for quarter 1 2024/25. This has been shared at the Clinical Governance Meeting in July 2024 and is to be shared at the next Quality and Safety Committee meeting (on behalf of the Board). The scorecard is published annually (expected August 2024), triangulation for Q2 will be undertaken in October 2024 and shared with Trust Board in December 2024.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Evidence requirements / progress update:

Evidence is required in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly. Monthly meetings have occurred since July.
Maternity and Neonatal Culture Improvement Plan was included in the Maternity and Neonatal Assurance group in August 2024. It will be an agenda item at the Maternity and Neonatal Assurance group going forward, see appendix I.

Risks: Score survey complete and awaiting results. The Quad will then develop an action plan with key stakeholder. There is a need to review the safety champions agenda to ensure key safety elements are escalated and discussed.

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

a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.

The division has a clear standard operating procedure in place that is followed for reporting qualifying cases to MNSI.

To date, 9 have been reported to MNSI, 2 case which were rejected – 1 due to abnormality and 1 due to normal MRI.

b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024.

The division works closely with the Claims team to ensure qualifying early notification cases are reported to has a clear standard operating procedure in place that is followed for reporting qualifying cases to MNSI. To date, 2 referrals have been made to NHS Resolution's EN Scheme that have met the reporting criteria.

c For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that:

- **i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and**
- **ii. ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.**

Leaflets are provided by member of the governance team or bereavement team regarding the role of MNSI and NHS Resolution's EN Scheme. The governance team have a spreadsheet of open MNSI investigations where they record evidence that this has been given and regarding Duty of Candour. This has been saved in the MIS file as evidence this month.

Qualifying cases	Family received information	Duty of candour	Leaflet given
9	9/9 (100%)	6/6 (100%)	9/9 (100%)

2 cases rejected were not applicable for duty of candour and 2 declined. 1 was exempt due to MNSI.

Appendix A: MSDS Maternity Scorecard

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 6: Safety Action 2

NHS England

The table below summarises the number of criteria met by each maternity service provider, by month. For Y6, there are two criteria to meet on MSDS data submission.
This scorecard will be updated and published each month.

The final assessment will be based on the final data for **July 2024** for which the submission deadline is **30th September 2024**.

Organisation Name

HULL UNIVERSITY TEACHING HOSPITALS ...

Notes:

All figures are Final except for the most recent month. All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

As of April 2024, this summary has been updated to reflect the two criteria for CNST year 6. This has been updated for all the time series data.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Provisional

Organisation Name	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	1	1	1	1	1	1

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

United by Compassion:
Driving for Excellence

Organisation Name

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Reporting Period

July 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	345			Passed
CQIMDQ14	385	400	96.3		Passed
CQIMDQ15	380	380	100.0		Passed
CQIMDQ16	355	380	93.4		Passed
CQIMDQ24	345	355	97.2		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	230	365	63.0	Passed
CQIMDQ08	365	390	93.6	Passed
CQIMDQ09	385	400	96.3	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	385	400	96.3		Passed
CQIMDQ11	135	385	35.1		Passed
CQIMDQ12	15	385	3.9		Passed
CQIMPPH	15	385		36	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	385	400	96.3		Passed
CQIMDQ22	380	380	100.0		Passed
CQIMDQ23	355	380	93.4		Passed
CQIMPreterm	25	380		69	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	385	400	96.3		Passed
CQIMDQ15	380	380	100.0		Passed
CQIMDQ16	355	380	93.4		Passed
CQIMDQ18	190	380	50.0		Passed
CQIMDQ20	10	175	5.7		Passed
CQIMTears	10	175		45	Passed

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	385	400	96.3	Passed
CQIMDQ15	380	380	100.0	Passed
CQIMDQ16	355	380	93.4	Passed
CQIMDQ18	190	380	50.0	Passed
CQIMDQ26	380	380	100.0	Passed
CQIMDQ27	355	355	100.0	Passed
CQIMDQ28	165	355	46.5	Passed
CQIMVBAC	0	5	0.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	385	400	96.3	Passed
CQIMDQ31	390	390	100.0	Passed
CQIMDQ32	355	390	91.0	Passed
CQIMDQ33	390	390	100.0	Passed
CQIMDQ34	190	390	48.7	Passed
CQIMDQ36	385	385	100.0	Passed
CQIMDQ37	360	385	93.5	Failed
CQIMDQ38	390	390	100.0	Passed
CQIMDQ39	340	385	88.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	355	400	88.8	Passed
CQIMDQ04	355	355	100.0	Passed
CQIMDQ05	50	355	14.1	Passed
CQIMSmokingBooking	50	355	14.1	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	365	385	94.8	Passed
CQIMSmokingDelivery	35	365	9.6	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	350	355	98.6	Passed

Appendix B: Transitional Care Audit

	TC Care Days								
	Care Days	Meeting Criteria for TC	%	Normal care days (HRG9) >48 hours before discharge	% Meeting criteria at admission	Average occupied cots/day	days closed due to staffing	Postnatal Ward Care Days (HRG4/5)	Potential TC Care Days (in SCBU)
Apr-24	126	120	95%	2	95%	4.2	0	34	12
May-24	107	101	94%	4	100%	3.5	0	61	19
Jun-24	103	98	95%	0	100%	3.4	3	75	

Appendix C: BAPM Neonatal Medical Workforce Action Plan

CNST MIS Year Six - Neonatal Medical Workforce Benchmarking

Hull University Teaching Hospitals NHS Trust

Requirements for Safety Action 4:

1. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations.

BAPM standard requirement		MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
All tiers separate rota compliance	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff at all times.	All medical Staff only have responsibility for NICU.	No further action required.	Dr E Peirce	-	-	-
Tier 1 separate rota compliance 24/7	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care.	Compliant - Fully funded 9 person Tier 1 rota with a mix of Trainees & ANNP's.	No further action required.	Dr E Peirce	-	-	-
Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport).	Compliant - Fully funded 12 person Tier 2 rota with a mix of Trainees & ANNP's.	.No further action to be compliant Still finalising full recruitment gaps covered by locums	Dr E Peirce			
Tier 3 separate rota compliance 24/7	Tier 3 (consultant) staff available 24/7 with principle duties, including out of hours cover, are to the neonatal unit.	Compliant - 9 WTE funded consultant rota with 13 hour resident consultant presence & on call overnight.	No further action required.	Dr E Peirce	-	-	-
BAPM standard requirement		**MIS Year 6 status**	**Action Required**	**Lead**	**Timescale**	**Status**	**Evidence**

Tier 3 presence on the unit	Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers).	Compliant 13 hours resident consultant presence job planned. 3 ward rounds/ day for ITU.	No further action required.	Dr E Peirce	-	-	-
Tier 1 compliance more than 7000 deliveries per year	Two dedicated Tier 1 (ANNP or junior doctor ST1-3) 24/7 to support emergency care	Not applicable	No further action required.	Dr E Peirce	-	-	-
Tier 2 compliance if more than 2500 IC (XA01Z) days per year	Two dedicated Tier 2 (or resident consultant presence in addition to tier 3 requirements) available 24/7 with duties only on the neonatal unit.	Dedicated two tier 2 rota in place for Sept 2024. With some issues with recruitment and discussion regarding funding for final post as above. This should be a short term issue resolved when trainee ANNP comes into numbers in 18 months.	In light of expansion and based on GMC feedback and 3 year delivery plan guidance moving to 2. Still some rota gaps but 12 person rota running.	Dr E Peirce		Completed	
Tier 3 compliance if more than 2500 IC days per year	Presence of at least two consultant led teams during normal daytime hours.	HUTH NICU already have consultant led teams 9am-5pm.	No further action required.	Dr E Peirce	-	-	-

BAPM standard requirement		MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
Tier 3 compliance if more than 4000 IC days per year	Consultant presence 24/7 in addition to Tier 2 staffing requirements	Not applicable	No further action required.	-	-	-	-
Tier 3 compliance if more than 4000 IC days per year (daytime hours)	Three consultant led teams during normal daytime hours	Not applicable	No further action required.	-	-	-	-
Minimum of 1 consultant with a designated lead interest in neonatology.		Compliant	No further action	Dr E Peirce	-	-	-
Tier 3 consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification / substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN.		Compliant		Dr E Peirce	01 October 2024		Written confirmation from Clinical Lead
All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).		Compliant	Evidence to be gathered from Neonatal Consultants	Dr E Peirce	01 October 2024		Training records / job plans / attendance at meetings

A Two tier 2 out of hours rota is now in place. There is 1 gap related to recruitment, and 1 gap related to funding discussions - as there is currently a cost pressure of trainee ANNP role which is not included in workforce numbers for the next 18 months.

The aim is to resolve both these gaps within the next 3 months.

Sources:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Optimal Arrangements for Neonatal Intensive Care Units in the UK: A BAPM Framework for Practice (2021) https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021

Appendix D: BAPM Neonatal Nursing Workforce Action Plan

CNST MIS Year Six - Neonatal Nursing Workforce – Benchmarking

Hull University Teaching Hospitals NHS Trust

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Neonatal Matron in post and works closely with the lead consultant in a MatNeo model of service delivery.	No further action required.	Deborah Bray	N/A	N/A	N/A
A minimum of 70% (special care) of the workforce should be registered A minimum of 80% (high dependency and intensive care) of the workforce should be registered.	95% Registered Nurses. 5% Unregistered Nurses (not included in baseline cot side nursing numbers).	No further action required.	Deborah Bray	N/A	N/A	N/A

A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS).	Prior to the new recruits starting in spring QIS stood at 53% compliant. With the new recruits from spring, and the ones expected in the coming weeks percentage will dip to 44.6% (cot side workforce). ***Please refer to appendix for training proposal and trajectories*.**	Meet with the network to gain knowledge of the changes to the Foundation programme and to discuss the national review on QIS provision. Review current training plan and send more staff onto the QIS programme (no more than 8 staff at any one time in the year).	Deborah Bray / Jenny Hemingway	Review 01 December 2024	Ongoing	Training compliance

BAPM standard requirement	**MIS Year 6 status**	**Action Required**	**Lead**	**Timescale**	**Status**	**Evidence**
Units have a minimum of two registered nurses/midwives on duty at all times, of which at least one is QIS.	Fully Compliant.	No further action required.	Deborah Bray	-	-	E-roster

Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC: 1 RN 2 HD: 1 RN 4 SC: 1 RN 4 TC: 1 RN	Fully compliant.	No further action required.	Deborah Bray	-	-	Badgernet / Training package and study day / Workforce Tool Hull Neonatal Workforce Tool Data
There is a nursing co-ordinator on every shift in addition to those providing direct clinical care.	Currently the supernumerary shift lead is a Band 6.	Plan to uplift this to a band 7 within the next six months following a review of the current establishment.	Deborah Bray	April 2025	Ongoing	E-roster
Neonatal units providing surgical services have a nurse/midwife with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery.	No Nurse/Midwife with clinical leadership. Surgical Link Team in place with 1 x Band 6 senior nurse who has completed the specialist surgical course. Where possible, any baby due for delivery with a known surgical condition, a member of the link team will support the parents alongside the consultant. Once staff have been on the unit for 18 months, they should be trained in facilitating advanced ICU & surgery.	To develop a business case for a Band 7 Neonatal Surgical Specialist Nurse	Deborah Bray	April 2026	Ongoing	Business Case

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
Neonatal units providing surgical services have at least one nurse/ midwife with neonatal surgical experience who has responsibility for co-ordinating transfer and discharge of babies pre- and post-surgery, liaising with primary and community services, and supporting parents and referring teams.	Neonatal Band 6 Shift Co-ordinator is responsible for liaising with the necessary transport team required for transfer. Discharge Lead Nurse also supports the staff with liaising with community services for discharge. More complex babies are often transferred to Paediatrics Surgical Ward for on-going care once they reach 44 completed weeks. The unit works closely with the Specialist Lead Nurse in Leeds and can reach out for support/advice if needed.	To develop a business case for a Band 7 Neonatal Surgical Specialist Nurse	Deborah Bray	April 2026	Ongoing	Business Case
There should be an appropriately resourced clinical education team to support the training and education requirements of the cot side workforce. This team should consist of Nurse Educators at both band 6 and band 7 and have a WTE resource that	75% compliant Current resource is 1 x FT B6 (funded from CPD monies on a fixed term basis for 12 months) and 1 x FT B7 (substantive).	Recruit an additional 0.76 WTE B6 substantive.	Deborah Bray	December 2024	Ongoing (currently recruiting)	E-roster

provides 1 WTE educator per 50 staff members.						
There should be a 1 WTE Band 7 Lead Nurse for Transitional Care Services who are Supernumerary 100% of the roster period.	Fully compliant	No action required.	Deborah Bray	-	-	-

BAPM standard requirement	MIS Year 6 status	Action Required	Lead	Timescale	Status	Evidence
Neonatal Outreach must be available 7 days a week.	Fully compliant for a 7 day service.	No action required.	Deborah Bray	-	-	-
Non-registered workforce should complete a minimum of NVQ level 3 training.	Fully compliant – monitored via the recruitment and employment checks. In addition the Trust also ensures the non-registered staff complete the competency packages for CSWs and gastric tube package.	No further action required.	Deborah Bray	-	-	 gastric tube competence (8).docx  CSW Programme.doc

	The Trust also asks all new non-registered staff to complete the care certificate which can be accessed on HEY247 if their role involves direct patient care.					

Appendix A

Current training plan
Due to the timings of the FP and QIS module we are sending no more than 8 staff off into training at any one time in the year.

Quarter 2 & 3 – FP 8 staff total
Quarter 4 – QIS 4 staff, FP 4 staff
Quarter 1 – QIS 4 staff, FP 4 staff

This plan gives 8 QIS per year, and 12 FP staff per year (FP in quarter 1 & 4 is the same intake of staff as the programme is 6 months)
Total number of study days over the year 224 days
Trajectory to meet 70% compliance QIS Dec 2027

With the condensed FP, it would be possible to send more staff into training which would equate to similar numbers for study time. To spread out these days, the FP will be exclusively virtual, allowing rostered study time to suit the service needs. During the autumn/winter months, this would also allow a 5th member of staff into practice to further the workforce.

Proposed plan from Jan 2025:
Quarter 2&3 – FP 11 staff total
Quarter 4 – QIS 5 staff, FP 4 Staff
Quarter 1 – QIS 5 staff, FP 4 staff

This plan would give 10 QIS staff per year, and 15 FP staff per year (FP in quarter 1 & 4 is the same intake of staff as the programme is 6 months). Total number of study days over the year 235 days

Trajectory to meet 70% QIS compliance Dec 2026.

Appendix E: Action plan for supernumerary status of co-ordinators

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

Supernumerary Status of the Co-Ordinator Action Plan

NHS Humber Health Partnership

Labour Ward Matron
Version 1.0 21st August 2024
Update 30th August 2024

No.	Recommendation	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress	RAG Status	Actual Completion Date	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
1	To ensure 2 Band 7s are on shift	are always 2 band 7's on shift, despite requests etc. To speak to e-roster to allow for a clearer rostering of staff i.e separate lines on the roster for the fulfilment of the band 7 coordinator and the second band 7.	To ensure more efficient spread of Band 7 cover	Kay Hartley	21/10/2024	Amber - On Track for completion			For audit in October 2024	
2	Increase in the uplift of 21% to cover sickness/annual leave and training	Awaiting uplift as a consequence planned of Birth rate plus tool.	As Above	Yvonne McGrath		Red - Not on track, deadline passed (Audits - Not achieved)			As per paper at Board October 2024	
3	Succession Planning: to cover planned retirement in November of 0.80 WTE	2 x Junior Sisters have been given 6 months acting up experience. From July they have been working as a Band 7 for 0.24 WTE hours each week.	To cover the gap	Kay Hartley	01.11.2024	Amber - On Track for completion			In place	
4	To utilise Band 5 scrub nurses, to alleviate the pressure on Band 6 Midwives requirement of scrubbing in Theatre and freeing up the second Band 7	5 WTE Band 5 Nurses are employed and Managed by Obstetric Theatres and Scrub in emergency cases for Theatre (initially recruited and employed by Kay Hartley, prior to re structure)	Alleviate Midwfery pressures	Kay Hartley	26.06.2023	Green - Completed (Audits - Minimum target reached)		26.06.2023	In post	

Appendix F: Triangulation of Claims Scorecard Q1 2024/25

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9)

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

NHS Humber Health Partnership

Claims Scorecard April 2012 – June 2023 (87 claims)

Top injuries by volume:	**Top injuries by value:**
Stillborn	Cerebral Palsy
Cardiac arrest	Brain damage
Bowel damage / dysfunction	Developmental delay
Admission / unnecessary operation(s)	Hypoxia
Fatality	Not specified
Top causes by volume:	**Top causes by value:**
Failure to recognise a complication	Failure / delay in treatment
Failure / delay in treatment	Fall / delay in diagnosis
Failure / delay in diagnosis	Failure to monitor the first stage of labour
Failure to warn / informed consent	Failure to act on abnormal test results
Failure to perform tests	

Incidents Q1 24/25

Top 5 incident by volume:

- Term NNU admissions **(23)**
- Post partum haemorrhage (PPH) >1500mls **(8)**
- Transfer out **(8)**
- Missed aspirin **(5)**
- Documentation missing / IT concerns **(5)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **396**

Complaints Q1 24/25

There have been 10 complaints received:

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

All 10 complaints are still open.

Learning Q1 24/25

- Ensure smoking cessation is offered to all Family members
- Ensure CO monitoring is undertaken at ever contact
- Reminder to all staff to use Amnisure when SROM is suspected to aid confirmation
- Ensure women are offered adequate pain relief in labour regardless of the stage of labour
- Escalation of underreporting on DATIX.

Themes Q1 24/25

- Hypothermic neonates on the wards (labour ward and postnatal ward)
- Incorrect interpretation of CTG's
- Escalation of a deteriorating baby on CTG's.

Action Plan Q1 24/25 Not started | In progress | Complete

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

Appendix I: Maternity Group Culture Improvement Plan

No.	Recommendation	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	Progress
1	Student support	Awareness of support available to students whilst on clinical placement. PLF in post 1.0 WTE for midwifery students. R&R and Pastoral Lead available to students to access, maintaining visibility on daily walk arounds and attending UoH for teaching sessions such as Neonatal Life Support. PLF and R&R lead working together to run half day student forums within clinical hours to maintain visibility and discuss topics such as PMA, compassionate conversations, active bystanders and F2SU. Students have requested a "mini-PROMPT" to practice skills and drills in safe environment with education lead	Students will feel supported in their clinical environment and know where to go if they need support in addition to clinical staff		Ongoing	Daily walkarounds by R+R lead, introducing self to students and checking in on wellbeing. Focussed conversations around Kings Fund ABC framework and ensuring students are able to raise concerns where necessary. SLEC framework launched in February 2024 guiding PLF work. Rosters available in advance on eroster to ensure work/life balance and continuation with supervisors
2	International midwives	Demonstrate awareness of support for IRMs both in the Trust and the community. Provide with preceptor and manager and regular check-in's from pastoral lead. Encourage welcoming and safe environment. Enhance staff knowledge on cultural diversity, unconscious bias and how our behaviours impact others.	12 international midwives now employed by the Trust. They will feel welcome and supported to adapt to their new place of work and home life.		Ongoing	Daily walkaround by R+R Lead to check-in on wellbeing and preceptorship/clinical competencies as acting as link for pastoral support since starting role in January. All individual midwives assigned their own preceptor to discuss progress and concerns as well as a manager. NHSE funding one place for PMA course in January. Awaiting EOI up to 16th August and PMA will appoint. Agreed by DoM that one midwife will be released for this training in January to ensure our workforce is represented by our PMA team. Previous HoM was holding monthly TEAMS calls but these have ceased

						as HoM now left Trust. R+R Lead has achieved Cultural Competency Certificate from Trust and other managers encouraged but not undertaken. R+R Lead attends MOST study day and TEAM days to raise awareness of pastoral issues for international midwives at each session - promoting empathy and encouraging staff support. Arranged for IRM's to have swimming lessons, supported to book coastal holidays, introduced to local amenities and supported with arranging childcare. Tickets arranged for IRM's to attend "NHSE Celebration event" in Leeds. One IRM sent on leadership course.
3	Leadership		Staff will feel well-led, psychologically safe, inspired and held by the senior management team but also each other. Staff being promoted into new bands will be well supported by a buddy to learn and flourish in their new roles. All staff will feel that the impact of the Safer Learning Environment Charter framework.		Ongoing	Matrons meeting with Organisational Development Lead every Monday morning to encourage cohesive working and a psychologically safe environment for expressing concerns. Regular drop-ins held by Director of Midwifery, Chief Nurse (North and South Bank) and F2SU Guardian. Private and closed Facebook group commenced 15th July for all staff to receive updates, praise, support and share positive stories - now has 200 members. R+R and Pastoral Lead attending MOST training and team days to discuss compassionate and courageous conversations, active bystanders and self-care in line with Capital Midwife Civility Toolkit. Midwives offered the opportunity to become "Preceptorship Champions" - teaching clinical skills to newly qualified midwives to offer investment, value recognition and

						show the investment in them that they are requesting.
4	Professional Midwifery Advocates	Raise awareness of PMA team to staff. Ensure cohesive PMA team with members appearing as representatives of workforce. To align with colleagues in NLaG joining forces with PNA teams and sharing strategy. Team need a Lead PMA to drive and grow service.	Staff will be familiar with members of the PMA team and have access to a PMA Monday to Friday 8am - 4pm via email and mobile phone. Staff will have a choice about which PMA they use and are not obligated to access PMA at any time. Staff to understand benefits of A-EQUIP model delivered by PMA team.		Ongoing	PMA register maintained by R+R Lead midwife currently. Weekly message with photograph featuring the PMA who is holding the phone and email on a rostered basis. PMA's providing support in their own time, in addition to their substantive posts. Three PMA's used more than others and not all team members contributing to workload currently. QR code used to capture activity then reported monthly to Jodie McVie to feedback to NHSE. Data previously collected by RM Sue Cooper who was given 7.5 hours Band 6 per week, in addition to community substantive post, but this contract ended 3rd June. 12 midwives on waiting list wishing to start the course. One place held for January 25 for an International Midwife - expressions of interest to be handed in to PMA team by 16th August. Team to determine appropriate selection process for midwives wishing to train to be a PMA based on qualities and values.

FAMILY SERVICES DIVISION

Hull University Teaching Hospital

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 6, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 1 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

July 2024

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Hull University Teaching Hospital Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

Late fetal losses – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

Stillbirths – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.

Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

Terminations of pregnancy: terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

The following deaths should be reviewed to meet safety action one standards:

All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
All stillbirths (from 24+0 weeks' gestation)
Neonatal death (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) (up to 28 days after birth)

2. STANDARDS

A report has been received by the Trust Executive Board each quarter from April 2024 to June 2024 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**Standard**
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**60%**
d) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in 2023-2024 (appendix A)

There has been a total of 11 incidents reported to MBRRACE-UK via the PMRT during MIS year six. 3 in Quarter 4 (01 January – 31 March 2024) in 8 in Quarter 1 (01 April – 30 June 2024). 0 cases were reported to MBRRACE but were for notification only and therefore not eligible for further measurement against CNST standards or review.

2 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 1 (appendix B)

There have been 11 incidents reviewed and published through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during January and March 2024 due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

4 cases had no issues identified that would have had an impact on the outcome.
5 cases had issues identified that would have had no impact on the outcome
2 cases had issues that may have had a difference to the outcome.

<u>Grading of care provided to the mother after the death of the baby</u>

11 cases had no issues identified that would have had an impact on the outcome
0 cases had issues identified that would not have had an impact on the outcome

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 3.

3.3 CNST Compliance as per MIS Year 6 Standards (Appendix C)

11/11 (100%) are currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of all Eligible Incidents Reported in Q4 and Q1 2023-2024

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	Parents involved and updated	MNSI	MBRRACE notified <7 days	Review started < 2mth	Review Publish < 6mth
Q4	**91674**	Neonatal death	41+1	28.01.24	02.02.24	3240g	HUTH - FABC	HUTH	HUTH	Yes	Yes – MI-	Yes	Yes	Report writing - <6 months
	91492	Neonatal death	33+3	10.01.24	22.01.24	1160g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Met
	92339	Antepartum stillbirth	24+2	12.03.24	12.03.24	154g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Report writing - <6 months
Q1	**92794**	Neonatal death	37+1	11.04.24	11.04.24	3045g	HUTH	HUTH	HUTH	Yes	Yes – MI-	Yes	Yes	Not yet met – <6 months
	92807	Antepartum stillbirth	25+5	12.04.24	12.04.24	137g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Report writing - <6 months
	93230	Antepartum stillbirth	26+4	09.05.24	09.05.24	975g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Report writing - <6 months
	93317	Neonatal death	34+3	26.04.24	14.05.24	2345g	HUTH	HUTH	Home	Yes	No	Yes	Yes	Not yet met – <6 months
	93319	Antepartum stillbirth	37+1	15.05.24	15.05.24	2775g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months
	93509	Antepartum stillbirth	33+1	27.05.24	27.05.24	1655g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months
	93693	Antepartum stillbirth	29+2	07.06.24	07.06.24	1235g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months
	93766	Antepartum stillbirth	24+2	12.06.24	12.06.24	403g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months

Appendix B – Summary of all incidents closed in Q1 of 2023-2024

Case	Cause of Death	Grading of Care	Issues Identified	Actions
90177	Multiple congenitala nomalies (coarctation of Aorta, Malrotation, hydronephr osi, ectopic hydroureter) Trisomy 18	**A/A/A**	Ongoing investigations on the neonatal unit were carried out appropriately but were not always timely It is not possible to tell from the notes if the relevant professionals involved in the ongoing care of the parents were informed about the death of their baby	Discussed with genetic lab and they already looked into it and they have got plans to work on Saturdays starting December 2023. Discuss with Martin House in future regarding who completes the notification to other health care professionals
89508	Acute chorioamnio nitis	**B/A**	This mother had sepsis during her pregnancy and there was a delay in the diagnosis Induction of labour or a caesarean section was indicated but not carried out and it is not clear from the notes why not	Review SOP for checking results and taking appropriate action Review electronic systems to capture results that require action Bereavement Lead to discuss with senior colleagues and develop clear guidance on the policy for confirmation scans for intrauterine deaths out of hours. Reflection to be undertaken with relevant medical staff involved

89885	Unexplained Stillbirth Evidence Acute Thymic Involution	**B/A**	This mother smoked during pregnancy but was not offered referral to smoking cessation services This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements This mother presented with reduced fetal movements at >28 weeks and a CTG was not performed At first presentation with reduced fetal movements this mother was not appropriately risk assessed This mother presented with reduced fetal movements and scan was indicated but not carried out This mother presented with reduced fetal movements at >=37 weeks but induction was not discussed This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not carried out This mother has a history of domestic abuse and her antenatal care was not appropriate given this history The confirmed/ suspected delay in this mother's labour was not managed appropriately This mother required oxytocin during her labour, but this was not managed appropriately	Highlight policy to refer all smokers for smoking cessation in PMRT and community newsletters Reminder to all staff via PMRT newsletter that information on fetal movements are provided and this is documented in the records. Providing written information to be included in the new electronic recorded for implementation 2024 Reminder to all staff via PMRT newsletter that woman who report changed fetal movements >28 weeks are advised to attend maternity triage for an assessment and CTG and scan if required Reminder to all staff via the PMRT newsletter that all women who report changed fetal movements >28 weeks to be advised to attend maternity triage fora risk assessment and a discussion on IOL if >=37 weeks Review local guideline to ensure they reflect the national guidance Reminder to staff importance of seeing women alone to ask the domestic violence enquiry question Review bereavement and care in labour guideline to ensure guidance clear on medical review Review of bereavement and care in labour guideline to ensure guidance clear on use of oxytocin to augment labour Reminder to staff the option for postnatal investigations relating to maternal substance misuse

			Although indicated this mother was not offered postnatal investigations relating to maternal substance misuse	Highlight policy to refer all smokers and family members who smoke for smoking cessation in PMRT and Community newsletters. Introduction of Badgernet as opt out now introduced
90354	acute hypoxic event large ventricular hemorrhage	**A/A**	No actions	No actions
90628	Klebsiella Pneumonia severe chronic lung disease with cystic changes extreme prematurity, 25 Wks	**B/B/A**	This baby was resuscitated and delayed cord clamping was not instituted although this was indicated line was removed by member of the nursing team during reorientation process before the baby was declared dead	Reminder to neonatal and maternity team and bereavement lead will circulate and make sure the feedback will be circulated to other members of maternity team. Nursing educator will make sure of staff training and competency before assigning to reorientation care.
90698	hypoplastic aorticarch with tight coarctation prematurity 32 weeks and IUGR	**D/B/A**	This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons Scribe sheet wasn`t available in the notes	Ongoing quality improvement project to investigate and improve pathway and accessibility of aspirin within the community. Preterm delivery and periprem passport not used. BAPM 7 and periprem passport usage now included on the mandatory training and within the new badgernet system Reminder to all neonatal team to make sure when assigning roles to make sure of a prescriber, so appropriateness of the resuscitation can be reviewed.

90897	MCCD Multi organ failure Septic shock Necrotizing enterocolitis prematurity 26 weeks	**D/B/A**	Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate due to organisation issues The ongoing skin care of the baby on the neonatal unit was not appropriate	This was due to high acuity on the ward. Delay occurred but did not impact the outcome. Nursing educator in conjunction with tissue viability has put skin care bundle in place and for continuous education and training for all nursing team.
90359	Unknown cause of death	**A/A**	During this mothers labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	Reminder to staff in PMRT newsletter. Highlight in bereavement training. Publish bereavement audit findings to highlight
90700	Unknown cause of death	**A/A**	No actions	No actions
90872	Severe growth restricted baby	**B/A**	This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements	Highlight in PMRT and Community Midwives Newsletters. Mandatory field on new computer system

GRADING OF CARE

Antenatal loss –

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Neonatal death –

Grading of care of the mother and baby up to the point of birth of the baby:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was born
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the baby from birth up to the death of the baby:

- ○ A - The review group concluded that there were no issues with care identified from birth up the point that the baby died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Appendix C – Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	100%	4/4 (100%)	8/8 (100%)	-	-	
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	4/4 (100%)	8/8 (100%)	-	-	
Multi-disciplinary reviews should be started within two months of the death.	95%	4/4 (100%)	5/5 (100%) - 3 not yet met but within dates	-	-	
Multi-disciplinary reviews should be published within six months of the death.	60%	4/4 (100%)	2/2 (100%) – 6 not yet but within dates	-	-	
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted April 2024	Submitted July 2024	-	-	

NHS Resolution - change to the verification period

The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this was not announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q4** and **Q1** cases PMRT reviews are as follows:

Sepsis pathway started but not completed
Induction of labour was not performed in a timely manor
Smoking cessation referrals were not completed
Routine enquiry not asked at every contact
The mother's risk status was not assessed at the onset / during the course of labour
Pre-term perinatal optimisation not sufficient
Reduced fetal movements guideline not followed

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/3 (0%)	2/8 (25%)	-	-	**2/11 (18%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/3 (33%)	0/8 (0%)	-	-	**1/11 (9%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/3 (33%)	0/8 (0%)	-	-	**1/11 (9%)**
Element 5.2k	Cases where the prevention, prediction, preparation or perinatal optimization of preterm birth was a relevant issue.	0/3 (0%)	0/8 (0%)	-	-	**0/11 (0%)**

FAMILY SERVICES DIVISION

Hull University Teaching Hospital

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 6, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 2 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

October 2024

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Hull University Teaching Hospital Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

Late fetal losses – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

Stillbirths – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.

Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

Terminations of pregnancy: terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

The following deaths should be reviewed to meet safety action one standards:

All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
All stillbirths (from 24+0 weeks' gestation)
Neonatal death (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) (up to 28 days after birth)

2. STANDARDS

A report has been received by the Trust Executive Board each quarter from April 2024 to June 2024 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**Standard**
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**60%**
d) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in 2023-2024 (appendix A)

There has been a total of 22 incidents reported to MBRRACE-UK via the PMRT during MIS year six.

Quarter	Eligible for full CNST assessment	Eligible for notification only	Total per Quarter
Q3 (15 Dec – 31 Dec 23)	1	1+2	**2**
Q4 (01 Jan – 31 Mar 24)	2	2+5	**4**
Q1 (01 Apr – 30 Jun 24)	7	2+6	**9**
Q2 (01 Jul – 30 Sept 24)	2	5+5	**7**
Total	**12**	**10+18**	**22**

10 cases were reported to MBRRACE so far in MIS year 6 but were for notification only due to joint case or MNSI cases and therefore not eligible for further measurement against CNST standards or review. 18 cases were reported to MBRRACE so far in MIS year 6 but were for notification only due to termination of pregnancy and therefore not eligible for further measurement against CNST standards or review

2 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI) during Quarter 2.

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 2 (appendix B)

There have been 7 incidents reviewed and published through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during April and June 2024 due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

1 cases concluded that there were no issues with care identified up the point that the baby was born (A)

3 cases identified care issues which they considered would have made no difference to the outcome for the baby (B)

2 cases identified care issues which they considered may have made a difference to the outcome for the baby (C)

1 case identified care issues which they considered were likely to have made a difference to the outcome for the baby (D)

Grading of care provided to the mother after the death of the baby

6 cases concluded that there were no issues with care identified up the point that the baby was born (A)

0 cases identified care issues which they considered would have made no difference to the outcome for the baby (B)

1 cases identified care issues which they considered may have made a difference to the outcome for the baby (C)

0 cases identified care issues which they considered were likely to have made a difference to the outcome for the baby (D)

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 3.

3.3 CNST Compliance as per MIS Year 6 Standards (Appendix C)

13/13 (100%) are currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of all Eligible Incidents Reported in Q2 2024-2025

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	Parents involved and updated	CNST	MNSI	MBRRACE notified <7 days	Review started < 2mth	Review Publish < 6mth
Q2	**94371**	Neonatal death	21+5	15.07.24	15.07.24	385g	HUTH	HUTH	HUTH	Yes	Yes	No	Yes	Yes	Not yet reviewed – <6 months
	94419	Neonatal death	30+3	08.05.24	22.07.24	1500g	YORK	YORK	HUTH	Yes	No	No	Yes	Yes	Not yet reviewed – <6 months
	94736	Antepartum stillbirth	34+4	13.08.24	13.08.24	2255g	HUTH	HUTH	HUTH	Yes	Yes	No	Yes	Yes	Not yet reviewed – <6 months
	94816	Antepartum stillbirth	38+6	19.08.24	20.08.24	3315g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met - <2 months	
	94846	Neonatal death	30+3	20.08.24	22.08.24	3490g	YORK	YORK	HUTH	Yes	No	Yes	Yes	Not yet met - <2 months	
	95327	Neonatal death	39+3	24.09.24	26.09.24	3875g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met - <2 months	
	95328	Antepartum stillbirth	39+2	26.09.24	26.09.24	4550g	HUTH	HUTH	HUTH	Yes	Yes	No	Yes	Not yet met - <2 months	

Appendix B – Summary of all incidents closed in Q2 of 2024-2025

Case	Cause of Death	Grade of Care	Issues Identified	Actions
91674	severe HIE- coroner ongoing investigation	**D/B/B**	1. A CTG was performed during established labour but the technical quality was poor 2. This mother required transfer of her care but the time from decision to the transfer was too slow because there was an 'other' reason for the delay 3. This baby was resuscitated and delayed cord clamping was not instituted although this was indicated 4. The final mode of birth was not appropriate for this mother and her baby 5. This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements 6. no ECG leads use while doubting presence or absence of circulation 7. The interpretation of the fetal heart rate monitoring in established labour was not correct 8. This mother did not receive one-to-one care through established labour 9. Induction of labour or a caesarean section was indicated but not carried out for 'other' reasons 10. The fetal heart monitoring in established labour was not carried out correctly	1. Fetal monitoring training mandatory training days to both midwifery and medical staff highlighting the importance of appropriate and quality of fetal monitoring. PMRT newsletter update to be sent to all staff – **COMPLETE 2/2** 2. Feedback given to members of staff and disseminated to all staff working on all wards. Mandatory training to all staff surrounding emergency buzzer and urgency of transfers between wards PMRT newsletter update to be sent to all staff – **COMPLETE 2/3** 3. the pathway for referring deliveries to neonatal team - reviewed with maternity by Dr Manou – **COMPLETE 1/1** 4. PROMPT training to include instrumental delivery and escalation process. Escalation policy updated and conflicting opinions guideline recirculated to all staff. Feedback given to all staff involved – **COMPLETE 2/3** 5. Guideline changed to align with Saving Babies Lives Bundle 3 and NICE guidance and all staff informed of changes. Feedback given to staff members PMRT newsletter update to be sent to all staff – **COMPLETE 3/3**

			11. This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs 12. This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance 13. This mother presented with reduced fetal movements at >28 weeks and the CTG performed was inappropriately interpreted 14. failure of IO insertion 15. This mother had pregnancy complications but they were not recognised as requiring specific birth planning advice 16. This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate 17. In retrospect this mother's care should have been transferred at the start of her care in labour but her risk status was not formally assessed at the start care in labour 18. This mother required transfer of her care but the decision to transfer her was not timely 19. The type of fetal monitoring used in established labour was not appropriate 20. During the move to the neonatal unit the baby's temperature was not maintained within an appropriate range 21. The baby was cold on arrival in the neonatal unit 22. During the resuscitation the baby's temperature was not maintained within an appropriate range	6. work with neonatal educator team about availability of ECG on resuscitation trolleys – **COMPLETE 1/1** 7. Fetal monitoring training mandatory training days to both midwifery and medical staff highlighting the importance of appropriate and quality of fetal monitoring. PMRT newsletter update to be sent to all staff – **COMPLETE 2/2** 8. Spotlight on 1 to 1 care in labour. Education to all staff, both midwifery and medical, through mandatory teaching days 1 to 1 care in labour is essential. PMRT newsletter update. Updates on the fetal monitoring training days – **COMPLETE 1/3** 9. Guideline changed to align with Saving Babies Lives Bundle 3 and NICE guidance and all staff informed of changes. Feedback given to staff members PMRT newsletter update to be sent to all staff – **COMPLETE 2/3** 10. Fetal monitoring training mandatory training days to both midwifery and medical staff highlighting the importance of appropriate and quality of fetal monitoring. PMRT newsletter update to be sent to all staff – **COMPLETE 2/2** 11. Mandatory training to all staff on importance of risk assessments on staff training days 2. Implementation of Badgernet and mandatory fields to ensure holistic risk assessments are performed regularly with prompts to aid staff decision making 3. PMRT newsletter update to be sent to all staff – **COMPLETE 1/2** 12. Mandatory training to all staff on importance of risk assessments on staff training days. Implementation of Badgernet and mandatory fields to ensure holistic risk assessments are performed regularly with prompts to aid staff decision making. PMRT

				newsletter update to be sent to all staff – **COMPLETE 3/3** 13. Guideline changed to align with Saving Babies Lives Bundle 3 and NICE guidance and all staff informed of changes. Feedback given to all staff involved. PMRT newsletter update to be sent to all staff – **COMPLETE 2/3** 14. IO skill teaching session to be arranged for neonatal team – **COMPLETE 1/1** 15. Guideline changed to align with Saving Babies Lives Bundle 3 and NICE guidance and all staff informed of changes. PMRT newsletter update to be sent to all staff – **COMPLETE 2/2** 16. Mandatory training to all staff on importance of risk assessments on staff training days. Implementation of Badgernet and mandatory fields to ensure holistic risk assessments are performed regularly. PMRT newsletter update to be sent to all staff – **COMPLETE 3/3** 17. Mandatory training to all staff on importance of risk assessments on staff training days. Implementation of Badgernet and mandatory fields to ensure holistic risk assessments are performed regularly. PMRT newsletter update to be sent to all staff – **COMPLETE 2/3** 18. Feedback given to members of staff and disseminated to all staff working on all wards. Mandatory training to all staff surrounding emergency buzzer and urgency of transfers between wards PMRT newsletter update to be sent to all staff – **COMPLETE 3/3** 19. Fetal monitoring training mandatory training days highlighting the importance of appropriate and quality of fetal monitoring. PMRT newsletter update to be sent to all staff – **COMPLETE 2/2**

				20. raising the awareness about hypothermia - temp management during resuscitation – **COMPLETE 2/2** 21. raising the awareness about hypothermia - temp management during resuscitation – **COMPLETE 2/2** 22. raising the awareness about hypothermia - temp management during resuscitation – **COMPLETE 2/2** **8 outstanding actions**
92794	Awaiting final postmortem from the coroner's office	**D/B/A**	1. The baby had to be transferred elsewhere for the post-mortem	1. We transfer all PM to Sheffield as there are not the facilities in HUTH.
93317	Awaiting final postmortem	**C/B/C**	1. This mother met the national guideline criteria for screening for gestational diabetes was offered screening, she did not attend, and the DNA policy was not instituted - 2. This mother developed an indication and was offered a GTT during her pregnancy but did not attend for the test and the DNA policy was not instituted 3. This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy 4. The baby had to be transferred elsewhere for the post-mortem	1. Process for GTT's has been changed since the delivery with fail safes in place within the diabetic team to ensure all are reappointed or random blood glucose/HBA1c is performed – **COMPLETE 1/1** 2. DNA policy is under review to cover all areas of maternity Dissemination to all staff about the importance of women attending appointments. DNA alert added to badgernet to aid identification – **COMPLETE 2/3** 3. DNA policy is under review to cover all areas of maternity Dissemination to all staff about the importance of women attending appointments. DNA alert added to badgernet to aid identification – **COMPLETE 2/3** 4. We transfer all PM to Sheffield as there are not the facilities in HUTH. **2 outstanding actions**

93230	Extreme premature rupture of membranes and large subchorionic haematoma	**A/A**	No issues of care identified in final report	
93509	Intrauterine growth restriction and placental disfunction	**C/A**	1. This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal care 2. This mother met the national guideline criteria for screening for gestational diabetes was offered screening, she did not attend and the DNA policy was not instituted 3. This mother had poor/no English and language line was used to interpret during her labour and birth 4. The baby had to be transferred elsewhere for the post-mortem 5. Aspirin prescribed and documented to be taken throughout pregnancy but later feedback the mother reported to have not been taking it regularly 6. The baby was small for gestational age at birth, scans were indicated and performed but the baby was not identified as IUGR	1. Learning to be sent to all staff and administrative staff on importance of using an interpreter at every contact via language line or the iPads. Update to all staff within the monthly newsletters and add to safety huddles in each area for further dissemination – **COMPLETE 2/2** 2. Updates to the guideline for DNA's for GTT. Explore the processes for community and antenatal clinic for reappointing and tracking DNA's – **COMPLETE 2/3** 3. Learning to be sent to all staff and administrative staff on importance of using an interpreter at every contact via language line or the iPads. Update to all staff within the monthly newsletters and add to safety huddles in each area for further dissemination – **COMPLETE 2/2** 4. We transfer all PM to Sheffield as there are not the facilities in HUTH. 5. Education to all staff on the importance of ensuring aspirin was being taken at every appointment and documenting between notes. Included within safety huddles throughout all areas of maternity. Update given via PMRT newsletter. Ongoing work with a QI project to make aspirin more accessible to patients – **COMPLETE 1/2, ONGOING QI** 6. Scan images reviewed within PMRT and outside the range of acceptability and no escalation. Escalated

				for review and education to ultrasound staff – **COMPLETE 0/1** **3 outstanding actions**
93693	Umbilical artery throbus	**B/A**	1. The baby had to be transferred elsewhere for the post-mortem	1. We transfer all PM to Sheffield as there are not the facilities in HUTH.
93766	Fetal growth restriction and placental dysfunction with possible abruption	**B/A**	No issues of care identified in final report	

GRADING OF CARE

Antenatal loss –

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Neonatal death –

Grading of care of the mother and baby up to the point of birth of the baby:

- A - The review group concluded that there were no issues with care identified up the point that the baby was born
- B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the baby from birth up to the death of the baby:

- A - The review group concluded that there were no issues with care identified from birth up the point that the baby died
- B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following the death of her baby:

- A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
- B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Appendix C – Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**	2/2 (100%)	8/8 (100%)	3/3 (100%)	-	**13/13 (100%)**
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**	2/2 (100%)	8/8 (100%)	3/3 (100%)	-	**13/13 (100%)**
Multi-disciplinary reviews should be started within two months of the death.	**95%**	2/2 (100%)	8/8 (100%)	3 – not yet reviewed but within dates	-	**10/10 (100%)**
Multi-disciplinary reviews should be published within six months of the death.	**60%**	2/2 (100%)	8/8 (100%)	3 – not yet reviewed but within dates	-	**10/10 (100%)**
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted April 2024	Submitted July 2024	Submitted October 2024	-	**3/3 (100%)**

NHS Resolution - change to the verification period

The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this was not announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q2** cases PMRT reviews are as follows:

Induction of labour was not performed in a timely manor
The mother's risk status was not assessed at the onset / during labour
Reduced fetal movements guideline not followed
1 to 1 care not met in labour
Ongoing aspirin accessibility and education issues
DNA policy not followed
Interpreter and/or language line not utilised in pregnancy and labour

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/3 (0%)	2/8 (25%)	1/4 (25%)	-	**3/15 (20%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/3 (33%)	0/8 (0%)	0/4 (0%)	-	**1/15 (7%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/3 (33%)	0/8 (0%)	1/4 (25%)	-	**2/15 (13%)**
Element 5.2k	Cases where the prevention, prediction, preparation or perinatal optimization of preterm birth was a relevant issue.	0/3 (0%)	0/8 (0%)	0/4 (0%)	-	**0/15 (0%)**

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Hull University Teaching Hospitals NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2024 to 31/3/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *4*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
1	0	1	0	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
4	1	2	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	1	0	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	0	0	1	0	1
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	1	0	1
Not Applicable	0	0	0	0	0	0	0
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	1	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	1	0	1
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	1	0	1
Hospital post-mortem declined	0	0	0	0	1	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	1	100% (1)
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	1	100% (1)
Management Team	0	0%
Midwife	6	100% (1)
Neonatal Nurse	1	100% (1)
Neonatologist	5	100% (1)
Obstetrician	2	100% (1)
Other	1	100% (1)
Risk Manager or Governance Team	3	100% (1)
Safety Champion	1	100% (1)

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	1	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**0 causes of death out of 0 reviews**
Neonatal deaths	**1 causes of death out of 1 reviews**
	1. Trisomy 18 2. Prematurity c. polyhydramnios
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
During resuscitation the baby required intubation but this was not attempted	1	No action entered
During the resuscitation of the baby surfactant was indicated but was not given	1	No action entered
ETT was dislodged during the attempt to change the neofit as it was loose.	1	agreed actions are, in similar situations where intubation and extubation is a changing point and if the patient is planned for cuddling, secure zinc oxide tape fixation will be used. also, to discuss in RESPECT and care plans regarding the agreed actions in reversible conditions as tubes and lines dislodgement. also, elective adjustment of ETT or its fixation to be done better during day times if not urgent. these agreed actions has been discussed during mortality reviews for all staff, will be disseminated through minutes of meeting and also through learning from mortality and datixes.
initial full examination at admission was not documented in the notes	1	a reminder for all staff regarding the importance of initial full examination was done during the mortality meeting and will be disseminated also in the learning points from the meetings.
One or more modes of birth which were attempted for this mother were not appropriate	1	No action entered
The baby required early review by a specialist whilst on the neonatal unit but the baby was not seen in a timely way	1	No action entered
The respiratory management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate	1	No action entered
This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth of the baby but serial scans were not planned	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

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

Gill Ponder and Helen Wright, Non-Executive Director Chairs

REFERENCES

Only PDFs are attached

BIC(24)189 - Performance, Estates & Finance Committees-in-Common Highlight Report.pdf

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)189

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	Gill Ponder, Helen Wright – Chairs of CIC
Contact Officer / Author	Gill Ponder, Helen Wright
Title of Report	Performance, Estates and Finance CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting(s) held on Wednesday 28 August 2024 and Wednesday 25 September 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Group financial position • Cancer performance • Elective Care • Urgent care, although small improvements were beginning to show • CQC Action on End-of-Life Data **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ☐ Information ✓ Review ☐ 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

	10 October 2024
	Performance, Estates and Finance Committees in Common
	28 August 2024, 25 September 2024
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance Estates and Finance Committees-in-Common at their meeting(s) held on 28 August 2024 and 25 September 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:

28 August 2024

- *Board Assurance Framework and High Level Risks*
- *CQC Actions Report*
- *Financial Report (Month 4) including Cost Improvements*
- *Forecast Financial Position (ICB Bridge)*
- *Finance Improvement Board Action Notes*
- *22-23 National Cost Collection Publication*
- *Group Integrated Performance Report*
- *Deep Dive – Organisational Data Controls*
- *Estates and Facilities*
- *Bank and Agency Demand Solutions*
- *Procurement Report including Scan4Safety*
- *Annual Fire Report*

25 September 2024

- *Board Assurance Framework and High Level Risks*
- *CQC Actions Report*
- *Annual Planning (Operational and Financial including CIP) Timetable for 2025/26*
- *Group Integrated Performance Report*
- *Deep Dive – LOS/Beds Review and Elective Care Review*
- *Estates and Facilities*

- *Finance Report (including year-end forecast and cash position)*
- *Update from Grant Thornton work for ICB*
- *Security/LSMS Annual Report and workplan*
- *Bank and Agency Demand Solutions*

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) Group Finance – The Group reported a £1.2m deficit against the year to date plan, mainly due to industrial action, but there was funding available which would cover the majority of that. The key issue was the heavily weighted second half of the year to achieve the Cost Improvement Programme and increased productivity levels. A half year fundamental review would be taking place. Elective Recovery Fund (ERF) income was behind plan for July and August. A number of schemes had been approved to achieve additional activity and income, but there were significant risks to achieving the year-end plan, which included
a £23.5m gap to forecast, £17m of embedded cost improvement plan (CIP) initiatives deemed high risk, £8m of anticipated income not yet confirmed and release of planned HUTH reserves earlier than anticipated to offset overspends.

There were a number of mitigations in place, including achievement of the temporary staffing target of 3.2% and a system level external review by Grant Thornton with 10 workstreams, which were in progress. Whilst there was optimism that the outcomes of the review and other actions being taken to control costs would give a more positive assurance level in the future, the CIC had limited assurance on the evidence currently available that the 2024/25 financial plan would be delivered. The ICB are fully aware of the current position and further escalation will be considered following the detailed half year review.

b) The HUTH cash position remains a concern and cash cannot be moved across the Trusts. There is an expectation that deficit cash support will be received in September to negate the need for external cash support in year. However, the Group cash position is heavily dependent on delivery of the financial plan, including all planned CIP. It has been confirmed that cash support will be provided in September.

c) The performance report highlighted slight improvements in ED with time to see first clinician at NLAG 67 minutes and at HUTH it had improved from 180 minutes to 122 minutes. The August new rotas placed workforce against demand meaning that 12 hour delays had reduced. GP referral letters meant that patients were being sent straight to assessment areas rather than being held in ED. Work was ongoing to standardise criteria led discharge to make decision making for clinicians more structured. Changes to the front end of the pathway and a focus on 3 priority enablers had resulted in improvements to both the 4 hour target and ambulance handover times.

UTC performance was as expected at HRI, with Beverley and Bransholme UTCs not yet meeting the 95% commissioned target. The Rossmore facility was now at 90% capacity and was sustaining performance. Work was ongoing with Hull City Council to support care workers in the Community. Limited assurance was agreed due to the performance targets not being met and a lack of evidence of the sustainability of the recent improvements, but the CIC recognised the achievements as a result of the targeted work by the teams.

d) Achievement of 0 RTT 65 week waits by the end of September would not be achieved, but the Group were aiming to eliminate 65 week waits by the end of October 2024. Delays in achieving this target were primarily due to ADHD, plastic surgery (hand), complex breast reconstruction surgery (which was a national problem) and community dental. Additional capacity had been sourced and there were weekend working arrangements in place.

e) Elective Care Deep Dive – There had been a 6% increase in the number of referrals, compared to the operational plan where a 3% reduction had been forecast. Many of these are urgent referrals where cancer is suspected, which have to be seen within 14 days. Cancer referrals were not converting into increased cases for treatment. Limited assurance was given by the CIC, whilst recognising the mitigations in place.

f) Cancer – both Trusts were short of the trajectory and target. There were issues with the 28 day faster diagnosis target and performance had dipped over the Summer, particularly in breast and skin. There were workforce issues in these two areas which were being addressed. Lower GI colonoscopy capacity and histopathology capacity were impacting on patients and the 28 day target. Improvement work was ongoing at tumour site level. There were also capacity issues in urology due to a shortage of cancer surgeons which meant that there were breaches every month. Mutual aid was being sought. The CIC agreed limited assurance for cancer performance.

g) The CIC received a presentation on Data Quality and issues relating to rules and reporting. A validation exercise had taken place which had resulted in an increase to the PTL for NLAG, but patients had not suffered additional delays to treatment as a result of the identified issues. This had been reported to NHS England. Additional resource and structure is being allocated to data governance. Further data quality issues were being improved by ensuring business rules were applied consistently and correctly across the group.

h) Estates – Car parking, catering price increases, the Group cleaning contract review and the CDC facilities contract negotiations were reported to the CIC. Reasonable assurance was agreed.

i) The CIC agreed to recommend approval of the Fire Annual Report to the Boards in Common.

4.0 Matters on which the committees have requested additional assurance:

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

a) The PEF CIC asked for further assurance around the high level risk mitigations and what was being done to manage the risks. An example of this was highlighted with long standing risks relating to boilers and electrical equipment.

b) Further clarity was requested around timings for the financial strategy. It was agreed that a high level plan should be created based upon estimates and to include known investments such as replacement of equipment.

c) Further assurance was requested regarding the £23.5m gap to achieving the financial plan. Elective Recovery Funding and increased productivity are the current focus areas.

d) Group CQC actions are now more embedded in the Care Groups and good progress was being made. However, a CQC action on End of Life Data had not been completed. The data had previously been manually presented by the Quality Improvement team, but that resource had been deployed onto other work. This issue would be reviewed and a report would be presented to the next meeting of the CIC. Limited assurance was agreed as actions were not yet embedded and sustained.

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

5.1 The committees considered the areas of the BAFs for which they have oversight and it was agreed that a review should take place to ensure all details remain valid and actions are updated.

It was confirmed that the Finance risk would remain at risk rating 25 in light of the risks inherent in the latest forecast. The CIC discussed the target risk rating of 5 and agreed this was ambitious. A review of the first half of the year was planned to understand the financial risk mitigations and to assess the confidence level of achieving the year end target.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the items for escalation in section 3.1
- Note the items where the CIC have requested additional assurance in section 4.1

Helen Wright, Non-Executive Director and CIC Chair, HUTH

Gill Ponder, Non-Executive Director and CIC Chair, NLAG

28 August/25 September 2024

3.2.1 - WINTER PLAN UPDATE

Paul Bytheway, Group Chief Delivery Officer

REFERENCES

Only PDFs are attached

BIC(24)190 - Winter Plan Update.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)190

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10th October 2024**
Director Lead	**Paul Bytheway, Interim Chief Delivery Officer**
Contact Officer / Author	**Neil Rogers, Managing Director, North Bank (on behalf of North & South Banks.)**
Title of Report	**Group Winter Plan 2024/25**
Executive Summary	The attached paper is to provide a high level update on progress with Winter Planning, including the approach that the Group has taken and a summary of the various plans that have been developed as part of the Winter Planning process. It is intended to provide assurance that the Group is working to manage and minimise the impact of Winter 2024/25 to be able to continue to deliver high quality, responsive urgent and emergency care services for the population we serve, and avoidance of any unintended consequences to the continued delivery of planned care. NHSE requires the Boards of NHS provider Trusts to have oversight of Winter planning arrangements. The full Winter Plan will go to the Performance, Estates and Finance Committee in Common on 30th October, and it is therefore requested that Board delegates this responsibility to PEF.
Background Information and/or Supporting Document(s) (if applicable)	Individual Care Group responses in preparation for Winter 2024/25 are being finalised alongside the prioritisation of different schemes that will provide maximum benefit within the limited funding envelope available; oversight is via the Winter Planning Group that is now meeting weekly. The planning assumption is that over the peak winter months we will see increased activity compared to 2023-24 of a worst case 8%, in line with the increase from 2022-23 to 2023-24.
Prior Approval Process	Winter Planning Group
Financial Implication(s) (if applicable)	Funding requests are currently undergoing a prioritisation process against available funding.
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: To delegate responsibility for oversight and sign off of the Winter Plan to PEF Committee in Common on 30th October 2024.

HUMBER HEALTH PARTNERSHIP

WINTER PLANNING 2024/2025

1 BACKGROUND

This paper has been developed to provide a high level summary regarding operational resilience for the Winter period 2024/25. It has been based on historical experience, the review of last year conducted in Q1 2024/25 and takes account of NHS England advice and guidance. An action plan and risk register and has been developed in conjunction with Care Groups spanning the North and South Banks.

The Executive lead for Winter planning is currently Paul Bytheway, Interim Group Chief Delivery Officer.

Every year during the winter period, pressures upon our acute hospitals increase because people are more likely to need admission to hospital or suffer winter illnesses. However, the level of pressure has been sustained and extreme over recent years, with many people working as if they were in the middle of a difficult winter for longer and longer periods during the year.

Experience shows us that the key to minimising the impact of winter pressures requires a response on many levels, including:

- Reducing delayed transfer of care through effective partnership working
- Reducing variation in practice across the 7 day week, including Pathway 0 discharge
- Effective primary care streaming
- New models to manage demand without inpatient admission, including speciality inreach and effective Same Day Emergency Care (SDEC)
- Flu planning and effective IPC measures to reduce bed closures
- Close liaison with ambulances services to manage peaks in conveyance

The Humber Health Partnership Winter Plan is required to ensure its systems and processes are fit for purpose and stand the test that Winter pressures bring, and that they align to the wider system.

The plan has been developed in accordance with the latest guidance and predicted demand modelling available. The plan takes into account normal winter pressures and the potential demand placed upon the Group in responding to any future COVID outbreaks. This plan encapsulates the lessons learned from previous Winters.

The plan should be considered as a standalone plan, however it should be noted that this plan will also form a significant component of the wider ICB system Winter Resilience Plan. It should also be read in conjunction with the following Group plans:

- Escalation and Surge Policy (including capacity) (HUTH February 2022; NLG April 2023) – currently under review
- Capacity Escalation Plan and Full Capacity Protocol (HUTH February 2022)
- Seasonal Influenza Plan/Policy (HUTH November 2023; NLG October 2021)
- Business Continuity Plan/Policy (HUTH July 2023; NLG June 2024)
- Major Incident Plan (HUTH December 2023; NLG August 2023)
- Adverse Weather Plan (June 2024)
- Respiratory Surge Plan
- OPEL framework – expected December 2024

Whilst the Winter command structure will take an active role in managing the Group response to winter pressures, the Group Escalation Plan and Full Capacity Protocol will continue to manage day-to-day pressures, as will similar plans across the system.

2 DEBRIEF OF WINTER 2023/24

A debrief of Winter 2023/24 was held during Q1 2024/25 for both Trusts just as they came in to the new Group structure, and the following points were specifically highlighted by Care Groups:

What worked well:

- Point of Care testing in ED – business case in development for 2024/25
- 18 winter beds opened at HUTH (H1 with cubicles)
- Use of virtual wards, OPAT and Home First programme (South Bank)
- Additional paediatric medical support (both Trusts)

What did not work as well:

- Impact of industrial action – reduction in staffing; reduction in elective activity
- Potential safety issues and poor patient experience with escalation areas put in place at short notice
- Consequence of lack of flow and available ward beds on ED / Major Trauma, and delayed ambulance offload
- Management of homeless patients
- Different pay rates for staff and late decision making on pay rates

3 CONSIDERATIONS FOR WINTER 2024/2025

On 27 March 2024, NHS England (NHSE) released its operational planning guidance for 2024/25, outlining the priority areas and objectives for the service. Further guidance has only recently been received, outlining plans for delivering operational resilience across the NHS during the coming winter. The 4 areas of focus for ICB systems to help prepare for Winter, from last year's planning, are:

- Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place.
- Complete operational and surge planning to prepare for different winter scenarios.
- Ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.
- Supporting the workforce to deliver over winter.

The threat of further industrial action, including GP collective action, growing urgent & emergency demand, long elective waiting lists and ongoing wider pressures, such as in social care, means 2024/25 is likely to be another tough year for all local services, alongside a challenged financial position, and requirement to continue to balance planned care and cancer performance.

In August 2023, in a collaboration between Getting It Right First Time (GIRFT) and the Society for Acute Medicine (SAM) guidance was released, setting out 6 steps acute hospitals should take to improve flow in acute medicine with the aim of helping hospitals manage their acute medical take during the winter months (https://gettingitrightfirsttime.co.uk/girft-issues-six-

measures-to-help-improve-acute-hospital-flow-during-winter/). This has been used by Care Groups to formulate their individual plans. The key points include:

1. Protect Same Day Emergency Care (SDEC) capacity and function
2. Ward rounds and handover
3. Pharmacy
4. Investigations
5. Workforce optimisation
6. Allied Health Professionals and Acute Frailty Service

3.1 Experience from Southern Hemisphere Winter 2024

The Australian Respiratory Surveillance Report Viral Respiratory Diseases Epidemiology and Surveillance Section, Report 8, 2024, presents a national epidemiological update for coronavirus disease (COVID), influenza and respiratory syncytial virus (RSV) with a focus on the current reporting period (15-28 July 2024) and earlier severity reporting periods (up to 14 July 2024).

The latest data from Australia (graphs below) suggests:

- Influenza levels are higher than normal
- RSV is over 1.5 times the number of RSV notifications in the same period in 2023 and have been highest in children aged 0–4 years, followed by children aged 5–9 years
- COVID levels are lower than the number of laboratory-confirmed notifications in the same period in 2023; however, this trend should be interpreted with caution due to a reduction in case ascertainment and reporting, and have been highest in people aged 70 years or over, followed by children aged 0–4 years
- Hospitalisations for influenza positive patients are also running lower and are below the peak activity seen around the same time last year.

Overall, this suggests we should plan for a normal flu season but be prepared for high activity in the usual time window - January to February.

On other infections, it is difficult to predict peaks in advance but there is likely to continue to be a considerable number of cases of COVID and RSV through winter. As with last year, coincidence of peaks in infection can lead to peaks in demand which will put pressure on services.

3.2 VACCINATION PROGRAMME WINTER 2024/2025

On 02 August 2024, the government released a statement saying they have accepted advice from the JCVI for an autumn COVID-19 vaccination programme this year.

The government are committed to protecting those most vulnerable from COVID and have accepted the independent advice from the JCVI for the autumn 2024 vaccination programme. On the advice of the expert JCVI all those aged 65 or over, all those in care homes for older people, and those aged 6 months or over who are in a clinical risk group will be eligible for vaccination this autumn.

Whilst the JCVI has not advised offering the vaccine to frontline health and social care workers, staff in care homes for older adults, unpaid carers and household contacts of people with immunosuppression as part of the national programme, the government has

decided to continue to offer this vaccination. It will be accessible through the national booking system in primary care.

The influenza vaccination programme commenced on 03 October 2024 in both the North and South Bank, via an appointment system and stationary hubs for the first 8 weeks, followed by a roving model. All Care Groups have committed to encourage uptake of the vaccine in their areas.

It is worth noting that the RSV vaccination is due to start in September 2024 - infants will be protected by maternal vaccination at around 28 weeks and continued use of passive immunity for immunocompromised babies; older adults will have been offered a new vaccine which cannot be given at the same time as flu and COVID jabs (75, plus 76-79 catch up) this September.

There may be ongoing higher levels of Measles and Whooping Cough (Pertussis) so it is important to ensure that staff are protected against these.

3.3 NO CRITERIA TO RESIDE (NCTR) PATIENTS

NCTR patients impact on our ability to manage flow from the ED, access to acute beds and to maintain elective capacity. Timely management of the bed base is set against the need to ensure compliance with the recommendations in the UK Infection Prevention and Control guidance to prevent and control COVID infection and other seasonal infections. It is therefore imperative that the number of NCTR patients is minimised and the progress that has already been achieved through the Summer months of 2024 in reducing the Pathway 1-3 NCTR numbers is continued. It is, however, important to note that during the winter period there may be times when the number of NCTR will rise due to outbreaks of influenza, COVID, VRE and other infections, rather than as a result of community and social care capacity.

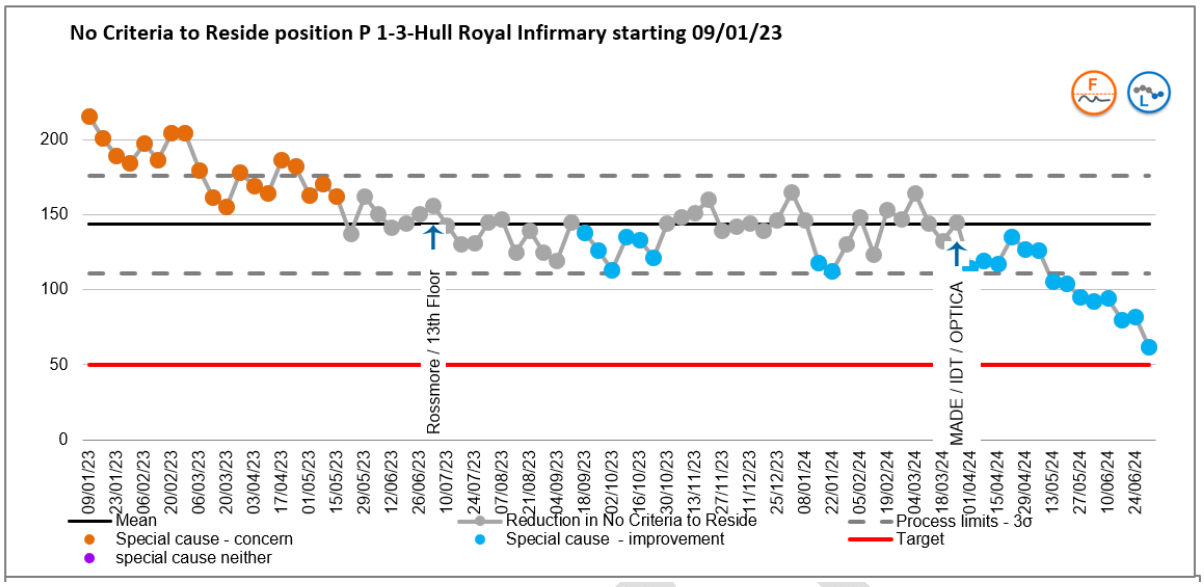
During Winter 2023/24, HUTH continued to provide care for an average of 150-170 NCTR patients, which had a severe impact on the Trust's ability to manage its elective and non-elective admissions. A bid was developed to build a 60-bedded social care facility on the old helipad site in Argyle Street with the intention that the Trust would use these beds (Rossmore, run by CHCP,) in conjunction with the creation of a Discharge to Assess unit on the 13th Floor of Hull Royal Infirmary, in order to improve flow and free up acute beds.

Over recent months significant improvements have been seen in relation to patient flow which has resulted in a reduction in the number of NCTR patients (pathways 1-3) occupying hospital beds, particularly at HUTH.

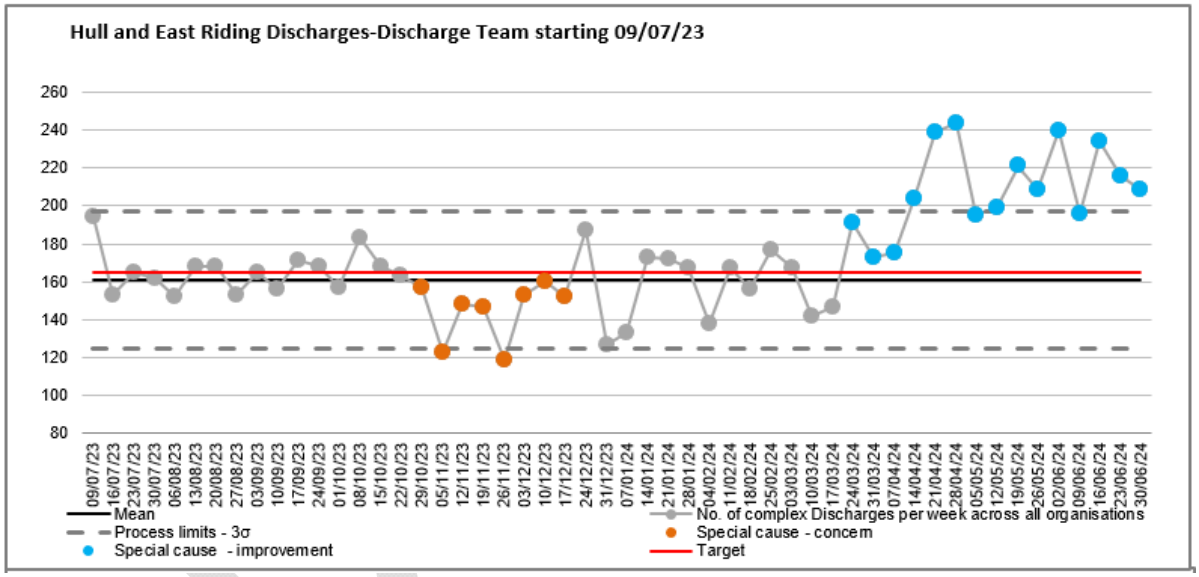
It is assumed that these arrangements will remain in place for the totality of the Winter period. Whilst an opportunity was taken to close a further NCTR ward at Castle Hill (C20) because of the stabilised NCTR position, that is currently under review as part of finalising the Winter plan, as a result of pressures that are impacting HUTH at an earlier stage than anticipated.

HULL UNIVERSITY TEACHING HOSPITALS

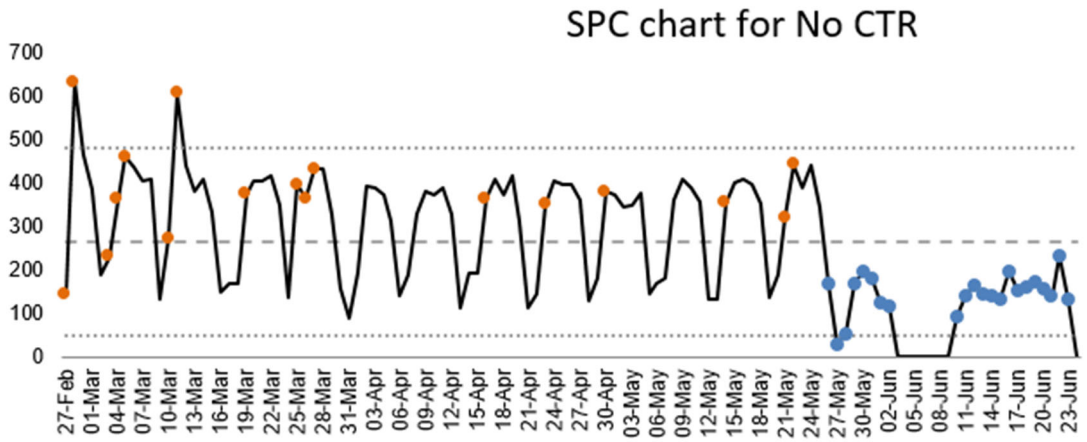
The graph below shows the success achieved in reducing NCTR numbers.



The graph below shows the increased number of complex discharges that have been seen this year:



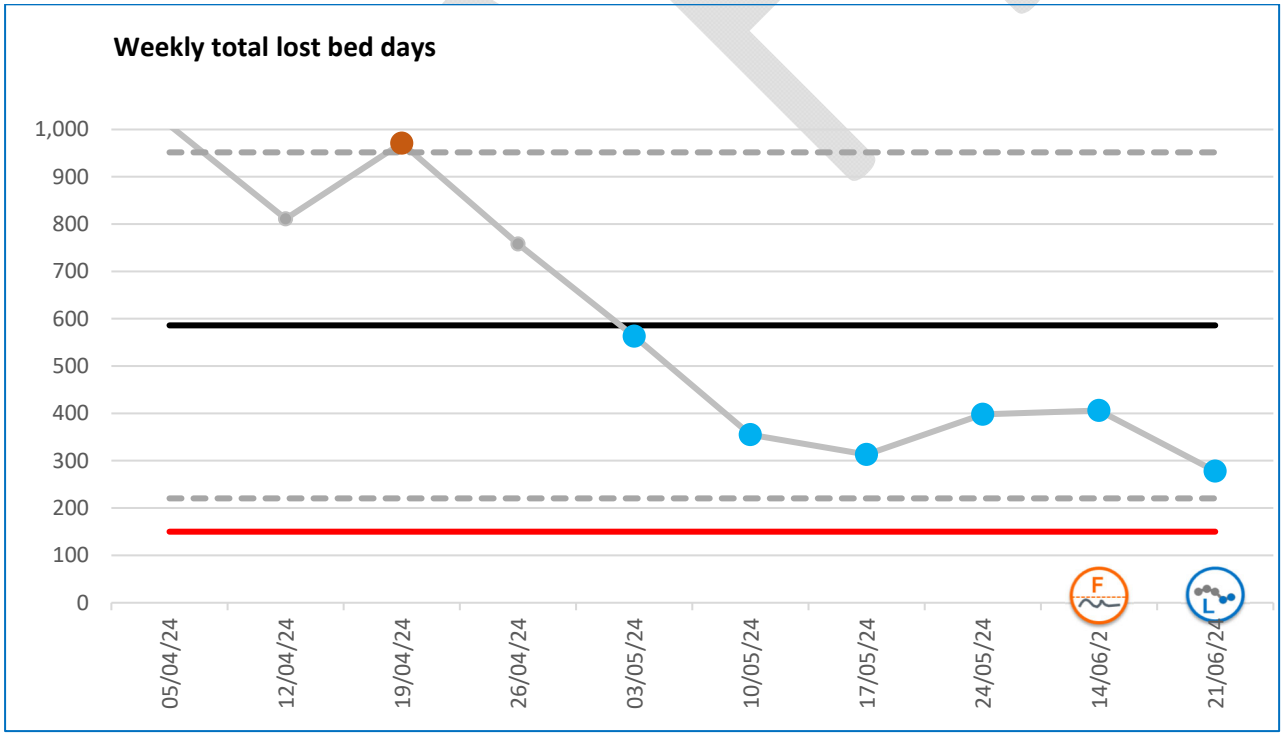
NORTHERN LINCOLNSHIRE AND GOOLE



3.4 LONGER LENGTH OF STAY

In addition to the reduction in the overall NCTR patient numbers, there has been a decrease in the cohort of those patients with a longer length of stay (LLoS). Unnecessary days in hospital may lead to increased hospital-acquired patient complications eg infection and falls. Patients' physical and mental capabilities, including mobility, physical strength and awareness levels, may also be negatively impacted. It is therefore imperative that we continue to focus on LLoS for both the

Top 10 LLoS NCTR work (HUTH)



4 PLAN OBJECTIVES

Implementation of the Winter Plan 2024/2025 aims to ensure that the Group:

- has appropriate resources and processes in place to cope with increased workload
- has appropriate escalation arrangements in place to cope with significant peaks in demand
- works effectively and efficiently with partner organisations to prevent admissions, where appropriate, and to ensure timely discharge

- continues to improve against Emergency Department (ED) performance indicators, including ambulance handover times and time in department, working towards zero tolerance to 24 hours and ultimately 12 hours
- provision of same day emergency care and acute frailty services is increased
- minimises the extent to which increases in emergency and acute activity adversely affects cancer services and performance against other waiting time targets, including post pandemic elective recovery
- has appropriate arrangements in place for dealing with severe weather events, such as snow and flooding
- has appropriate arrangements in place for dealing with a severe seasonal influenza outbreak
- effectively manages infection prevention and control, complying with latest NHSE IPC guidance

5 PLANNING PRINCIPLES

A national NHSE Winter Letter was recently summarised by the ICB, and the key points to be taken forward by the wider system are outlined below:

- National UEC team - developed suite of measures to support winter delivery, working with NHSE regional team
    - **UEC Recovery Plan Assurance –** ICB to repeat a self-assessment exercise against 10 High Impact Interventions from UEC. Recovery Plan – for ICB to submit to National UEC team 16/09/24
    - **System Coordination Centre Assurance Process -** ICB to submit to regional team 16/09/24 - to achieve formal accreditation of the SCC by April 2025
    - **Bed Capacity Assurance -** ICBs to provide assurance on sufficient bed capacity to manage winter. Planning and Performance team meeting with Place planning leads
- Internal NHSE review of the **GIRFT Summary Emergency Department Indicator Table (SEDIT)**
- **Winter Planning events –** both national NHSE event and regional Winter event
- **7 day reporting** from 01/11/24
- Greater level of focus from NHSE on **delivery of ED performance** in October 2024
- NEY hosting **Ambulance handover improvement workshop** 05/09/24 - to test ICB and acute Trusts ambulance handover and escalation plans
- Increased focus on **reducing 72 hour waits in department** and **8 hour handover delays**
- NHSE guidance documents to underpin winter delivery including – **vaccination programme including flu and RSV and Virtual Ward guidance**
- UKSHA **shared winter scenarios** on the levels of predicted infection circulating to support winter planning
- **Revised OPEL framework for 24/25** for implementation in December 2024

Within the letter, NHS acute trusts were asked to:

- Review general and acute core and escalation bed capacity plans:
    - With board assurance on delivery by the peak winter period
- Review and test full capacity plans:
    - this should be in advance of winter
    - in line with letter of 24 June 2024, include ensuring care outside of a normal cubical or ward environment is not normalised; only used in periods of elevated pressure; always escalated to an appropriate member of the

executive and at system level; and used for the minimum amount of time possible

- Ensure the fundamental standards of care are in place in all settings at all times:
    - particularly in periods of full capacity when patients might be in the wrong place for their care
    - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- Ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow:
    - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- Ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:
    - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

Prior to submission to PEF, we will ensure that all of the above points are covered within our plan.

6 CURRENT SYSTEM PRESSURES

The system continues to experience high pressure and reports high OPEL levels. Current system pressures / risks impacting on the ICB regional health and social care system are as follows:

- **Increased demand** across all providers; Acute Trusts, Mental Health, Urgent Care (NHS 111, UTC, GP OOH) Primary Care, Ambulance service.
- **Increased numbers** of patients attending the Emergency Department who could be seen in other services.
- **Higher acuity** of patients attending the Emergency Department resulting in the requirement of more assessment/treatment time.
- Ongoing **mental health bed capacity** issues.
- **Workforce**: Recruitment and retention of staff. Increased staff sickness and staff absences.
- **COVID presentations** continue to fluctuate following anticipated waves in infection which continues to create challenges across the system both in hospital and in the community.
- Increase in other infections, eg **paediatric demand** due to respiratory viruses, flu and norovirus
- Increased demand for services in the **community** to support people in their own homes
- **Flow issues** - complexity of needs, matching demand / capacity and patient choice.
- **Independent provider fragility**,eg Care Home and Domiciliary Care market.

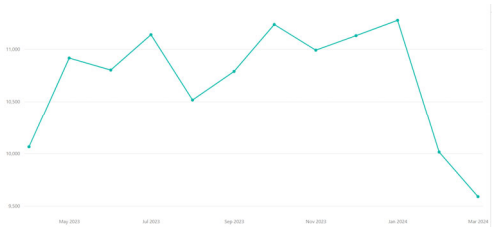
7 REVIEW OF 2023/2024

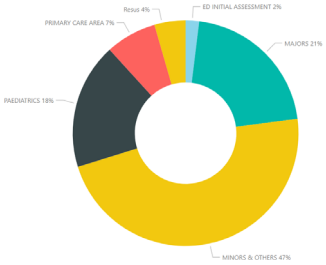
7.1 NORTH BANK

There was an increase of 11.5% in attendances to the Emergency Department at HRI, with a 3.4% increase in non-elective admissions compared to the previous year. Major cases

accounted for 21% of all attendances, minor cases 47%, paediatric cases 18% and primary care cases 7%. In addition, it is worth noting that there has been a 15.3% decrease in attendances in the last 12 months (Aug 23 compared to August 24) due to the opening of the UTC in February 2024, and this is clearly the minor / primary care workload.

ATTENDANCES AND ARRIVALS BY STREAM (HRI)





Attendances were significantly higher during January and February 2024 compared to the pattern seen during previous winters.

MONTH	2022/23	2023/24	*Majors*	*Minors*	*Paeds*	*Primary Care*	*Resus*
April	10197	10063	*2304*	*4497*	*1647*	*1015*	*460*
May	11011	10915	*2283*	*4854*	*1982*	*1146*	*487*
June	10460	10801	*2284*	*4917*	*1995*	*989*	*461*
July	10735	11137	*2537*	*5043*	*1946*	*1033*	*516*
August	9957	10516	*2372*	*5070*	*1611*	*869*	*482*
September	9878	10788	*2297*	*5142*	*1929*	*790*	*475*
October	10093	11234	*2226*	*5342*	*2071*	*849*	*474*
November	10100	10990	*1995*	*5222*	*2236*	*760*	*465*
December	10316	11128	*2196*	*5354*	*2140*	*648*	*488*
January	9431	11274	*2219*	*5593*	*2021*	*642*	*502*
February	9072	10013	*2112*	*4885*	*1784*	*589*	*416*
March	10439	9589	*2196*	*4725*	*1862*	*54*	*508*

7.2 SOUTH BANK

There was an increase of 17.6% in attendances to the Emergency Departments at NLG, with a 5.7% increase in non-elective admissions compared to the previous year. Thre has also been a 7.7% increase in attendances last 12 months (Aug 23 compared to August 24)

8 WINTER FUNDING PRIORITIES

8.1 CARE GROUP WINTER FUNDING PRIORITIES

For the financial year 2023/24, HUTH allocated £0.5m from reserves to support winter pressures. NLG did not allocate any funding.

Whilst the funding position for Winter 2024-25 remains unclear, as part of the Winter Planning process, the Winter Planning Group have identified priorities for any possible investment.

Previous winter funding priorities have included an additional Paediatric Consultant and Group-wide Point of Care Testing programme for COVID, Influenza and Respiratory Syncytial Virus (RSV) in all acute direct admission areas (ie Emergency Departments, SDECs, Cardiology, Queen's Centre and Paediatrics). These 2 measures were to ensure

that patient flow and capacity were maintained. Increased laboratory testing would result in significantly higher costs when compared to the cost of POC testing.

9 CARE GROUP PLANS FOR WINTER 2024/2025

All Care Groups have been asked to consider their responses to a number of questions to address their preparedness for Winter 2024/25; these are currently going through a "confirm and challenge" process and will be provided as an appendix to the plan presented to PEF on 30th October.

10 ESCALATION

The Group has in place a well-rehearsed Trust Escalation Plan and Full Capacity protocol, in line with System requirements, and this was reviewed via a workshop held on 1st October and will now be further refined, particularly to identify actions to prevent escalation to Level 4, and further contingency actions including lowering the discharge threshold when Level 4 is reached. This plan is the primary means of managing and escalating capacity issues, but the key issue is that some of the escalation capacity is deployed for much of the year, and therefore does not provide significant additionality to deal with peaks.

In line with system requirements, the Group has developed an Escalation Plan which has been reviewed and is used throughout the year. The process complies with NHSE and System guidance and requirements, and is frequently utilised. All managers are well versed in implementing and managing the Escalation process on a regular basis, and during periods of on call.

11 WINTER PLANNING GROUP

The Group has established a Winter Planning Group to manage the impact of winter pressures across the Group. The Winter Planning Group is responsible for providing co-ordinated plans for the winter period 2024/2025, taking into account relevant risks, guidance, policies, protocols and noting the agreed framework of contractual and performance trajectories. All Care Groups are represented via a member of their triumvirate. The Winter Planning Group is to meet fortnightly until March 2025 (it is currently stepped up to weekly) and has an action plan to ensure key areas of work are undertaken and where off track escalated appropriately. There is also a risk register.

12 OTHER DEPARTMENTAL PLANS

12.1 PATIENT TRANSPORT

Recently when the Trust (HUTH) has been at OPEL 3 or 4, there have been occasions when the Trust has required two extra crews each day. It is likely that additional staffing will be required over Winter. It is likely that ad hoc reliance on a local medical transport company will increase, with associated expenditure.

12.2 PORTERING

Porters will provide cross-site working to ensure additional portering support wherever it is required. This will be contained within North and South Bank sites, to avoid costly cross bank travel. Weekly roster reviews will be undertaken to ensure sufficient porter provision is in place to enable patient moves. Recruitment to vacant positions and active pursuing of applicants will take place. Porter provision at OPEL 3 and OPEL 4 is continually being reviewed and provided to meet the needs of patient activity.

12.3 SECURITY

The security establishment will not be uplifted during winter. However, ad-hoc additional staffing will be considered, and an assessment based on risk. Routine, customer-service activities will be reduced to the meet most urgent needs.
Business hours for access card and parking permit applications will be compressed to release staff to urgent activity demands.

Traffic management will be dynamically assessed and parking enforcement will be controlled in main parking areas to ensure flow continues for blue light ambulances, for admissions and PTS for discharges.

Patient 1:1 security may be reduced to meet increased core security functions. Alternative provisions need to be considered.

13 RISK MANAGEMENT

The Winter Planning Group will maintain a risk register of all risks identified and the control measures adopted. They will be recorded through Care Group risk registers and updated via the Winter Planning Group. The key risk currently is the reliance on additional funding to implement plans, the source of which is currently unknown. Based on the challenges to achieving planned care performance, the instruction to Care Groups so far has been not to stand down any clinics or routine operating to liberate workforce or space to deal with UEC demand.

14 SUMMARY

The Winter Plan remains a live document and will be adapted to address the issues faced by Humber Health Partnership through Winter 2024/25, via the action plan. It will be supported through daily oversight and appropriate escalation and surge planning, with regular input from the clinical Care Groups aligned to both North and South Banks, supported by a proactive and effective command structure.

15 RECOMMENDATION

The Board in Common is requested to note the content of the report and to delegate oversight of Winter planning for the Group to the Performance, Estates & Finance Committee in Common.

To:
- Integrated care board:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Integrated care partnership chairs
- All NHS trust and foundation trust:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Regional directors

cc.
- Local authority:
  - chief executive officers

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 September 2024

Dear colleagues

Winter and H2 priorities

Further to the meeting with ICB and provider chief executives on 3 September, we are now confirming operating assumptions for the remainder of this financial year.

This letter outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter.

Planning and financial framework

You are all aware of the tight financial environment both across the NHS and for the government more widely; it remains essential in H2 that systems continue their work to return to their agreed 2024/25 plans.

Providing safe care over winter

As set out in our letter of 16 May, we are in the second year of the delivery plan for recovering urgent and emergency care (UECRP).

Colleagues across the country have worked incredibly hard to implement the priority interventions identified in the UECRP. This has delivered improvements in performance on the 4-hour emergency department (ED) and Category 2 ambulance response time ambitions, against an extremely challenging backdrop.

The delivery priorities for this winter remain unchanged from those agreed in system plans.

We all recognise, however, that despite these improvements, far too many patients will face longer waits at certain points in the pathway than are acceptable.

Given demand is running above expected levels across the UEC pathway, ahead of winter we collectively need to ensure all systems are re-confirming that the demand and capacity plans are appropriate and, importantly, are taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

Supporting people to stay well

As a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign.

As well as eligible population groups, it is imperative that employers make every possible effort to maximise uptake in patient-facing staff – for their own health and wellbeing, for the resilience of services, and crucially for the safety of the patients they are caring for.

More detail on eligible flu cohorts is on gov.uk:

- National flu immunisation programme 2024 to 2025
- COVID-19 autumn/winter eligible groups

We confirmed campaign timings for both vaccines in our system letter on 15 August.

This year for the first time, the NHS is offering the RSV vaccine to those aged 75 to 79 and pregnant women. This is a year-round offer but its promotion ahead of winter by health professionals is vital, particularly to those at highest risk.

To support vaccination efforts, NHS England will:

- ensure all relevant organisations receive information as quickly as possible for flu, COVID-19 and RSV
- maintain the National Booking Service, online and through the NHS 119 service for COVID and flu (in community pharmacy settings)
- continue to share communication materials to support local campaigns

ICBs are asked to work with:

- local partners to promote population uptake with a focus on underserved communities and pregnant women
- primary care providers to ensure good levels of access to vaccinations, ensuring that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
- primary care and other providers, including social care, to maximise uptake in eligible health and care staff

NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders
- record vaccination events in a timely and accurate way, as in previous campaigns
- monitor staff uptake rates and take action accordingly to improve access and confidence
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely

Maintaining patient safety and experience

We recognise this winter is likely to see UEC services come under significant strain, and many patients will face longer waits at certain points in the pathway than acceptable.

It is vital in this context to ensure basic standards are in place in all care settings and patients are treated with kindness, dignity and respect.

This means focusing on ensuring patients are cared for in the safest possible place for them, as quickly as possible, which requires a whole-system approach to managing winter demand and a shared understanding of risk across different health and care settings.

Evidence and experience shows the measures set out in the UECRP are the right ones, and systems and providers should continue to make progress on them in line with their local plans, with assurance by regional teams.

In addition, NHS England will continue to support patient safety and quality of care by:

- standing-up the winter operating function from 1 November:
  - providing capabilities 7 days a week, including situational reporting to respond to pressures in live time
  - this will be supported by a senior national clinical on-call rota to support local escalations
- completing a Getting It Right First Time (GIRFT) data-led review of support needs of all acute sites:
  - across all systems, and deploying improvement resources as appropriate, to support implementation of key actions within the UECRP, with a dedicated focus on ensuring patient safety
- convening risk-focused meetings with systems:
  - to bring together all system partners to share and discuss key risks and work together to agree how these can be mitigated
- expanding the Operational Pressures Escalation Levels (OPEL) framework:
  - to mental health, community and 111, and providing a more comprehensive, system-level understanding of pressures

NHS England will continue to support operational excellence by:

- co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored
- running an exercise in September to test the preparedness of system co-ordination centres (SCCs) and clinical oversight for winter, including issuing a new specification to support systems to assess and develop the maturity of SCCs

NHS England will continue to support transformation and improvement by:

- continuing the UEC tiering programme to support those systems struggling most to help them to enact their plans
- reviewing updated maturity scores for UEC high-impact interventions with regions and ICBs, to identify further areas for improvement
- as part of NHS IMPACT, launching a clinical and operational productivity improvement programme in September:
  - this will include materials and data for organisations to use, as well as a set of provider-led learning and improvement networks, to implement and embed a focused set of actions

ICBs are asked to:

- ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter:
  - primary care and community services should be working with these patients to actively avoid hospital admissions
- provide alternatives to hospital attendance and admission:
  - especially for people with complex needs, frail older people, children and young people and patients with mental health issues, who are better served with a community response outside of a hospital setting
  - this should include ensuring all mental health response vehicles available for use are staffed and on the road ahead of winter
- work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
- assure at board level that a robust winter plan is in place:
  - the plan should include surge plans, and co-ordinate action across all system partners in real time, both in and out of hours
  - it should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
- make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
- review the 10 high-impact interventions for UEC published last year to ensure progress has been made:
  - systems have been asked to repeat the self-assessment exercise undertaken last year, review the output, consider any further actions required, and report these back through regions

NHS trusts are asked to:

- review general and acute core and escalation bed capacity plans:
  - with board assurance on delivery by the peak winter period
- review and test full capacity plans:
  - this should be in advance of winter
  - in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member

of the executive and at system level; and it is used for the minimum amount of time possible

- ensure the fundamental standards of care are in place in all settings at all times:
  - particularly in periods of full capacity when patients might be in the wrong place for their care
  - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow:
  - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:
  - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

Next steps

In addition to existing guidance in the UECRP Year 2 letter and elsewhere, we have recently published further evidence-based guidance in the following areas to support further optimisation of winter plans:

- Same day emergency care service specification
- Single Point of Access hubs
- Virtual wards operational framework

As set out above, system risk discussions will follow during September.

We want to thank you and everyone across the NHS for your continued hard work this year.

Together, we are committed to doing everything we can to support the provision of safe and effective care for patients this winter, as well as continuing to improve services for the longer term.

Yours sincerely,

Sarah-Jane Marsh

National Director for Urgent and Emergency Care and Deputy Chief Operating Officer

Dr Emily Lawson DBE

Chief Operating Officer

Professor Sir Stephen Powis

National Medical Director

Duncan Burton

Chief Nursing Officer for England

3.3 - WORKFORCE, EDUCATION & CULTURE COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Tony Curry, Non-Executive Director Chair

REFERENCES

Only PDFs are attached

BIC(24)191 - Workforce, Education & Culture Committees-in-Common Highlight Report.pdf

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)191

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	Tony Curry, Chair of Committees in Common
Contact Officer / Author	Tony Curry, Chair of Committees in Common
Title of Report	Workforce, Education and Culture Committees in Common escalation report
Executive Summary	This report sets out the items of business considered by the Committees-in-Common at their meeting held on Thursday 29 August 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. There was no meeting held in September 2024. The CIC gave limited assurance to the following items and details are included in the escalation report: • CQC Actions • Workforce, Race Equality Standards **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Any financial implications will be included in the report
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

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

	10 October 2024
	Workforce, Education and Culture Committees in Common
	29 August 2024
	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(s) held on 29 August 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*
- *CQC Actions progress HUTH and NLAG*
- *Workforce Race Equality Standard (WRES)*
- *Workforce Disability Equality Standard (WDES)*
- *Group's response to the recent riots*
- *Guardian of Safe Working Q1 Report HUTH*
- *Guardian of Safe Working Q1 Report NLAG*
- *Learning and OD Progress Report*

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) Maternity industrial action continued at NLAG and discussions were ongoing. The Group Chief People Officer was meeting with ACAS but it was still a challenging position.
b) The NLAG Governors had raised a number of issues that the CIC discussed.
    - CDC staffing and the impact on clinicians and quality of care – a number of new staff had been appointed and there would also be a rotation of

staff implemented. The CIC agreed to review the impact on the workforce at future meetings once the workstream was live. The quality of care impact was referred to the Quality and Safety CIC.

4.0 Matters on which the committees have requested additional assurance:

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

a) CQC Actions – Limited assurance was given as although the review meetings and changes to rag ratings had been completed there were still a number of actions that were rated red and had seen no movement for some time. The CIC Chair to write to the Group Chief Nurse to clarify when the actions were expected to be closed.
b) Workforce Race Equality Standard – HUTH were showing improvements particularly since the Zero Tolerance to Racism policy and processes had been implemented. NLAG were showing a more static position with little movement. Both organisations were still reporting bullying and harassment cases and this was not an improving position.
c) Workforce Disability Equality Standard – Both HUTH and NLAG were similar in the work they were carrying out particularly regarding reasonable adjustments and flexible working. It was noted that there was more work to do and a further report showing what was being done across the Group would be received in October 2024.
d) The CIC heard about the support that was given to all staff following the recent riots in Hull. The reaction of the Trust was commended by the CIC.
e) The CIC awarded significant assurance to the Learning and OD work around induction, recruitment and Care Group support during the recent changes.

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

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

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

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the items for escalation in section 3.1.
- Note the items for further assurance in section 4.1

Tony Curry, Non-Executive Director and Chair of Workforce, Education and Culture Committees in Common

30 August 2024

3.3.1 - WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT

Simon Nearney, Group Chief People Officer

REFERENCES

Only PDFs are attached

BIC(24)192 - Workforce Disability Equality Standard (WDES) Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)192

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	10th October 2024
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	Lucy Vere, Group Director of Learning and Organisational Development
Title of the Report	Workforce Disability Equality Standard (WDES) Report – HUTH & NLaG
Executive Summary	The NHS WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS. The WDES follows the NHS WDES as a tool and an enabler of change. <u>HUTH</u> • Of the 10,051 staff, 22.94% (2,306) had not declared being disabled or non-disabled and are recorded as 'unknown or null'. This metric has improved from 24.25% (2023). • 366 staff have reported as Disabled on ESR; an increase from 325 staff (2023). • The metric with the highest disparity between Non-disabled staff and Disabled staff Percentage was staff reporting that the Trust valued their work. (Staff Survey December 2023 data). This metric actually improved for Disabled staff from 28.6% (2022) to 29.7% (2023) for non disabled staff this improved from 38.6% (2022) to 43.2% (2023). • The metric with the lowest disparity between Non-disabled staff and Disabled staff is staff that saying that the Trust provides equality of opportunity in career progression (Staff Survey December 2023 data). This metric has improved for Disabled staff from 49.2% (2022) to 54.5% (2023), this is a nearly 11% improvement. • The data shows there are improvements to be made across all of the indicators and the

	disparity between the experience of Disabled staff measured against Non-disabled staff remains a challenge for the Trust. The integrity of the data would be increased by an improvement in the declaration of staff regarding being disabled or non-disabled on ESR. <u>NLaG</u> • The percentage of disabled staff in both the non-clinical and clinical workforce is very low standing at 4.5% of the total workforce. This percentage has increased by 0.93% since 2023. • Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts in 2022-23 was 1.31 times more likely to be appointed from shortlisting compared to disabled staff, in 2023-24 the ratio has improved to show that Non-Disabled staff were 1.15 times more likely to be appointed from shortlisting. • Overall staff experience for our disabled staff has improved in terms of bullying, harassment and discrimination. • Disabled staff are still 2.58% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff. • Disabled staff felt 9.25% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff. This gap as deteriorated since last year. • 73.58% of disabled staff from the staff survey feel we have made adequate adjustments to enable them to carry out their work. An improvement of 4.28% compared to the previous year. • The engagement score for disabled staff as improved and is now above the national average for disabled staff. The Trust Boards-in-Common is asked to note the content of this report. Action plans are being created and they will be submitted at the October Workforce, Education and Culture Committees-in-Common for approval prior to publishing on our Trust Website by 31st October 2024
Background Information and/or Supporting	N/A

Document(s) (if applicable)	
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	This report highlights that there remains significant inequity of Disabled staff experience at HUTH and NLaG.
Recommended action(s) required	✓ Approval ☐ Information ✓ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES)
Trust Submission 2024

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2024 and proposed action plan.

2 Background

The NHS Workforce Disability Equality Standard (WDES) was commissioned in 2019 and is overseen by the NHS Equality and Diversity Council and NHS England.

The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES aims to help inform year on year improvements in reducing those barriers that impact most on the career and workplace experiences of Disabled staff; driving changes in attitudes, increasing employment and career opportunities and implementing long lasting change for Disabled people.

The WDES enables NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators and to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff.

By using the WDES, NHS England expects that all NHS organisations will, year on year, improve workforce disability equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WDES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

3 WDES Submission 2024

The Trust is required to submit a number of returns. These include:

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2024. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust was required to submit the Data Template by 31 May 2024 and this was achieved.
- Reporting Template (see Appendix 1) which is supported by accompanying data report for Indicator 1: Staff employed across Agenda for Change Bandings (see Appendix 2).
- WDES Action Plan which is based on the outcomes from the technical data results and is intended to address disparities in the experiences of disabled staff compared to non-disabled staff (TBC).
- This report should be read in the context that only 366 staff self-reported with a disability whereas when completing the Staff Survey (December 2023) a higher number of staff reported themselves as disabled or having a Long Term Condition.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 31 October 2024.

4 Achievements throughout 2023/24

There have been a number of achievements in the past year, which are detailed below:

4.1 Zero Tolerance to Ableism

The Zero Tolerance to Ableism (Disability Discrimination) Framework and reporting tool was launched to in the middle of October 2023 as Disability History month concluded. A Circle Group has been established to examine all reports and triage for action.

4.2 Recruitment

The work the recruitment team have done to ensure that the number of people shortlisted utilising the disability confident preferred interview option has increased significantly, this hasn't necessarily translated to a proportionate increase of the likelihood of being appointed from shortlisting but has resulted in an absolute increase in appointments.

4.3 Disability Staff Network

After 2 years at the helm after establishing the network Elaine Hillaby stood down to focus on her role as an organisational development practitioner to be replaced by Tracey Sargeson who stepped up from being a deputy. During the year Elaine was deservedly recognised for her contribution for raising the profile of disabled staff with the award for Inclusion at the Golden Hearts awards.

4.4 Disability Leadership programme

The Disability Leadership Programme run in collaboration with Disability Rights UK was delivered online via zoom over four months from September 2023 to March 2024 - 4 full day sessions

The programme was complemented by a bespoke version of the 90 days challenge the cohort consisted of 12 staff members.

4.5 Sunflower Lanyard Scheme

One of the projects from the Disability Leadership Programme 90 days challenge was to establish the feasibility of introducing the scheme and this has now been introduced for staff in the Trust.

5 Key Findings for 2024

The WDES seeks to ask questions in the following areas:

1. The percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers compared with the percentage of staff in the overall workforce at 31 March 2023.
2. The relative likelihood of Disabled staff compared to Non-disabled staff being appointed from shortlisting across all posts.
3. The relative likelihood of Disabled staff compared to Non-disabled staff entering the formal capability process.
4. The percentage of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse.
5. The percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. The percentage of Disabled staff compared to Non-disabled staff saying they have felt pressure from their managers to come to work when they have not felt well enough to do their duties.

7. The percentage of Disabled staff compared to Non-disabled staff saying they are satisfied with the extent to which their organisation values their work.
8. The percentage of Disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.
9. A) The staff engagement scores for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation.

   B) Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?
10. The percentage difference between the organisation's Board voting membership and its organisation's overall workforce at 31 March 2024.

The key findings from the technical data for 2024 are:

- The Trust employed 10,051 staff at 31 March 2024.
- Of the 10,051 staff, 22.94% (2,306) had not declared being disabled or non-disabled and are recorded as 'unknown or null'. This metric has improved from 24.25% (2023).
- 366 staff have reported as Disabled on ESR; an increase from 325 staff (2023).

- The metric with the highest disparity between Non-disabled staff and Disabled staff Percentage was staff reporting that the Trust valued their work. (Staff Survey December 2023 data). This metric actually improved for Disabled staff from 28.6% (2022) to 29.7% (2023) for non disabled staff this improved from 38.6% (2022) to 43.2% (2023).

- The metric with the lowest disparity between Non-disabled staff and Disabled staff is staff that saying that the Trust provides equality of opportunity in career progression (Staff Survey December 2023 data). This metric has improved for Disabled staff from 49.2% (2022) to 54.5% (2023), this is a nearly 11% improvement.

The data for 4 to 9 B) above is from the Staff Survey and inherently more staff report themselves as disabled or having a Long Term Condition when completing the staff survey compared to the staff who report themselves as disabled through ESR.

The data shows there are improvements to be made across all of the indicators and the disparity between the experience of Disabled staff measured against Non-disabled staff remains a challenge for the Trust. The integrity of the data would be increased by an improvement in the declaration of staff regarding being disabled or non-disabled on ESR.

6 Recommendation

The Workforce Education and Culture Committee is asked to note the content of this report subject to any amendments. Action plans are being created and they will be submitted at the October Committee for approval prior to publishing on our Trust Website by 31st October 2024

WORKFORCE DISABILITY EQUALITY STANDARD REPORTING TEMPLATE

Workforce Disability Equality Standard

Name of organisation:	Hull University Teaching Hospital NHS Trust
Date of report:	March 2024
Name and title of Board lead for the Workforce Disability Equality Standard:	Simon Nearney, Director of Workforce & OD
Name of lead compiling this report:	Mano Jamieson, EDI Manager
Names of commissioners this report has been sent to:	Humber & North Yorkshire Health & Care Partnership ICB
Name of co-ordinating commissioner this report has been sent to:	HNY ICB
Unique URL link on which this report and associated Action Plan will be found:	www.hey.nhs.uk
This report has been signed off by on behalf of the Board on (insert name and date):	Jonathan Lofthouse, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however 22.94% of the workforce have not declared as disabled or non-disabled, which represents 2,306 of the total workforce.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 10,051

Proportion of disabled staff employed within the Trust at the date of the report: 3.64% of the total staff employed as self-declared through ESR.

3. Self-Reporting

The proportion of total staff who have self-reported disabled/non-disabled: 73.42%

Have any steps been taken to increase declaration rates? All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on ESR. Existing staff continue to be reminded to check their personal details and update their ESR entry where appropriate and we have run a number of “bridging the gap” sessions. It is now highlighted on ESR with reminders that staff can update their disability status on ESR self service.

Are any steps planned during the current reporting period to improve the level of self-reporting The Trust are exploring the Occupational Health software system to see if disability declaration can be compared against ESR to see if declaration rates can be improved. To support this process we will continue the “bridging the gap initiative to encourage declaration as well as continue to raise the profile of disabled staff through the recently introduced Zero Tolerance to Ableism framework.

4. Workforce Data

What period does the organisation’s workforce data refer to: Staff in post at 31 March 2023 and activity during the financial year 2023/24.

5. Workforce Disability Equality Indicators

	Indicator	Data for reporting year 2023/24		Data for previous year 2022/23		Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Appendix 2 for breakdown by pay banding (From ESR). Where disability is known for 31 March 2024:				In total 72.33% of Trust staff declared themselves as disabled or non-disabled. The highest percentage of disabled employees are within the clinical workforce (non-medical) whilst the lowest percentage of disabled employees are within the clinical workforce (medical and dental)	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
		Non-clinical workforce (Non-disabled) =	20.41%	Non-clinical workforce (Non-disabled) =	16.66%		
		Non-clinical workforce (Disabled) =	1.01%	Non-clinical workforce (Disabled) =	0.86%		
		Clinical workforce (non-medical Non-disabled) =	43.74%	Clinical workforce (non-medical Non-disabled) =	44.47%		
		Clinical workforce (non-medical Disabled) =	2.20%	Clinical workforce (non-medical Disabled) =	2.22%		
		Clinical workforce (medical and dental non-disabled) =	9.27%	Clinical workforce (medical and dental Non-disabled) =	11.19%		
		Clinical workforce (medical and dental Disabled) =	0.61%	Clinical workforce (medical and dental Disabled) =	0.34%		
2	Relative likelihood of Non-disabled staff being appointed compared to disabled applicants from shortlisting across all posts.	Non-disabled: 0.20 Disabled: 0.15 Relative likelihood: 1.36		Non-disabled: 0.26 Disabled: 0.16 Relative likelihood: 1.56		The data shows that Non-disabled staff are more likely than Disabled staff to be appointed from shortlisting. However we are shortlisting more disabled staff through the activity of the recruitment	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2023/24	Data for previous year 2022/23	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
				team ensuring Managers adhere to the preferential interview offer under the Employer Confident Scheme	
3	Relative likelihood of Disabled staff entering the formal capability process compared to Non-disabled staff. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled: N/A Non-disabled: N/A Relative likelihood: N/A	Disabled: N/A Non-disabled: N/A Relative likelihood: N/A	The numbers of staff entering the formal capability process are low, the relative likelihood of entering the formal capability process is nil for both Disabled and Non-Disabled staff.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
4 a) i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Non-disabled: 23.1% Disabled: 32.7% (From Staff Survey December 2023)	Non-disabled: 27.5% Disabled: 34.5% (From Staff Survey December 2022)	The percentage of Disabled and Non-Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has increased.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
4 a) ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months.	Non-disabled:9.0% Disabled: 17.0% (From Staff Survey December 2023)	Non-disabled:12.3% Disabled: 20.6% (From Staff Survey December 2022)	The percentage of Disabled and Non-disabled staff experiencing harassment, bullying or abuse from managers has increased.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
4 a) iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months.	Non-disabled: 16.3% Disabled: 27.1% (From Staff Survey December 2023)	Non-disabled: 20.7% Disabled: 29.0% (From Staff Survey December 2022)	The percentage of Non-disabled and Disabled staff experiencing harassment, bullying or abuse from other colleagues has decreased.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
4b	Percentage of staff that the last time they	Non-disabled: 44.6% Disabled: 45.3%	Non-disabled: 43.2% Disabled: 47.6%	The percentage of Disabled staff reporting harassment,	Please see action plan.

	Indicator	Data for reporting year 2023/24	Data for previous year 2022/23	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
	experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	(From Staff Survey December 2023)	(From Staff Survey December 2022)	bullying or abuse at work has increased.	Actions link to EDS2022 goals and the Trust Equality Objectives.
5	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	Non-disabled: 62.0% Disabled: 54.5% (From Staff Survey December 2023)	Non-disabled: 58.9% Disabled: 49.2% (From Staff Survey December 2022)	The percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion has decreased.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
6	Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non-disabled: 21.2% Disabled: 29.3% (From Staff Survey December 2023)	Non-disabled: 22.9% Disabled: 35.8% (From Staff Survey December 2022)	The Percentage of Disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has remained the same.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
7	Percentage of staff saying they are satisfied with the extent to which their organisation values their work.	Non-disabled: 43.2% Disabled: 29.7% (From Staff Survey December 2023)	Non-disabled: 38.6% Disabled: 28.6% (From Staff Survey December 2022)	The percentage of Disabled staff saying they are satisfied with the extent to which their organisation values their work has decreased.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
8	Percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	76.0% (From Staff Survey December 2023)	71.4% (From Staff Survey December 2022)	The percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work has decreased.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
9a	Staff engagement score for Disabled staff, compared to Non-disabled staff and the	Non-disabled staff: 6.8 Disabled: 6.2 Organisation: 6.7	Non-disabled staff: 6.5 Disabled: 6.0 Organisation: 6.4	The staff engagement score for Disabled staff continues to be lower than for Non-disabled staff.	Please see action plan.

	Indicator	Data for reporting year 2023/24	Data for previous year 2022/23	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
	overall score for the organisation.	(From Staff Survey December 2023)	(From Staff Survey December 2022)		Actions link to EDS2022 goals and the Trust Equality Objectives.
9b	Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?	Yes	Yes	The Trust has an Enabled Staff Support Network and held a Network Conference.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	4.0%	2.0%	Considering the percentage of staff who have self-reported as Non-disabled and the percentage of staff who have self-reported as Disabled the disaggregated percentage difference would be expected to be very low. The Trust acknowledges that, in respect of disability, the Board is not representative of the population it serves. Within Hull and East Riding the disabled population is 19%, whilst within HUTH the declaration is 3.43%.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.

6. Are there any other factors or data which should be taken into consideration in assessing progress? No

7. Organisations should produce a detailed WDES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WDES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2022. You are asked to attach the WDES Action Plan or provide a link to it.

The WDES Action plan will be attached in time for uploading by 31st October.

				Snapshot of data as at 31st MARCH 2024						
				Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall
Metric	Indicator		Measure	# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/Null	% Unknown/Null	Total
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	**1a) Non Clinical Staff**								
		Under Band 1	Headcount	2	18.2%	8	72.7%	1	9.1%	11
		Bands 1	Headcount	1	5.9%	8	47.1%	8	47.1%	17
		Bands 2	Headcount	37	3.1%	904	75.5%	257	21.5%	1198
		Bands 3	Headcount	29	4.6%	468	74.4%	132	21.0%	629
		Bands 4	Headcount	11	3.9%	206	73.6%	63	22.5%	280
		Bands 5	Headcount	8	4.1%	153	79.3%	32	16.6%	193
		Bands 6	Headcount	5	3.6%	100	71.4%	35	25.0%	140
		Bands 7	Headcount	2	1.8%	87	77.0%	24	21.2%	113
		Bands 8a	Headcount	3	4.3%	48	69.6%	18	26.1%	69
		Bands 8b	Headcount	1	2.1%	30	63.8%	16	34.0%	47
		Bands 8c	Headcount	0	0.0%	8	42.1%	11	57.9%	19
		Bands 8d	Headcount	1	9.1%	5	45.5%	5	45.5%	11
		Bands 9	Headcount	0	0.0%	3	75.0%	1	25.0%	4
		VSM	Headcount	2	6.3%	23	71.9%	7	21.9%	32
		Other (e.g. Bank or Agency) Please specify in notes.	Headcount	0		0		0		0
		Cluster 1: AfC Bands <1 to 4	Auto-Calculated	80	3.7%	1594	74.7%	461	21.6%	2135
		Cluster 2: AfC bands 5 to 7	Auto-Calculated	15	3.4%	340	76.2%	91	20.4%	446
		Cluster 3: AfC bands 8a and 8b	Auto-Calculated	4	3.4%	78	67.2%	34	29.3%	116
		Cluster 4: AfC bands 8c to VSM	Auto-Calculated	3	4.5%	39	59.1%	24	36.4%	66
		Total Non-Clinical	Auto-Calculated	102	3.7%	2051	74.2%	610	22.1%	2763
		1b) Clinical Staff								
		Under Band 1	Headcount	7	9.86%	62	87.32%	2	2.82%	71
		Bands 1	Headcount	0		0		0		0
		Bands 2	Headcount	22	2.29%	777	80.85%	162	16.86%	961
		Bands 3	Headcount	19	4.15%	320	69.87%	119	25.98%	458
		Bands 4	Headcount	5	2.98%	122	72.62%	41	24.40%	168
		Bands 5	Headcount	81	3.82%	1705	80.39%	335	15.79%	2121
		Bands 6	Headcount	41	3.82%	813	75.77%	219	20.41%	1073
		Bands 7	Headcount	20	2.99%	427	63.92%	221	33.08%	668
		Bands 8a	Headcount	6	3.03%	126	63.64%	66	33.33%	198
		Bands 8b	Headcount	2	3.51%	32	56.14%	23	40.35%	57
		Bands 8c	Headcount	0	0.00%	7	36.84%	12	63.16%	19
		Bands 8d	Headcount	0	0.00%	2	50.00%	2	50.00%	4
		Bands 9	Headcount	0	0.00%	1	50.00%	1	50.00%	2
		VSM	Headcount	0	0.00%	2	25.00%	6	75.00%	8
		Other (e.g. Bank or Agency) Please specify in notes.	Headcount	0		0		0		0
		Cluster 1: AfC Bands <1 to 4	Auto-Calculated	53	3.2%	1281	77.3%	324	19.5%	1658
		Cluster 2: AfC bands 5 to 7	Auto-Calculated	142	3.7%	2945	76.3%	775	20.1%	3862
		Cluster 3: AfC bands 8a and 8b	Auto-Calculated	8	3.1%	158	62.0%	89	34.9%	255
		Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	12	36.4%	21	63.6%	33
		Total Clinical	Auto-Calculated	203	3.5%	4396	75.7%	1209	20.8%	5808
		Medical & Dental Staff, Consultants	Headcount	6	1.10%	390	71.43%	150	27.47%	546
		Medical & Dental Staff, Non-Consultants career grade	Headcount	1	1.54%	48	73.85%	16	24.62%	65
		Medical & Dental Staff, Medical and dental trainee grades	Headcount	54	6.21%	494	56.85%	321	36.94%	869
		Total Medical and Dental	Auto-Calculated	61	4.12%	932	62.97%	487	32.91%	1480
		Number of staff in workforce	Auto-Calculated	366	3.64%	7379	73.42%	2306	22.94%	10051
2	**Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.** Note: i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES Online Survey to ensure comparability between organisations.	Number of shortlisted applicants	Headcount	660		7011		159		
		Number appointed from shortlisting	Headcount	96		1385		37		
		Likelihood of shortlisting/appointed	Auto-Calculated	0.15		0.20		0.23		
		Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	Auto-Calculated	1.36						
3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** **This Metric will be based on data from a two-year rolling average of the current year and the previous year (April 2020 to March 2021 and April 2021 to March 2022).**	Average number of staff entering the formal capability process over the last 2 years for any reason. (i.e. Total divided by 2.)	Headcount	0		0		0		
		Of these, how many were on the grounds of ill-health?	Headcount	0		0		0		
		Likelihood of staff entering the formal capability process	Auto-Calculated	0.00		0.00		0.00		
		Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	Auto-Calculated	#DIV/0!						
10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** **• By Voting membership of the Board** **• By Executive membership of the Board** **This is a snapshot as of at 31st March 2023.**	Total Board members	Headcount	2	12.50%	14	87.50%	0	0.00%	16
		of which: Voting Board members	Headcount	1	7.69%	12	92.31%	0	0.00%	13
		: Non Voting Board members	Auto-Calculated	1	33.33%	2	66.67%	0	0.00%	3
		of which: Exec Board members	Headcount	2	25.00%	6	75.00%	0	0.00%	8
		: Non Executive Board members	Auto-Calculated	0	0.00%	8	100.00%	0	0.00%	8
		Difference (Total Board - Overall workforce)	Auto-Calculated		9%		14%		-23%	
		Difference (Voting membership - Overall Workforce)	Auto-Calculated		4%		19%		-23%	
		Difference (Executive membership - Overall Workforce)	Auto-Calculated		21%		2%		-23%	

EDS 2022 Domains

Domain 2; Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source

2D: Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed

3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Workforce Disability Equality Standard (WDES) Report 23/24
Northern Lincolnshire and Goole Hospitals Foundation Trust

1.0	**PURPOSE OF THE REPORT**
1.1	To update the Trust Board on progress against the Workforce Disability Equality Standard Indicators (WDES). https://www.england.nhs.uk/wp-content/uploads/2019/01/wdes-2021-metrics.pdf
1.2	To update the Trust Board on the trust submission and the data, as per trust contractual requirements.
1.3	To highlight key priorities and actions required to make improvements against the WDES.
2.0	**BACKGROUND/CONTEXT**
2.1	As set out in the National Health Service (NHS) Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare.
2.2	The NHS WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS. The WDES follows the NHS WDES as a tool and an enabler of change.
2.3	The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.
2.4	The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission (CQC) inspections under the 'Well Led' domain.
2.5	It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
2.6	The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

3.0 DATA ANALYSIS – METRICS

3.1 Metric 1

Metric 1 shows the percentage of Northern Lincolnshire and Goole NHS Foundation Trust NLaG) staff who have classified themselves as having a disability compared to those staff who do not have a disability using Agenda for Change (AfC) pay bands, medical and dental subgroups and Very Senior Managers (VSMs), (including Executive Board members). The percentages are clustered into 4 pay groups for non-clinical staff and 7 groups for clinical staff. This is due the small numbers of staff in each pay band.

This data has been collected from Electronic Staff Records (ESR) as of 31 March 2023 and 31 March 2024.

Metric 1a Non-Clinical Workforce							Mar-23	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1 AfC Band 1 – 4	58	3%	1574	89%	145	8%	1777	81%
Cluster 2: AfC Band 5 – 7	16	5%	275	89%	18	6%	309	14%
Cluster 3: AfC Band 8a – 8b	5	7%	64	91%	1	1%	70	3%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	2	4%	43	96%	0	0%	45	2%
Total	**81**	**4%**	**1956**	**89%**	**164**	**7%**	**2201**	

Metric 1a Non-Clinical Workforce							Mar-24	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	85	5%	1616	88%	127	7%	1828	81%
Cluster 2: AfC Band 5 - 7	19	6%	291	90%	14	4%	324	14%
Cluster 3: AfC Band 8a – 8b	7	10%	65	89%	1	1%	73	3%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	1	3%	36	98%	0	0	37	2%
Total	**112**	**5%**	**2008**	**89%**	**142**	**6%**	**2262**	

Metric 1b Clinical Workforce							Mar-23	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	72	4%	1514	95%	16	1%	1602	31%
Cluster 2: AfC Band 5 – 7	103	4%	2494	96%	3	0%	2600	51%
Cluster 3: AfC Band 8a – 8b	3	2%	124	98%	0	0%	127	2%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	0	0%	28	100%	0	0%	28	1%
Cluster 5: Medical and Dental staff, Consultants	2	1%	227	99%	0	0%	229	4%
Cluster 6: Medical and Dental staff, Non-consultant career grade	1	0%	201	99%	2	1%	204	4%
Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	2	1%	299	99%	0	0%	301	6%
Total	**183**	**4%**	**4887**	**96%**	**21**	**0%**	**5091**	

Metric 1b Clinical Workforce							Mar-24	
	Disabled		Non-Disabled		Unknown or Null			
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	
Cluster 1: AfC Bands 1 – 4	89	5%	1475	87%	131	8%	1695	
Cluster 2: AfC Band 5 – 7	135	5%	2456	88%	198	7%	2789	
Cluster 3: AfC Band 8a – 8b	5	4%	128	92%	4	4%	137	
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	0	0%	26	100%	0	0%	26	
Cluster 5: Medical and Dental staff, Consultants	2	1%	211	89%	23	10%	236	
Cluster 6: Medical and Dental staff, Non-consultant career grade	2	1%	209	93%	14	6%	225	

Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	4	5%	283	88%	22	7%	309	6%
Total	**237**	**4%**	**4788**	**88%**	**392**	**7%**	**5417**	

In the tables, metric 1a and metric 1b clearly show that the percentage of disabled staff in both the non-clinical and clinical workforce is very low standing at 4.5% of the total workforce. This percentage has increased by 0.93% since 2023. This is comparable to what is reported nationally across NHS trusts as 4.9% of NHS staff declaring as having a disability (2023 WDES report). The tables above highlights that there are a small proportion of the workforce which record their disability status as either unknown, not declared or a null response. The number of unknown responses has increased in the last year, across all staff groups.

3.2

Metric 2

The table below shows the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts for 2022-23 and 2023-24.

	Indicator	2022-23			2023-24		
Metric 2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**
		Number of shortlisted applicants	589	7632	303	3495	248
		Number appointed from shortlisting	88	1493	59	771	166
		Ratio shortlisted / appointed Likelihood candidates are appointed from shortlisting	88/589= 0.15	1493/7632= 0.20	Ratio shortlisted / appointed Likelihood candidates are appointed from shortlisting	59/303 = 0.19	771/3495 =0.22
		Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts is 1.31			Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts is 1.15		

Note: This refers to both external and internal posts Disability Unknown have been excluded).

Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts in 2022-23 was 1.31 times more likely to be appointed from shortlisting compared to disabled staff, in 2023-24 the ratio has improved to show that Non-Disabled staff were 1.15 times more likely to be appointed from shortlisting.

*It should also be noted that NLaG as part of the Department of Work and Pensions scheme are a Disability Confident Employer, and therefore operate a guaranteed interview scheme for disabled applicants who meet the minimum person specification.

3.3 **If the organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.*

Metric 3

Metric 3 explores the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. Data is based on the number of staff entering the formal capability procedure from a two-year rolling average of the current year and the previous year. This metric applies to capability on the grounds of performance and not ill health.

	Indicator	2022-24		
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**
		Number of staff in workforce	349	6796
		Average number of staff entering the formal capability process for any reason	0	6
		Of these, how many are on the grounds of ill health only?	0	1
		As there are fewer than 10 Disabled members of staff (on average) entering the formal capability process over the previous two years. Therefore, this metric has been suppressed due to the small numbers involved.		

3.4 No disabled staff entered into the formal capability process during this period.

2023 NHS Staff Survey Results Analysis Metrics 4, 5, 6, 7, 8 and 9a

The metrics 4, 5, 6, 7, 8 and 9a overleaf represent unweighted question level responses to key findings in the NHS for NLaG staff. The staff survey results surrounding the disabled workforce between 2022 and 2023 are similar, with slight improvements to some of the metrics.

Metric 4

	Metric	2022 Staff Survey Result		2023 Staff Survey Result	
Metric 4.1	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months	Disabled	31.9%	Disabled	28.15%
		Non-disabled	22.7%	Non-disabled	24.35%
		NHS Average Score		NHS Average Score	
		Disabled	33.0%	Disabled	30.35%

		Non-disabled	26.2%	Non-disabled	23.76%
Metric 4.2	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	Disabled	20.3%	Disabled	15.92%
		Non-disabled	12.6%	Non-disabled	8.74%
		NHS Average Score		NHS Average Score	
		Disabled	17.1%	Disabled	15.87%
		Non-disabled	9.9%	Non-disabled	8.74%
Metric 4.3	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Disabled	34.3%	Disabled	28.21%
		Non-disabled	20.1%	Non-disabled	19.41%
		NHS Average Score		NHS Average Score	
		Disabled	26.9%	Disabled	25.86%
		Non-disabled	17.7%	Non-disabled	16.6%
Metric 4.4	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	Disabled	50.2%	Disabled	51.77%
		Non-disabled	46.9%	Non-disabled	47.83%
		NHS Average Score		NHS Average Score	
		Disabled	48.4%	Disabled	50.44%
		Non-disabled	47.3%	Non-disabled	49.33%

Staff feel harassment, bullying or abuse in the last 12 months from:

- Overall, there are some notable improvements in this standard across all areas.

Metric 5

Metric 5	Percentage believing that the Trust provides equal opportunities for career progression or promotion	Disabled	44.0%	Disabled	52.75%
		Non-disabled	56.3%	Non-disabled	55.33%
		NHS Average Score		NHS Average Score	
		Disabled	51.4%	Disabled	51.54%
		Non-disabled	57.3%	Non-disabled	57.52%

This standard as improved but Disabled staff are still 2.58% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to

non-disabled staff.

Metric 6

Metric 6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled	30.5%	Disabled	29.56%
		Non-disabled	21.9%	Non-disabled	20.31%
		NHS Average Score		NHS Average Score	
		Disabled	30.0%	Disabled	28.55%
		Non-disabled	20.8%	Non-disabled	19.46%

Disabled staff felt 9.25% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff. This gap as deteriorated since last year.

Metric 7

Metric 7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	28.4%	Disabled	31.17%
		Non-disabled	37.0%	Non-disabled	41.36%
		NHS Average Score		NHS Average Score	
		Disabled	32.5%	Disabled	35.66%
		Non-disabled	43.6%	Non-disabled	47.19%

Disabled staff felt 10.19% less satisfied that the organisation valued their work compared to non-disabled staff. This gap as deteriorated since last year.

Metric 8

Metric 8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled	69.3%	Disabled	73.58%
		NHS Average Score		NHS Average Score	
		Disabled	71.8%	Disabled	73.38%

73.58% of disabled staff from the staff survey feel we have made adequate adjustments to enable them to carry out their work. An improvement of 4.28% compared to the previous year.

Metric 9a

Metric 9 Part a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Disabled	5.9	Disabled	6.65
		Non-disabled	6.6	Non-disabled	6.26
		Organisation Score	6.4	Organisation Score	6.79
		NHS Average Score		NHS Average Score	
		Disabled	6.4	Disabled	6.46
		Non-disabled	6.9	Non-disabled	7.04
	The engagement score for disabled staff as improved and is now above the national average for disabled staff.				
Metric 9 Part b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) If no what actions are planed?	Yes As part of the Trust's Equality Objectives plans the Trust has developed a Disability Network to give disabled staff a voice.			

Metric 10

Metric 10	The percentage of NLaG Board and Executive Team who classify themselves as having a disability or long-term condition of 31 March 23. (Includes both executive and non-executive directors)	**31-Mar-23**			
		Trust Board and Executive Team	**Disabled**	**Non-Disabled**	**Not Declared**
			14.29%	85.71%	0.00%
		31-Mar-24			
		Trust Board and Executive Team	**Disabled**	**Non-Disabled**	**Not Declared**
			0	100%	0

As of 31 March 2024, there are no board members who have declared having a disability on ESR.

Recommendations

4 The Workforce Education and Culture Committee is asked to note the content of this report subject to any amendments. Action plans are being created and they will be submitted at the October Committee for approval prior to publishing on our Trust Website by 31st October 2024

3.3.2 - WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT

Simon Nearney, Group Chief People Officer

REFERENCES

Only PDFs are attached

BIC(24)193 - Workforce Race Equality Standard (WRES) Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)193

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	10th October 2024
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	Lucy Vere, Group Director of Learning and Organisational Development
Title of the Report	Workforce Race Equality Standard (WRES) 2023/24 Report - HUTH & NLaG
Executive Summary	The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BAME representation. <u>HUTH</u> There has been an overall increase in head count for all staff with BAME Staff increasing from 18.7% to 21% this year: Improvements have been made across the following indicators: • The total number of BAME staff has increased across the staff groups by 335 (from 1777 to 2112) which is a positive, however further work to provide career progression opportunities, to BAME colleagues (in line with the national WRES Model Employer goals) needs to continue. • BAME staff are now slightly less likely to enter into the formal disciplinary process compared to White staff. • BAME staff are marginally more likely to access non-mandatory training and CPD compared to White staff. Further improvements need to be made across the following indicators: • Although the percentage of BAME staff being appointed from shortlisting increased in the last 12 months, the relative likelihood of White staff being appointed from shortlisting compared to BAME staff only decreased slightly.

	• Whilst there have been improvements in lived experiences further work to improve the experiences of BAME staff in relation to bullying and harassment and career progression/promotion needs to continue. • There needs to be initiatives to improve the diversity of the Trust Board. The Trust continues to be committed to closing the gap between White and BAME work life experience and will have a detailed Action Plan for 2024/25. <u>NLaG</u> • in 2024 BAME staff represents 17.89% of all staff in Agenda for Change (AfC) bands 1-9, Medical Workforce and Very Senior Managers (VSM's). This is an increase on last year of 1.91%. The increase in BAME representation is largely due to an increase in BAME staff within the clinical workforce. • The percentage of BAME staff in a Band 8 position or above (including VSM) has remained largely the same. There is a lower percentage of BAME staff in Bands 8-9 and VSM (6.96%) compared to BAME representation within the overall workforce (17.89%). • In 2023/24 this likelihood increased, to a ratio of white staff having a 1.82 times greater chance of being appointed from shortlisting compared to BAME applicants. • In 2024, the relative likelihood of BAME staff entering a formal disciplinary process compared to white staff increased to 1.67 times more likely. This indicates that BAME staff are more likely to enter the formal disciplinary process than white staff. • BAME staff report a 10.8% higher negative experience than their white colleagues. There has been an increase of 1.5% from the 2022 for BAME staff. • In 2024, the Trust Board BAME representation has decreased compared to the previous year from 14.29% in 2023 to 11.2% in 2024. We have a number of actions in place with progress in terms of good outputs. The data is however not moving in the right direction for many of our indicators and action plans now need a full review to ensure the work we do has an impact going forward.

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)	This report highlights that there remains significant inequity of BAME staff experience at HUTH and NLaG despite the increase of BAME colleagues in our headcount.
Recommended action(s) required	✓ Approval ☐ Information ✓ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Workforce Race Equality Standard (WRES) 2023/24 Report
Hull University Teaching Hospitals NHS Trust

1. Background

This report details the Trust's 2023/24 Workforce Race Equality Standard (WRES) technical data, and key findings from this data. An Action Plan, designed to address the gaps in workplace experience between White and BAME staff, will be developed and issued when available.

This report and Action Plan must be published on the Trust's external website by 31 October 2023.

2. Introduction

The Trust employed 10,051 staff at 31 March 2024. This is an increase of 546 staff in total compared to the previous reporting period (9,505 staff as at 31 March 2023).

The number and percentage of staff by ethnicity is as follows:

Ethnicity	31 March 2023	31 March 2024
White	7541 (79.34%)	7740 (77.01%)
BAME	1777 (18.70%) (+219)	2112 (21.01%) (+335)
Not Stated	187 (1.96%)	199 (1.98%)
Grand Total	**9,505**	**10,051**

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

2 WRES 2023/24 Data

3.1 Indicator 1: Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and Very Senior Managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Non-Clinical Staff

In the non-clinical category, there has been a total increase of 485 staff across all ethnicities (from 2278 to 2763). Of this there has been an increase of BAME staff by 35 (from 103 to 138).

Table 1: The number and percentage of ***NON-CLINICAL*** staff at 31 March 2023

	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Under B1	10	90.91	0	**0.00**	1	9.09
B1	16	94.12	1	**5.88**	0	0.00
B2	1106	92.32	77	**6.43**	15	1.25
B3	599	95.23	28	**4.45**	2	0.32
B4	271	96.79	7	**2.50**	2	0.71
B5	184	95.34	9	**4.66**	0	0.00
B6	136	97.14	4	**2.86**	0	0.00
B7	103	91.16	5	**4.42**	5	4.42
B8a	65	94.20	3	**4.35**	1	1.45
B8b	44	93.61	2	**4.26**	1	2.13
B8c	19	100.00	0	**4.17**	0	0.00
B8d	11	100.00	0	**0.00**	0	0.00
B9	4	100.00	0	**0.00**	0	0.00
VSM	29	90.63	2	**6.25**	1	3.12
Total	**2597**		**138**		**28**	

Clinical Non-Medical Staff

In the clinical non-medical category, there has been a total increase of 215 staff across all ethnicities (from 5628 to 5843). Which includes there has been an increase of BAME staff by 164 (from 731 to 895).

The most significant contributor to the increase in BAME staff headcount is due to the Trust's continued sourcing of internationally educated nurses who will account for the majority of the increase in Band 5 BAME nurses.

Table 2: The number/percentage of ***CLINICAL NON-MEDICAL*** staff at 31 March 2024

	White		BAME		Unknown	
	Headcount	**%**	**Headcount**	**%**	**Headcount**	**%**
Under B1	61	95.31	3	**4.69**	0	0.00
B1	1	100.00	0	**0.00**	0	0.00
B2	1061	92.99	69	**6.05**	11	0.96
B3	487	95.49	17	**3.33**	6	1.18
B4	209	96.31	7	**3.23**	1	0.46
B5	1287	66.27	621	**31.98**	34	1.75
B6	911	87.85	115	**1109**	11	1.06
B7	605	92.79	41	**6.29**	6	0.92
B8a	163	88.81	19	**10.27**	3	1.62
B8b	51	98.08	1	**1.92**	0	0.00
B8c	20	95.24	1	**4.76**	0	0.00
B8d	3	100.00	0	**0.00**	0	0.00
B9	2	100.00	0	**0.00**	0	0.00
VSM	14	87.50	1	**6.25**	1	6.25
Total	**4875**		**895**		**73**	

Medical and Dental Staff

There has been a total increase of medical and dental staff across all ethnicities by 88 (from 1304 to 1392) included in this is an increase of BAME staff by 31 (from 751 to 782).

Table 3: The number/percentage of ***MEDICAL AND DENTAL*** staff at 31 March 2024

	White		BAME		Unknown	
	Headcount	**%**	**Headcount**	**%**	**Headcount**	**%**
Consultants	234	44.73	271	**52.34**	15	2.93
Non-Consultant Career Grade	14	22.58	46	**74.19**	2	3.23
Trainee Grades	273	33.70	465	**57.41**	72	8.89
Other	0	0.00	0	**0.00**	0	0.00
Total	**521**		**782**		**89**	

Table 4: The number and percentage of ***NON-CLINICAL*** staff in each band over 2 years

	2022/23		2023/24		2022/23		2023/24		2022/23		2023/24	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	**8**	100.00	**8**	90.91	0	**0.00**	0	0.00	0	0.00	1	9.09
B1	**17**	94.44	**17**	94.12	1	**5.56**	1	5.88	0	0.00	0	0.00
B2	911	92.96	911	92.32	58	**5.92**	77	6.43	11	1.12	15	1.25
B3	464	95.67	464	95.23	18	**3.71**	28	4.45	3	0.62	2	0.32
B4	207	96.28	207	96.79	6	**2.79**	7	2.50	2	0.93	2	0.71
B5	159	95.78	159	95.34	7	**4.22**	9	4.66	0	0.00	0	0.00
B6	130	97.74	130	97.14	3	**2.26**	4	2.86	0	0.00	0	0.00
B7	89	90.82	89	91.15	4	**4.08**	5	4.42	5	5.10	5	4.42
B8a	65	94.20	65	94.20	2	**2.90**	3	4.35	2	2.90	1	1.45
B8b	44	93.62	44	93.62	2	**4.26**	2	4.26	1	2.13	1	2.13
B8c	19	100.00	19	100.00	0	**4.17**	0	0.00	0	0.00	0	0.00
B8d	8	88.89	8	100.00	0	**0.00**	0	0.00	1	11.11	0	0.00
B9	4	100.00	4	100.00	0	**0.00**	0	0.00	0	0.00	0	0.00
VSM	25	92.59	25	90.63	2	**7.41**	2	6.25	0	0.00	1	3.13
Total	**2150**		**2597**		**103**		**138**		**25**		**28**	

Table 5: The number and percentage of ***CLINICAL NON-MEDICAL*** staff in each band over 2 years

	2022/23		2023/24		2022/23		2023/24		2022/23		2023/24	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	61	95.31	66	92.96	3	**4.69**	5	7.04	0	0.00	0	0.00
B1	1	100.00	0	0.00	0	**0.00**	0	0.00	0	0.00	0	0.00
B2	1061	92.99	860	89.49	69	**6.05**	86	8.95	11	0.96	15	1.56
B3	487	95.49	423	92.36	17	**3.33**	30	6.55	6	1.18	5	1.09
B4	209	96.31	160	95.24	7	**3.23**	8	4.76	1	0.46	0	0.00
B5	1287	66.27	1318	62.14	621	**31.98**	781	36.82	34	1.75	22	1.04
B6	911	87.85	945	88.07	115	**1109**	118	11.00	11	1.06	10	0.93
B7	605	92.79	619	92.66	41	**6.29**	42	6.29	6	0.92	7	1.05
B8a	163	88.81	175	88.38	19	**10.27**	20	10.10	3	1.62	3	1.52
B8b	51	98.08	56	98.25	1	**1.92**	1	1.75	0	0.00	0	0.00

B8c	20	95.24	18	94.74	1	**4.76**	1	5.26	0	0.00	0	0.00
B8d	3	100.00	4	100.00	0	**0.00**	0	0.00	0	0.00	0	0.0
B9	2	100.00	2	100.00	0	**0.00**	0	0.00	0	0.00	0	0.00
VSM	14	87.50	8	100.00	1	**6.25**	0	0.00	1	6.25	0	0.00
Total	**4875**		**4654**		**895**		**1092**		**73**		**62**	

Table 6: The number and percentage of ***MEDICAL AND DENTAL*** staff in each band over 2 years

	2022/23		**2023/24**		**2022/23**		**2023/24**		**2021/22**		**2023/24**	
	White Headcount	**White %**	**White Headcount**	**White %**	**BAME Headcount**	**BAME %**	**BAME Headcount**	**BAME %**	**Unknown Headcount**	**Unknown %**	**Unknown Headcount**	**Unknown %**
Consultants	234	44.73	247	44.50	271	**52.34**	289	**52.07**	15	2.93	19	9.23
Non-Consultant Career Grade	14	22.58	13	20.00	46	**74.19**	46	**70.77**	2	3.23	6	3.23
Trainee Grades	273	33.70	236	27.16	465	**57.41**	549	**63.18**	72	8.89	84	9.67
Other	0	0.00	0	0.00	0	**0.00**	0	**0.00**	0	0.00	0	0.00
Total	**521**		**496**		**782**		**884**		**89**		**109**	

3.2 Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts

In comparison to the 2022/23 WRES data, this year's data shows:

- 1926 BAME applicants were shortlisted and 409 appointed compared to last year (which showed 1606 BAME applicants were shortlisted and 322 appointed).
- The percentage of BAME staff being appointed from shortlisting has improved. This reflects through in the slight improvement in the relative likelihood of appointment. The relative likelihood is that White staff are 1.19 times more likely to be appointed from shortlisting compared to BAME colleagues.

Table 7: The percentage of staff ***SHORTLISTED*** and ***APPOINTED*** over 2 years

Ethnicity	2022/23	**2023/24**
White	26.00%	25.17%
BAME	20.05%	21.24%
Not Stated	31.67%	58.06%
Relative likelihood	**1.30**	**1.19**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.3 Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

This indicator takes into account staff who have been through the formal disciplinary process by ethnicity.

In comparison to the 2022/23 WRES data, the 2023/24 data shows:

- BAME staff are now again less likely to enter into the disciplinary process than White staff.
- The number of disciplinaries in total across all ethnicities from 1 April 2023 to 31 March 2024 has increased by 53 (from 76 to 129).
- The number of BAME staff entering the formal disciplinary process has increased by 8 (from 15 to 23 in total over the last year).

Table 8: Percentage of staff who entered into a ***FORMAL DISCIPLINARY PROCESS***

Ethnicity	2022/23	**2023/24**
White	0.80%	1.33%
BAME	0.84%	1.03%
Not Stated	0.53%	1.51%
Relative likelihood	**1.06**	**0.82**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.4 Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

In comparison to the 2022/23 WRES data, this year's data shows:

- The number of BAME staff accessing training has increased marginally by 74 employees (from 1361 to 1435).
- Within the Trust, the relative likelihood shows that BAME staff are more likely to access non-mandatory training and CPD than White staff, though in effect there is equality of access.

Table 9: Percentage of staff who accessed ***NON-MANDATORY TRAINING*** and ***CPD***

Ethnicity	2022/23	**2023/24**
White	74.69%	65.22%
BAME	76.59%	67.95%
Not Stated	74.33%	61.81%
Relative likelihood	**0.98**	**0.96**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.5 Indicator 5-8 Staff Survey Results

The 2023/24 Staff Survey results show in comparison to the 2022/23 data:

- Bullying & Harassment by patients and service users towards BAME staff and White staff has fallen significantly.
- Bullying and harassment from staff has increased for White staff but decreased for BAME staff.
- The number of staff who feel that the Trust provides equal opportunities for career progression or promotion has increased by 16% for BAME staff, whilst increasing by a lesser amount for White staff.
- The number of BAME staff who stated that they personally experienced discrimination at work from a manager/team leader or other colleagues has increased by nearly 8%.

Table 10: Data for Indicators 5 to 8

Staff Survey Indicators	**White %**		**BAME %**	
	2022/23	**2023/24**	**2022/23**	**2023/24**
Indicator 5: KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	28.8%	24.9%	33.0%	30.4%
Indicator 6: KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21.5%	22.6%	31.3%	28.5%
Indicator 7: KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	58.1%	61.5%	46.6%	54.1%
Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues	6.6%	5.9%	16.4%	17.7%

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.6 Indicator 9: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

As at 31 March 2024, the Trust has 18 Board members in total, of which:

- 16 (88.9%) are of White ethnicity compared to 15 in the previous year.
- 2 (11.1%) are BAME staff members which is the same as the previous year.

Table 11: Percentage difference between the ***BOARD MEMBERSHIP VS. OVERALL WORKFORCE***

Ethnicity	2022/23	2023/24
Difference (total Board – overall workforce)	-6.9%	-10.0%

4 Achievements throughout 2023/24

There have been a number of achievements in the past year, which are detailed below:

4.1 Zero Tolerance to Racism

Zero Tolerance to Racism reporting tool & launched August 2022 consolidated through the year and became a core part of the workload of the EDI manager.

The Circle group that was established meeting on a fortnightly basis, has been able to offer support to BAME staff who raise issues and ensure that outcomes are delivered to the impacted staff.

4.2 Career Enrichment Programme

This has now been established with 6 people being provided with career mentoring from a qualified group of mentors who will work with them on an individual basis wasn't believed that the shadow board concept would be a practical solution to the issue of BAME representation in the Trust, instead an alternative programme is being developed in conjunction with the BAME staff network that will offer BAME staff opportunities at career enhancement, involving a blend of development, secondments and mentoring.

4.3 BAME Conference

Another successful conference was held at the Mercure in December the keynote speaker was Louie Horne a Filipino Nurse from NHS England who talked about the journey of an international nurse and expressed her surprise at the Trusts lack of International Nurses at management level.

4.4 BAME Staff Network

To support Yoghini Nagandran as Chair. Andrew Mooraby, Jay Choudhury & Michio Abe were appointed as joint deputies. The focus has been to increase the number of members and also the engagement with the network.

4.5 Withstand Leadership Programme

The Trust in in association with BRAP, ran a successful leadership programme with engagement with over 30 staff members. We will now track the careers of the participants to assess the success of the programme.

5 Summary

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 335 (from 1777 to 2112) which is a positive, however further work to provide career progression opportunities, to BAME colleagues (in line with the national WRES Model Employer goals) needs to continue.
- BAME staff are now slightly less likely to enter into the formal disciplinary process compared to White staff.
- BAME staff are marginally more likely to access non-mandatory training and CPD compared to White staff.

Further improvements need to be made across the following indicators:

- Although the percentage of BAME staff being appointed from shortlisting increased in the last 12 months, the relative likelihood of White staff being appointed from shortlisting compared to BAME staff only decreased slightly.
- Whilst there have been improvements in lived experiences further work to improve the experiences of BAME staff in relation to bullying and harassment and career progression/promotion needs to continue.
- There needs to be initiatives to improve the diversity of the Trust Board.

The Trust continues to be committed to closing the gap between White and BAME work life experience and will have a detailed Action Plan for 2024/25.

WRES Indicators

1. Indicator 1 - compare the data for white and BAME staff: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. KF: 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8. Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues
9. Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

Workforce Race Equality Standard Report
Northern Lincolnshire and Goole Hospitals Foundation Trust

1.0	**PURPOSE OF THE REPORT**
1.1	To update the committee on progress against the Workforce Race Equality Standard (WRES) Indicators.
1.2	To update the committee on the trust submission and the data, as per trust contractual requirements.
1.3	To highlight key priorities and actions required during 2024/25, to make improvements against the WRES.
2.0	**BACKGROUND/CONTEXT**
2.1	The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the National Health Service (NHS) Equality and Diversity Council (EDC).
2.2	The link provided signposts to a short four minute video clip describing the Workforce Race Equality Standard. https://www.youtube.com/watch?v=G44C9yn-oo0
2.3	Research and evidence suggest less favourable treatment of Black and Minority Ethnic (BAME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.
2.4	The WRES seeks to prompt enquiry to better understand why BAME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.
2.5	In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BAME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BAME staff in the NHS. The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator.
2.6	The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BAME representation.
3.0	**IMPLICATIONS FOR THE ORGANISATION**
3.1	As of the 1st April 2015, the WRES forms part of the standard NHS (National Health Service) contract. From April 2016 it has also formed part of the CQC (Care Quality Commission) inspections framework under the 'Well Led' domain.
3.2	A fundamental component to enable making progress against this standard is staff engagement and involvement.

4.0 DATA ANALYSIS – METRICS FOR THE 9 WRES INDICATORS

4.1 WRES 1

	Indicator	31st March 2023		31st March 2024	
		Descriptor	**Indicator**	**Descriptor**	**Indicator**
WRES 1	Percentage of BAME staff in Bands 8-9, Very Senior Managers (VSM), compared with the percentage of BAME staff in the overall workforce *Note: VSM includes Executive Board Members and Senior Medical Staff but excludes Medical and Dental Grades e.g., Medical Consultants. There are a small number of staff with Ethnicity unknown/null and these have also been excluded	Number of BAME Staff in Bands 8-9 and VSM	19	Number of BAME Staff in Bands 8-9 and VSM	19
		Total Number of Staff in Bands 8-9 and VSM	270	Total Number of Staff in Bands 8-9 and VSM	273
		Percentage of BAME Staff in Bands 8-9	**7.04%**	**Percentage of BAME Staff in Bands 8-9**	**6.96%**
		Number of BAME Staff in overall workforce	1165	Number of BAME Staff in overall workforce	1374
		Number of Staff in overall workforce (including all staff groups and not disclosed staff)	7292	Number of Staff in overall workforce (including all staff groups and not disclosed staff)	7679
		Percentage of BAME Staff in overall workforce	**15.98%**	**Percentage of BAME Staff in overall workforce**	**17.89%**

The table above shows that in 2024 BAME staff represents 17.89% of all staff in Agenda for Change (AfC) bands 1-9, Medical Workforce and Very Senior Managers (VSM's). This is an increase on last year of 1.91%. The increase in BAME representation is largely due to an increase in BAME staff within the clinical workforce. The percentage of BAME staff in a Band 8 position or above (including VSM) has remained largely the same. There is a lower percentage of BAME staff in Bands 8-9 and VSM (6.96%) compared to BAME representation within the overall workforce (17.89%).

As recommended by NHS England, Medical and Dental Grades (which includes Trainee Grades) are excluded in the Bands 8-9 and VSM figures as these groups generally have a much higher proportion of BAME staff. This staff group in 2023 consisted of 556 BAME staff (81.3%) and 128 white staff, and in 2024, 593 BAME staff (81.3%) and 136 white staff.

4.2 WRES 2

	Indicator	31st March 2023			31st March 2024		
		Descriptor	**White**	**BAME**	**Descriptor**	**White**	**BAME**
WRES 2	Relative likelihood of BAME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts. *Staff who declined to state Race not included in figures	Number of shortlisted applicants	6040	2246	Number of shortlisted applicants	2884	974
		Number appointed from shortlisting	1324	285	Number appointed from shortlisting	721	133
		Ratio shortlisted / appointed	1324/6040	285/2246	Ratio shortlisted / appointed	721/2884	133/974
		Likelihood candidates are appointed from shortlisting	**0.219**	**0.128**	Likelihood candidates are appointed from shortlisting	**0.25**	**0.137**

		The relative likelihood of White staff being appointed compared to BAME staff is **1.71 greater**			The relative likelihood of White staff being appointed compared to BAME staff is **1.82 times greater**			

The above table shows the relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts. The data periods used are between 1st April 2022 and 31st March 2023 and, 1st of April 2023 and 31st March 2024. The 2022/23 data shows white staff have a likelihood that is 1.71 times greater than BAME staff to be appointed from shortlisting. In 2023/24 this likelihood increased, to a ratio of white staff having a 1.82 times greater chance of being appointed from shortlisting compared to BAME applicants.

As a comparator from the 2023 WRES data the National Picture shows that white staff are more likely to be appointed from shortlisting than BAME staff 76% of NHS Trusts.

4.3

WRES 3

	Indicator	31st March 2023				31st March 2024			
		Descriptor	**White**	**BAME**	**Unknown**	**Descriptor**	**White**	**BAME**	**Unknown**
WRES 3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	Number of staff in workforce	5916	1165	211	Number of staff in workforce	6098	1374	207
		Number of staff entering formal disciplinary process	13	1	2	Number of staff entering formal disciplinary process	35	15	5
		Likelihood of entering a formal disciplinary process	13/5916= 0.002	1/1165= 0.001	n/a	Likelihood of entering a formal disciplinary process	35/6098= 0.57	15/1374= 1.09	n/a
		The relative likelihood of BAME staff entering a formal disciplinary process compared to White staff is therefore 0.001/0.002= 0.4 **(BAME staff are less likely to enter the formal disciplinary process compared to white staff)**				The relative likelihood of BAME staff entering a formal disciplinary process compared to White staff is therefore 1.09/0.57 = 1.91 **(BAME staff are more likely to enter the formal disciplinary process compared to white staff)**			

*Note: this indicator is based on year end data.

The table above shows the relative likelihood of BAME staff entering a formal disciplinary process compared to white staff. In 2023 the relative likelihood of BAME staff entering a formal disciplinary process compared to white staff was 0.4 (Less likely). In 2024, the relative likelihood of BAME staff entering a formal disciplinary process compared to white staff increased to 1.67 times more likely. This indicates that BAME staff are more likely to enter the formal disciplinary process than white staff. The numbers are proportionately low compared to the whole workforce. This increase is largely due to disciplinary cases and formal suspensions throughout the course of 2023 reducing significantly owing to the roll out of the Just and Learning Culture Framework implemented towards the end of 2022/23. The framework was developed to ensure a just and learning approach to the management of adverse events involving people ensuring a compassionate approach in the management of concerns at an informal stage. However, now the framework is fully in place disciplinary cases will continue to be monitored for fairness.

4.4 **WRES 4**

	Indicator	31st March 2023				31st March 2024			
		Descriptor	**White**	**BAME**	**Unknown**	**Descriptor**	**White**	**BAME**	**Unknown**
WRES 4	Relative likelihood of BAME staff accessing non-mandatory training and CPD as compared to White staff	Number of staff in workforce	5916	1165	211	Number of staff in workforce	6098	1374	207
		Number of staff accessing mandatory training	5902	1152	211	Number of staff accessing mandatory training	6005	1340	200
		Likelihood of accessing non-mandatory training	5902/5916= 1.00	1152/1165= 0.99	n/a	Likelihood of accessing non-mandatory training	6005/6098 = 0.98	1340/1374 = 0.98	n/a
		Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff 0.92/0.86= **1.07 more likely**				Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff 0.98 /0.98 = **1.00 (no difference)**			

The relative likelihood of staff accessing non-mandatory training in 2023 and 2024 is similar or the same for both staff groups.

4.5 **NHS Staff Survey 2023**

The WRES indicators 5, 6, 7 and 8 represent unweighted question level responses to key findings in the NHS staff survey for the Northern Lincolnshire and Goole NHS Foundation Trust staff. It also includes the average scores for acute Trusts as a comparator.

WRES 5

	Indicator	2022 Staff Survey Result		2023 Staff Survey Result	
WRES 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	Ethnicity	%	Ethnicity	%
		White	23.5%	White	23.8%
		BAME	33.1%	BAME	34.6%
		Average Acute Trust score White 26.9% BAME 30.8%		Average White 24.72% BAME 28.11%	
	BAME staff report a 10.8% higher negative experience than their white colleagues. There has been an increase of 1.5% from the 2022 for BAME staff. This is above the average acute Trust score for the BAME staff.				

WRES 6

WRES 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Ethnicity	%	Ethnicity	%
		White	27.9%	White	24.8%
		BAME	37.3%	BAME	35.5%
		Average Acute Trust score White 23.3% BAME 28.8%		Average White 22.4% BAME 26.2%	

There has been a slight decrease in staff experiencing harassment, bullying or abuse from colleagues for all staff. However, it remains significantly worse for our BAME staff with a gap of 10.7% between white and BAME staff. This is 9.3% higher than the national average.

WRES 7

WRES 7	Percentage believing that trust provides equal opportunities for career progression or promotion	Ethnicity	%	Ethnicity	%
		White	54.7%	White	56.0%
		BAME	47.1%	BAME	45.8%
		Average Acute Trust score White 58.6% BAME 47.0%		Average White 58.8% BAME 49.6%	

In 2023, 45.8% of BAME staff felt that the trust provides equal opportunities for career progression or promotion. This percentage has decreased since 2022 from 47.1%.

WRES 8

WRES 8	In the last 12 months have you personally experienced discrimination at work from the Manager/team leader or other colleagues	Ethnicity	%	Ethnicity	%
		White	7.6%	White	6.8%
		BAME	22.4%	BAME	21.9%
		Average Acute Trust score White 6.5% BAME 17.3%		Average White 6.7% BAME 16.2%	

In 2023, BAME staff felt 15.1% more likely to have personally experienced discrimination at work from their manager/team leader or other colleagues compared to white staff. This remains higher than the reported National average for BAME staff.

WRES 9

WRES 9	Boards are expected to be broadly representative of the population they serve	Ethnicity	%	Ethnicity	%
		White	85.71%	White	88.8%
		BAME	14.29%	BAME	11.2%

In 2024, the Trust Board BAME representation has decreased compared to the previous year from 14.29% in 2023 to 11.2% in 2024.The numbers are very small but Trust Board BAME representation is still much less than the overall percentage of BAME staff in the total workforce (17.89%).

5

Recommendations

The Committee is asked to note the contents of the report. There is an overall trend of a worsening position for the Trust and there needs to be a full review of the action plans from the previous years. While there is significant commitment from the Trust to improve the working lives of our BAME staff with significant outputs and actions, they do not seem to have had the impact expected. Full and comprehensive actions plans will be brought back to the committee connected to improving the measures laid out in the WRES.

3.4 - CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Gill Ponder and Helen Wright, Non-Executive Director Chairs

REFERENCES

Only PDFs are attached

BIC(24)194 - Capital & Major Projects Committees-in-Common Highlight Report.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)194

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	Helen Wright, Gill Ponder, Chair of Committees in Common
Contact Officer / Author	Helen Wright, Chair of Committees in Common
Title of Report	Capital and Major Projects Committees in Common escalation report
Executive Summary	This report sets out the items of business considered by the Committees-in-Common at their meeting(s) held on Thursday 27 August 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • EPR Benefits Realisation • Risk mitigations • Windows 11 Upgrade **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Any financial implications will be included in the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

	10 October 2024
	Capital and Major Projects Committees in Common
	27 August 2024
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Capital and Major Projects Committees-in-Common at their meeting(s) held on 27 August 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- *Board Assurance Framework and Risk Register Report*
- *Group Capital Plan Funding and Delivery*
- *Review and evaluation of new Business Cases, Investments and Dis-Investments within Delegated Limits and/or endorsement for Trust Board Approval/ Post Project Evaluation Schedule*
- *Humber Acute Services Review – including Key Risks*
- *Community Diagnostic Centre Programme – including Key Risks*
- *Digital Plan Delivery – Including Key Risks*
- *Group Capital Committee Meeting Minutes*

3.0 Matters for reporting / escalation to the Trust Boards

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

a) All risks have now been reviewed by the Care Groups but there was further work to be carried out regarding the risk scores pre and post risk mitigation. A further report would be received at the October 2024 meeting with clearer mitigation proposals.

b) A risk relating to the cladding of the new Day Surgery Unit at Castle Hill is being managed with the local Council. The existing cladding complies with building regulations but does not comply with the latest Health Technical Memorandum guidelines. There is a £0.3m risk associated with replacement of the cladding.
c) The CIC approved the updated Capital Plan funding proposal and agreed the approach to allocating £6.6m to priorities agreed by Cabinet.
d) A post project evaluation schedule was presented and approved.
e) A referral had been made to the Secretary of State regarding the HASR processes and the impact on local population. There were no concerns raised in the meeting as the process had been reviewed by the Clinical Senate and was deemed to be sound.
f) CDC building delays were forecast due to a variety of reasons outside the Group's control, leading to concerns about the impact on the revenue plan due to reduction in planned activity levels. The Estates teams were working closely to mitigate the risks where possible and alternative sites to carry out some of the potentially delayed activity were being sought.

4.0 Matters on which the committees have requested additional assurance:

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

a) EPR Benefits realisation – there remains an action to review as an independent committee including Jane Hawkard & Helen Wright. The Boards in Common and ICB had approved the outline business case and it was progressing through the National Federation Data Platform approval process. The local programme team staffing was being procured.
b) Further work was required regarding risk mitigation and how risk targets would be met as noted above.
c) Up-coming digital and equipment upgrades to be discussed further by the CIC, particularly the Windows 11 mandatory upgrade programme.

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

5.1 The committees considered the areas of the BAFs for which it has oversight and no changes were proposed.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the matters for escalation in item 3.1 above.

Helen Wright, Non-Executive Director/CIC Chair, HUTH

Gill Ponder, Non-Executive Director/CIC Chair, NLAG

27 August 2024

3.5 - AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Jane Hawkard & Simon Parkes, Non-Executive Director Chairs

REFERENCES

Only PDFs are attached

BIC(24)217 - Audit, Risk and Governance Committees-in-Common Highlight Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)217

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	10 October 2024
Director Lead	Simon Parkes & Jane Hawkard – Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Simon Parkes / Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – October 2024 - Public**
Executive Summary	The attached highlight / escalation report summarises the key matters presented to and discussed by the meeting of the Audit, Risk and Governance Committees-in-Common meeting on 1 October 2024. The Trust Boards are asked to: • Note the public highlight report from the October 2024 Audit, Risk and Governance Committees-in-Common meeting.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 1 October 2024
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:

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

	10 October 2024 – Public
	Audit, Risk and Governance Committees-in-Common
	1 October 2024
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 1 October 2024 including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- HUTH External Audit Recommendations Action Plan Update
- Annual Review of External Auditor Performance / Additional Fees – HUTH
- Group Internal Audit (IA) Progress Report 2024/25 YTD
- Group Internal Audit Recommendations Status Report
- Group LCFS Progress Report
- EPRR Core Standards Compliance Action Plans Update - Group
- BAF and Risk Register – Group
- Procurement Update (including Waiving of Standing Orders, KPI's and expired contracts recovery action plan)
- Review of Losses and Compensations – Group
- Review of Standards of Business Conduct Declarations – Group
- Document Control Report – Group
- NLAG External Audit Routine Progress Update
- Annual Review of External Auditor Performance / Additional Fees – NLAG

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

3.0 Matters for reporting / escalation to the Trust Boards

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

a) **Emergency Preparedness, Resilience and Response (EPRR) Core Standards Compliance Action Plans Update – Group** – Following a paper received at the July 2024 ARG CiC meeting and limited assurance at that time, the Committees requested an update at its October 2024 meeting to provide an overview of progress made to date on the NHS England Core Standards for EPRR 2023/24 action plans and the governance oversight of these action plans. The interim Group Chief Delivery Officer and the Group Operations Director (EPRR) provided a comprehensive report which showed a much-improved self-assessed compliance rate as at 11 September 2024 (NLAG at 91.9% compliance, up from 40% and HUTH at 85.5% compliance, up from 18%). The 2024/25 annual assurance process has commenced, including ICS peer review and the compliance results will be submitted to the December 2024 Boards-in-Common meeting for approval.
The ARG CiC agreed there had been substantial progress and were therefore ***reasonably assured*** on the 2023/24 standards action plans, noting that the compliance position with the 2024/25 standards was currently not known as the national annual assessment process had only recently commenced.

b) **Board Assurance Framework (BAF) and Risk Register – Group** – The ARG CiC discussed various aspects of the Group BAF report including the significant number of risks (over 600) on the Risk Register and the issue of mixing divisional / care group risks with strategic risks; the number of high risks; the scoring of risks and misalignment between current / strategic risks; the lack of mitigation details; the lack of a residual / mitigated risk score; and the number of high risks overdue for review (although it was noted fewer than previously but still a significant number). The crystallisation of risks was commented on and the extent to which the organisations could effectively manage such significant numbers of risks and whether there was a need to reduce the numbers in order to focus effort on those linked directly to the Group's strategic priorities. A focus on mitigations was recommended which would result in an assessment of residual risk which could be reviewed in terms of risk appetite of the organisation. The Group Director of Assurance provided details of actions being taken to further improve the risk management process, including a forthcoming refreshed Risk Management Strategy; the appointment of a new Head of Risk and Compliance and the implementation of a new risk meeting by the Group Chief Nurse to look at risks specifically across the Care Groups.
Following discussion the ARG CiC agreed that their role was to gain assurance as to the effectiveness of risk management and risk reporting and currently they only had ***limited assurance*** that this was the case.

c) **Procurement Update (including Waiving of Standing Orders, Procurement KPI's and expired contracts recovery action plan) - Group** – the Director of Procurement responded to questions around the use of single suppliers in HUTH advising that this was due in the main to maintenance contracts for existing equipment which should have been purchased at the same time as the equipment to maintain their warranty. The ARG CiC were pleased to see a recovery plan to address the number of overdue contracts, noting that the

number of overdue contracts was already reducing due to the data cleanse exercise and therefore a greater confidence in the data. The ARG CiC look forward to receiving further updates on progress against the recovery plan at future meetings. The Procurement Director also confirmed that there was a lot of work going on around improving inventory management, including cleansing 550,000 lines of catalogue data as the catalogues drive inventory management; getting out and talking to stakeholders about the variety of the same items they were using and reducing those accordingly to drive financial benefits for the Group; reviewing minimum / maximum strategies for store rooms and improving the general state of stock rooms to reduce the amount of stock held on site but with robust systems for ensuring stock arrives on the shelves when needed. It was acknowledged that there is significant potential from rationalising catalogues, etc. for cost improvements.
The ARG CiC welcomed the recovery plan for expired contracts and recognised that there was good progress being made in this area. In addition, work was underway on inventory management improvements and also in relation to single source waiver reduction. It was agreed that the ARG CiC had received ***reasonable assurance*** from the update on a pathway to substantial assurance.

d) **Review of Losses and Compensations – Group** – A number of questions were raised by ARG CiC members around HUTH overseas visitors debts and write-offs, HUTH salary overpayment write-offs and the potential inconsistent reporting of pharmacy waste across the two organisations. The interim Group Chief Financial Officer took an action to review the questions raised on the report and advise the ARG CiC members accordingly before the next meeting in January 2025.
The ARG CiC agreed that until they knew whether there were process failures or simple reporting issues involved, they were only **reasonably assured** by the report.

e) **Review of Standards of Business Conduct Policy Declarations – Group** – The ARG CiC queried the data in the report around declarations made and it was confirmed that it was not showing the complete picture i.e. the number of declarations made against the potential number of staff required to make annual declarations, including nil declarations. The ARG CiC requested that this data be produced no later than the end of the current financial year. The two organisations have different systems in place for making declarations and the Group Director of Assurance advised that they were working to harmonise the process across the Group.
The ARG CiC agreed that they only had ***limited assurance*** at this stage due to not knowing the full picture around compliance with making annual declarations.

f) **Document Control Report – Group** – The report identified eleven overdue HUTH documents from 2018 (1) and 2019 (10) and considered the potential impact of the documents being overdue for review. There were also a significant number of documents overdue for review from 2020 to date. It was also considered that these may be extant but had simply not had their review date updated. The accountability for policies was discussed and the Group Director of Assurance advised that all policies had been assigned to the relevant Care Groups and a proposal had been made to take details of overdue documents to Care Group review meetings to maintain a focus on

such issues. The ARG CiC highlighted a number of clinical areas where it was more important to ensure reviews were completed.
The ARG CiC agreed that only **limited assurance** has been received due to the number of long overdue documents.

g) **Group Internal Audit Reporting and Recommendations** - The ARG CiC received a joint internal audit report on Smart Card Access which included nine recommendations for action across the Group, all to be completed between September 2024 and 31 January 2025. An additional internal audit review had been requested on stock management which had resulted in a request to move the internal audit on the Integrated Performance Reporting (IPR) to Q4. The requests were agreed by the ARG CiC. The Internal Auditors gave an update regarding two internal audits nearing completion (Group Cost Improvement Programme (CIP) Waste reduction and the NLAG only Lorenzo review).

4.0 Matters on which the committees have requested additional assurance:

4.1 The ARG CiC requested additional assurance in relation to items as detailed above.

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

4.2 The ARG CiC considered the Board Assurance Framework (BAF) at item B in section 3 above.

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to note the highlight report from the Audit, Risk and Governance Committees-in-Common.

Simon Parkes
NLAG ARG CiC Chair / NED

Jane Hawkard
HUTH ARG CiC Chair / NED

1 October 2024

4 - GOVERNANCE & ASSURANCE

4.1 - BOARD ASSURANCE FRAMEWORK & STRATEGIC RISK REGISTER - NLAG & HUTH

David Sharif, Group Director of Assurance

REFERENCES

Only PDFs are attached

BIC(24)195 - Board Assurance Framework (BAF).pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)195

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	David Sharif, Group Director of Assurance
Title of Report	Board Assurance Framework and Strategic Risk Register – September 2024
Executive Summary	The attached report now includes the September 2024 position for: • Group BAF risks for Workforce, Leadership, Finance, Estates, Digital, Performance and Strategy • HUTH/NLAG Quality Risks • High level risks for each Committee in Common Following the Executive time-out, a revised set of strategic risks has been developed and following the 10 October Board, a full refresh of the BAF risks will follow. The current BAF has been updated following the Committees-in-Common. Following discussion at the Performance, Estates and Performance CIC, the financial BAF risk will be focused on the sustainable long-term delivery of balanced finances and the in-year financial position will feature as a high-level risk to that achievement. Recommendations: • note that there have been no changes to the risk ratings since September 2024 • note the High-level risks aligned to the BAF risks • review the BAF financial risk as detailed above
Background Information and/or Supporting Document(s) (if applicable)	The full BAF is attached at Appendix 1
Prior Approval Process	Group Cabinet Risk and Assurance Committee and Committees in Common
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

Group Board Assurance Framework
September 2024

1. Purpose of the Report

The purpose of the report is to update the Boards in Common regarding the September 2024 Board Assurance Framework which now includes merged risks for workforce, leadership, finance, performance, estates, digital and strategy.

2. Background

The Board Assurance Frameworks for both Trusts (HUTH/NLAG) have now been merged into one document. Cabinet members undertook a facilitated review of the strategic risks on 13 September. A separate report is due to be presented to Trust Boards in private on 10 October setting out the proposed strategic risks, in light of the Group's strategic framework and risk appetite, and next steps.

3. Board Assurance Framework Development

The risk ratings for September 2024 are shown in the table below. The table shows the will show risk movement from Q1 2024/25. There has been no changes to any of the risk ratings since Q1 2024/25. The detailed BAF is attached at Appendix 1.

No	Description of Risk	Lead	Committees in Common	Current Risk Rating	Movement since last Qtr	Target Risk Rating
Group						
1	**Group Workforce** – The Group does not effectively manage its risks around staffing levels, both quantitative and qualitative and does not provide quality of care to its patients	Group Chief People Officer	Workforce, Education and Culture Committees in Common	16 4 x 4	↔	12 3 x 4
2	**Group Culture and Leadership** – The Group does not make progress towards further improving a positive working culture this year and must have leadership capacity to develop an outstanding working environment	Group Chief People Officer	Workforce, Education and Culture Committees in Common	16 4 x 4	↔	12 3 x 4
3	**Group Finance** – There is a risk that the Group does not achieve delivery of the in-year financial plans or manage the underlying position appropriately	Group Chief Financial Officer	Performance, Estates and Finance Committees in Common	25 5 x 5	↔	5 1 x 5
4	**Group Estates** - There is a risk that the Trust's estate, infrastructure and engineering equipment may fail through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action. This would impact on the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.	Group Chief Financial Officer	Performance, Estates and Finance Committees in Common	20 4 x 5	↔	15 3 x 5
5	**Group Digital (IT Failure)** – There is a risk that the Group will suffer a major failure of its digital systems, leading to loss of life, finance and reputation through inability to maintain business continuity	Group Chief Medical Officer	Capital and Major Projects Committees in Common	15 3 x 5	↔	10 2 x 5
6	**Group Digital (Cyber Security) –** There is a risk that the Group will suffer a Cyber-Attack, leading to loss of life, finance and reputation through inability to maintain business continuity	Group Chief Medical Officer	Capital and Major Projects Committees in Common	15 3 x 5	↔	10 2 x 5

No	Description of Risk	Lead	Committees in Common	Current Risk Rating	Movement since last Qtr	Target Risk Rating
7	**Group Performance –** The risk is that the Group fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care	Group Chief Delivery Officer	Performance, Estates and Finance Committees in Common	20 4 x 5	↔	16 4 x 4
8	**Group Strategy -** There is a risk that the Group Strategy is not effective and does not allow the Group to deliver high quality and sustainable care and that the list of priorities do not align to investments, causing conflict	Group Chief of Strategy and Partnerships	Boards in Common	12 3 x 4	↔	8 2 x 4
9	**Group Strategic Capital -** The risk that the Group fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades	Group Chief of Strategy and Partnerships/Group Chief Financial Officer		15 3 x 5	↔	15 3 x 5
10	**Group Strategic Partnerships and Collaboration -** There is a risk that the Group does not prioritise actions at PLACE and ICB to fulfill its Anchor role which increases health inequalities, competition and competition in workforce. The Group also fails to work collaboratively to innovate and change pathways	Group Chief of Strategy and Partnerships		12 3 x 4	↔	8 2 x 4
		HUTH/NLAG				
	HUTH – Quality – There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating	Group Chief Nurse	Quality and Safety Committees in Common	16 4 x 4	↔	12 3 x 4
	HUTH – Patient Harm – There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED and Patients with No Criteria to Reside require partnership working to determine improvement plans.	Group Chief Medical Officer/Group Chief Nurse/Group Chief Delivery Officer	Quality and Safety Committees in Common	20 4 x 5	↔	16 4 x 4
	HUTH – Research and Innovation – There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	Group Chief Medical Officer	Quality and Safety Committees in Common	**12 3 x 4**	↔	8 2 x 4
	NLAG – Quality of Care - The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience	Group Chief Medical Officer/Group Chief Nurse	Quality and Safety Committees in Common	**15 3 x 5**	↔	15 3 x 5

4. High Level Risk Register

This section provides a summary of the high-level risks across HUTH and NLAG as at 12 September 2024. Aligning the risk registers to the new Care Groups is challenging by virtue of the two different risk management systems used across the Group, (HUTH use Datix and NLAG use Ulysses). With the advent of a group-wide system we anticipate the assignment of risks to categories, to CiC and strategic risks to improve. We also aim to provide more information on the changes to risks over time now that an aggregated dataset is available. The chart below shows the total number of risks on the Group Risk Register, split by risk rating.

The number of moderate risks are dominant across the Group
Chart 1:

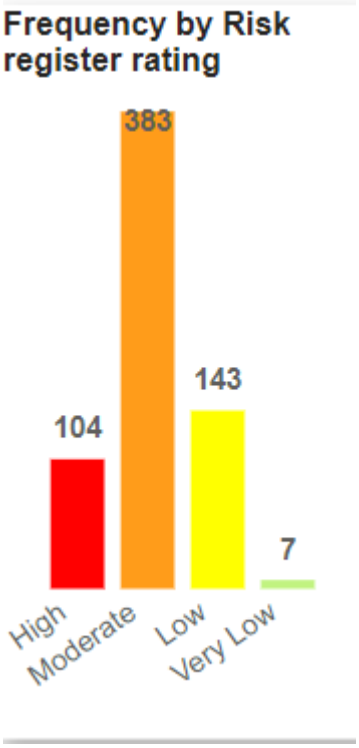


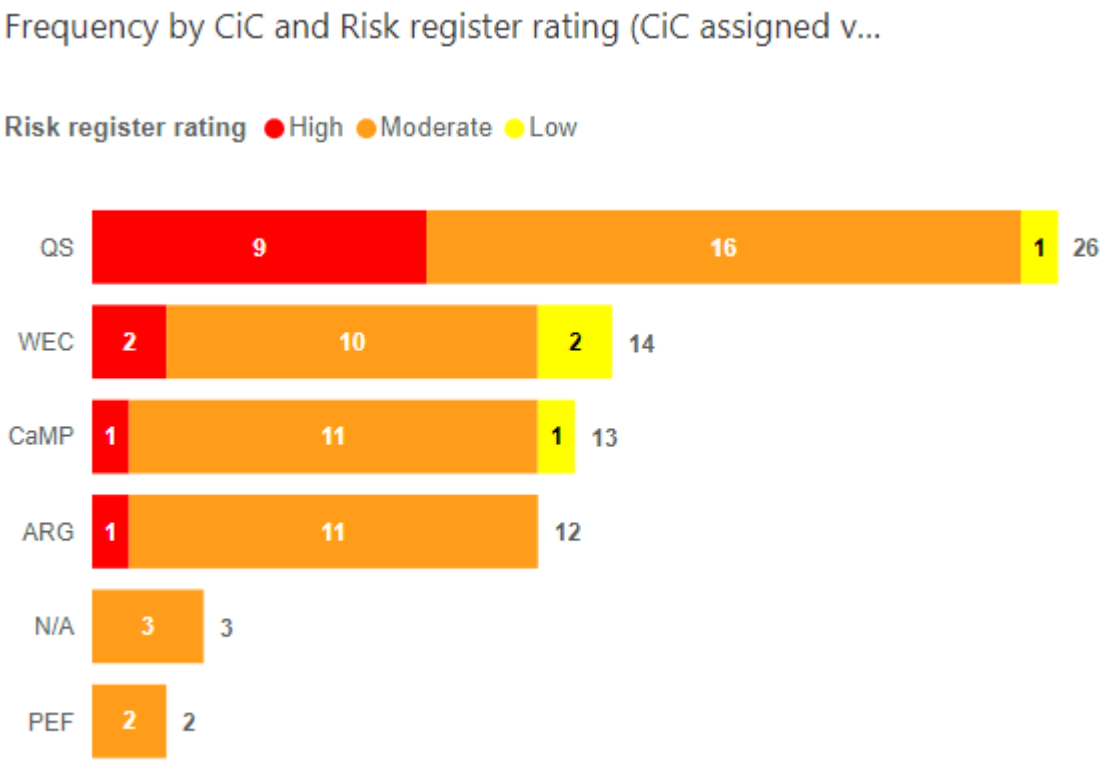
Table 1 below shows the profile of risks that are past their planned review date.

Table 1 – Time profile for risks overdue against the requirement to review

Risk register rating	12/09/2024
High	13
Moderate	53
Low	4
Total	**70**

In total there are 13 high-level risks that are overdue against the requirement to review every 30 days. Chart 2 shows all the risks past their planned review date by Committees in Common.

Chart 2 – High-level risks overdue against the requirement to review by CiC



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The high-level risks, including those that are overdue are now highlighted in each CIC BAF report and a breakdown of those risks are appended (appendix 2).

5. Next Steps

The management of all risks will continue to be assessed through the Care Groups and the escalation processes in place via site and Group arrangements.

The Group expects to publish its Group Risk Management Strategy in September, and incorporate system harmonisation and a Group wide risk management training programme.

6. Recommendation

The Boards in Common are asked to:

- note that there have been no changes to the risk ratings since September 2024
- note the High-level risks aligned to the BAF risks

David Sharif
Group Director of Assurance
September 2024

Appendix 1

Group BAF Risks – July 2024/25

Group BAF - Workforce			16
The Group does not effectively manage its risks around staffing levels, both quantitative and qualitative and does not provide quality of care to its patients.			
Executive Lead	Group Chief People Officer	Assurance Committee	Workforce Education and Culture Committees in Common
Executive Group	Workforce	Latest review date	12/09/24

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture		Partnership and integrated services		Link to BAF and CRR	S3162 - Acute And Emergency Medicine - Quality of Care and Patient Safety based on Nurse Staffing Position (20) S3232 - Community, Frailty And Therapy Services - Speech and Language Therapy Stroke staffing resource (20) N3983 - Specialist Cancer And Support Services - There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment (20) N4032 - Specialist Cancer And Support Services - Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting (20) N2949 - Specialist Cancer And Support Services - Oncology Service (20) N3646 - Specialist Cancer And Support Services - There is a risk to patient safety due to the lack of Haematology Medical Staffing (20) S3918 - Acute And Emergency Medicine - Lack of Adequate Substantive Consultant Workforce in Acute Medicine (16) S2898 - Acute And Emergency Medicine - Medical Staff - Mandatory Training Compliance (16) N4037 - Cardiovascular - Lack of Suitably Trained Staff to Perform Cardiac Stress Testing (16) N4324 - Cardiovascular - There is a risk of failing our perfusion accreditation due to non-compliance of utilising data management record keeping (16) N3045 - Digestive Diseases - Medical Workforce Vacancies in Gastroenterology (16) N3988 - Specialist Cancer And Support Services - Lack of Therapeutic Radiographer Staffing (16) S4130 - Specialist Medicine - Funding provision for 7 day IP DSN Service within Diabetes (16) S4148 - Specialist Medicine - Capacity Shortfalls in DEXA scanning (16) S3475 - Family Services - Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology (15)
	Well-led, skilled and sufficient workforce	✓	Research and innovation			
	High Quality Care		Financial Services			
	Great Clinical Services					

						S3346 - Family Services - Clinical capacity within hysteroscopy at DPOW (15) S4173 - Specialist Medicine - Nintedanib Change in guidance impacting on clinical capacity to deliver increasing numbers of patients (15)

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)			Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4	4			↔	4	12
Consequence	4	4				5	
Risk Score	16	16				20	

Controls and Assurance	
Key controls	Assurances
• HUTH Current People Strategy • NLAG Current People Strategy • Group Workforce Plan 2024/25 • Annual National Staff Survey	Internal • Development of the new Group People Strategy • Group Workforce Transformation Committee in development • Group Executive Management Committee will receive escalation reports from the Group Workforce Transformation Committee • Workforce, Education and Culture Committees in Common • Remuneration Committees in Common • Integrated Performance Report (Sickness, vacancy, appraisal rate, retention) • International recruitment drives • Certificate of Eligibility for Specialist Registration (CESR Programme) – specialist qualification before becoming a consultant External • HNY and Care Partnership ICB Workforce Board • Internal Audits • HR Director Chairs meeting (NHS Employers) • HR Network
	Gaps in Assurance **NLAG** • Vacancy position reducing overall • Nursing vacancies reducing • Consultant vacancy position remains high. • Agency spend remains high • Turnover reducing, but above target
Gaps in controls and assurances	
• Hard to recruit roles in medical specialties • Attract, recruit and retain staff to work in the geographical area • Culture and staff engagement	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Group People Strategy to be developed and launched 2025	SN	January 2025	
Launch new recruitment drives using the Group name to attract high caliber candidates	SN		All new roles are advertised with the Group recruitment standards

Group BAF – Culture and Leadership				16
The Group does not make progress towards further improving a positive working culture this year and must have leadership capacity to develop an outstanding working environment				
Executive Lead	Group Chief People Officer	Assurance Committee	Workforce Education and Culture Committees in Common	
Executive Group	Workforce	Latest review date	12/09/24	

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture	✓	Partnership and integrated services		Link to BAF and CRR	S3048 - Acute And Emergency Medicine - Challenges to recruitment of acute care physician vacancies in Acute (16)
	Well-led, skilled and sufficient workforce		Research and innovation			
	High Quality Care		Financial Services			
	Great Clinical Services					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)			Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4	4			↔	4	12
Consequence	4	4				5	
Risk Score	16	16				20	

Controls and Assurance	
Key controls	Assurances
• HUTH Current People Strategy • NLAG Current People Strategy • Group Workforce Plan 2024/25 • Annual National Staff Survey • NLAG Leadership Strategy • CQC Well Led Framework	Internal • Development of the new Group People Strategy • Group Workforce Transformation Committee in development • Group Executive Management Committee will receive escalation reports from the Group Workforce Transformation Committee • Workforce, Education and Culture Committees in Common • Disability Network • BAME Network • Group Leadership quarterly events • Group Values workshops • Circle Group • Care Group Recruitment • Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System External • HNY and Care Partnership ICB Workforce Board • Internal Audits

	• HR Director Chairs meeting (NHS Employers) • HR Network
	Gaps in Assurance • Risk around the New Care Group coming together and going live. There is an Organisational Development plan being developed to support the development of the 14 Care Groups
Gaps in controls and assurances	
• Group Staff Survey Results 2023	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Group People Strategy to be developed and launched 2025	SN		Monitored through WEC CIC
Organisational Development Plan being developed to support the new Care Groups	SN		Monitored through WEC CIC

Group BAF - Finance	
There is a risk that the Group does not achieve delivery of the in-year financial plan or manage the underlying position appropriately	25

Executive Lead	Group Chief Financial Officer	Assurance Committee	Performance Estates and Finance Committees in Common
Executive Group	Finance	Latest review date	12/09/24

Strategy and Risk Register

Link to Strategy					Link to BAF and CRR	
	Honest, caring and accountable culture		Partnership and integrated services			S4275 - Specialist Medicine - Risk to deliver the financial plan for medicine (20) S3202 - Acute And Emergency Medicine - Delivery of Balanced Financial position to include CIP savings (16)
	Well-led, skilled and sufficient workforce		Research and innovation			
	High Quality Care		Financial Services	✓		
	Great Clinical Services					

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)			Change from previous quarter	Inherent Risk	Target Risk
Likelihood	5	5			↔	5	5
Consequence	5	5				5	
Risk Score	25	25				25	

Controls and Assurance

Key controls	Assurances
• Operational and Financial Plan 2024/25 • Group Executive to Triumvirate Performance Review meetings • NHS E/ICS engagement • Group Counter Fraud and Internal Audit Plans • Group Budgetary Control System	**Internal** • Minutes of Audit Risk and Governance Committees in Common (Quarterly) • Minutes of Performance, Estates and Finance (Monthly) • Highlight reports to the Trust Board (Monthly) **External** • Internal Audit Reports • Financial planning updates to ICS • Meetings with NHSE Regional Team • Benchmarking

	Gaps in Assurance • £84m Cost Improvement Programme • Underlying deficit 2024/25 • Bed Pressures • ERF Delivery • Profile of EPR vs funding allocation • CQC Quality issues – financial implications • Junior Doctors strike implications
Gaps in controls and assurances	
• Ongoing development of accountability of Care Groups • Industrial Action • Cost Improvement Programme not fully formed. • Delivery plan to support activity targets not 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 planning assumptions	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Cost Improvement Plan to be developed 2024/25	LB		Monitored through PEF CIC

Group BAF Estates

There is a risk that the Trust's estate, infrastructure and engineering equipment may fail through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action. This would impact on the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

20

Executive Lead	Chief Financial Officer	Assurance Committee	Performance, Estates Finance Committees in Common
Executive Group	Estates	Latest review date	12/09/24

Strategy and Risk Register

Link to Strategy

To give great care	✓	To provide good leadership		
To be a good employer				
To live within our means	✓			
To work more collaboratively				

Link to BAF and CRR

2951 - Estates And Facilities - Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide (20)
2655 - Estates And Facilities - SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers (20)
2959 - Estates And Facilities - Replacement/Repa irs of flat roof - Trustwide (20)
1774 - Estates And Facilities - Poor condition of Fuel Oil Storage Tanks - SGH (16)
2905 - Estates And Facilities - Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW (16)
2035 - Estates And Facilities - Equality Act 2010 compliance - Trustwide (16)
2036 - Estates And Facilities - Heating, Ventilation and Air Conditioning - (HVAC) - Trustwide (15)

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)			Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4	4			↔	3	**15**
Consequence	5	5				5	
Risk Score	20	20				20	

Controls and Assurance

Key controls	Assurances
• Capital Programme in place and risk assessed • Comprehensive maintenance programme in place • Group Capital and Major Projects Committees in Common • Service level business continuity plans in place	• 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) • Premises Assurance Model <u>Internal</u>: • Minutes of Performance, Estates and Finance Committees in Common, Audit Risk & Governance Committees in Common, Capital and Major Projects Committees in Common • Non-Executive Director Committee Chair Highlight Report to Trust Board • Specialist Technical Groups • Patient led assessment of care environment

	External: ● ERIC (Estates Return Information Collection)

Gaps in controls and assurances	
Gaps in Controls: ● ICS CDEL not sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providersInsufficient Capital funding	**Gaps in Assurance:**

Actions planned

Action	Lead	Due date	Progress update
Capital Programme 2024/25	LB		Monitored through PEF CIC, C&MP CIC and Group Capital Committee

BAF Digital – IT Failure			15
There is a risk that the Group will suffer a major failure of its digital systems, leading to loss of life, finance and reputation through inability to maintain business continuity.			
Executive Lead	Chief Medical Officer	Assurance Committee	Capital and Major Projects Committees in Common
Executive Group	Digital	Latest review date	12/09/24

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	S3439 - Acute And Emergency Medicine - Crowding in the Emergency Department (25) N2755 - Specialist Cancer And Support Services - SGH MRI scanner past end of 7 year life (20) S4278 - Specialist Medicine - Lack of reporting software for Bronchoscopy (20) N4344 - Cardiovascular - Risk to patient diagnostic/treatment delays due to Information management systems do not meet the requirements of the service (16) S3300 - Family Services - Colposcopy chair (16) N2996 - Specialist Cancer And Support Services - Provision of EMIS eMM standalones in both Pharmacy dispensaries (16) N3108 - Specialist Cancer And Support Services - Non compliance with MHRA guidance for managing medical devices Jan 21, NatPSA/2023/010/MHRA and Medical Device Management & Procurement Policy DCP047 (15) N4048 - Specialist Cancer And Support Services - There is a risk to the continuity of the service due to the ageing Radiotherapy Linac (Bunker 6) (15)
	To be a good employer					
	To live within our means					
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔		**10**
Consequence	5	5					
Risk Score	15	15					

Controls and Assurance	
Key controls	**Assurances**
• Up to date Organisational and Digital / IT policies, procedures and guidelines. • Infrastructure investment and improvement plan in progress, but with scope to expand. • Up to date software and hardware, with procedures for patching and replacement once at end of life • Robust EPRR links with up to date, exercised BC/DR plans across all care groups. • 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.	• NLAG N08/2024 IT Disaster Recovery Plan – Limited Assurance. Tracked at Internal Audit, Risk and Governance Committee. • NLAG N12/2024 Change Control Management – Limited Assurance. Tracked at Internal Audit, Risk and Governance CIC. • Internal Audit, Data Security and Protection Toolkit 2023/24 **Planned** <u>Internal</u>: • Board awareness session around responsibilities under NIS 2018 (Maintenance of critical infrastructure) to be scheduled. • Digital strategy to be produced for the group, laying down our investment case for Group Digital Foundations. <u>External</u>: • TBC
Gaps in controls and assurances	
Gaps in Controls: • Legacy systems that cannot be retired and modernised due to reliance on out of date software and equipment (i.e, WebV and NLAG door access system). • Lack of policies and governance on HUTH estate.	**Gaps in Assurance:** • No oversight of major digital systems that sit outside of the digital directorate. • Not currently compliant with industry standards such as ITIL V4, COBIT and ISO27001

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Complete our DSPT Audit to identify gaps in controls across the Group and develop a robust remediation plan.	CMO	Q1 24/25	2023/24 submission made and all Group actions have been collated in a single action plan. This will be monitored through the Group Information Governance Committee
Plan to align digital governance across the Group	GCDO / GCTO	Q3 24/25	This is being monitored at the C&MP CIC

BAF Cyber Security			15
There is a risk that the Group will suffer Cyber-Attack, leading to loss of life, finance and reputation through inability to maintain business continuity.			
Executive Lead	Chief Medical Officer	Assurance Committee	Capital and Major Projects Committees in Common
Executive Group	Digital	Latest review date	12/09/24

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	S3439 - Acute And Emergency Medicine - Crowding in the Emergency Department (25) N2755 - Specialist Cancer And Support Services - SGH MRI scanner past end of 7 year life (20) S4278 - Specialist Medicine - Lack of reporting software for Bronchoscopy (20) N4344 - Cardiovascular - Risk to patient diagnostic/treatment delays due to Information management systems do not meet the requirements of the service (16) S3300 - Family Services - Colposcopy chair (16) N2996 - Specialist Cancer And Support Services - Provision of EMIS eMM standalones in both Pharmacy dispensaries (16) N3108 - Specialist Cancer And Support Services - Non compliance with MHRA guidance for managing medical devices Jan 21, NatPSA/2023/010/MHRA and Medical Device Management & Procurement Policy DCP047 (15) N4048 - Specialist Cancer And Support Services - There is a risk to the continuity of the service due to the ageing Radiotherapy Linac (Bunker 6) (15)
	To be a good employer					
	To live within our means					
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔		**10**
Consequence	5	5					
Risk Score	15	15					

Controls and Assurance	
Key controls	**Assurances**
• Up to date Organisational and Digital / IT policies, procedures and guidelines • Up to date software and hardware, with procedures for patching and replacement once at end of life • Cyber security partner to provide support in the event of an attack. • Digital Strategy Board • Digital Solutions Delivery Group in NLAG • Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation. • Annual Penetration Tests • Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication	**Positive** • Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023 **Planned** <u>Internal</u>: • Board awareness session on Cyber-Security and Board statutory responsibility. • Digital strategy to be produced for the group, laying down our posture and approach to cyber security. <u>External</u>: • Data Security and Protection Toolkit (DSPT) audit Apr-Jun this year to assess our cyber and information governance performance and plans for the future.
Gaps in controls and assurances	
Gaps in Controls: • Legacy systems that cannot be retired and modernised due to reliance on out of date software and equipment (i.e, WebV and NLAG door access system). • Variation in cyber-resilience across the two organisations within the Group. • Incomplete rollout of Multi-Factor Authentication (MFA) to secure our accounts from being compromised. • Lack of dedicated cyber personnel across the group. • Low levels of cyber awareness and digital maturity in some staff groups.	**Gaps in Assurance:** • No oversight of major digital systems that sit outside of the digital directorate. • Lack of Data Security Mandatory Training (critical that operational managers across all divisions ensure that staff completed the training) • No organizational wide preparation or exercising of BCDR plans in relation to a cyber-attack.

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Complete our DSPT Audit to identify gaps in controls across the Group and develop a robust remediation plan.	CMO	Q1 24/25	On track to deliver Q2 DSPT submitted and Group plan in place
Roll out MFA across the Group.	CMO	June 24	

Conduct Board Cyber Awareness training, highlighting Board and wider organizational accountability.	CMO	Q1 24/25	On the Board Development Programme 24/25
Conduct organizational EPRR cyber-attack exercise	TBC	Q2 24/25	Monitored through the EPRR Board

BAF Performance

The risk is that the Group fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care	20

Executive Lead	Group Chief Delivery Officer	Assurance Committee	Performance Estates and Finance Committees in Common
Executive Group	Delivery	Latest review date	12/09/24

Strategy and Risk Register

Link to Strategy					Link to BAF and CRR	
	Honest, caring and accountable culture		Partnership and integrated services	✓		S4319 - Specialist Medicine - ERG - 25% Reduction in Follow ups for Medical specialties (16)
	Well-led, skilled and sufficient workforce		Research and innovation			
	High Quality Care	✓	Financial Services			
	Great Clinical Services	✓				

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3	Q4	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4	4			↔	5	16
Consequence	5	5				5	
Risk Score	20	20				25	

Controls and Assurance

Key controls	Assurances (Positive, Negative and Planned)
• External scrutiny from NHSE/ICB/CQC • Constitutional performance targets • Operational Plan 2024/25 • Access Policy • Capacity and Demand planning • Unplanned Care Board • Cancer Improvement Plans • Primary and Secondary Care Collaborative Outpatient Transformation Programme • Planned Care Board • Emergency Department and Medicine Specialties Quality & Safety Groups • Planning and Performance • **Cancer Delivery Group** • **Diagnostic Delivery Group** • **RTT Delivery Group**	• Urgent Treatment Centre • Same Day Emergency Care review ongoing • Revised Cancer trajectories submitted to ICB and further funding received • Benchmarking reports • Internal Audit Reports • Completed job plans for relevant clinicians for 2024/25 • Waiting List Assurance Meetings • Winter Planning Group • Policies, procedures, guidelines, pathways supporting documentation & IT systems • MDT Business Meetings • Risk stratification • Emergency Care Quality & Safety Group • System-wide Ambulance Handover Improvement Group • Executive to Triumvirate meetings

	• Executive Management Committee to be developed • Care Group Structure development • Performance, Estates and Finance Committees in Common challenge • Performance report to the PEF CIC • Integrated performance Report • **Cancer Delivery Group** • **Diagnostic Delivery Group** • **RTT Delivery Group** • **Planned Care Board** • **Unplanned Care Board** <u>External</u>: • Audit Yorkshire, RSM Internal Audit • NHSE Intensive Support Team •
aps in controls and assurances	
• Mismatch between demand and capacity • Flow through the ED department • Patients with NCTR • Ambulance handover position • Cancer performance • Increase in GP referrals - referral triage and Advice and guidance • Impact of Industrial Action • IPC risks • Patient Choice and willingness to accept alternative providers • Quality of reports to board assurance committees • Quality and timeliness of data • Recruitment and development of Consultants, specialist nurses	• 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

Actions planned			
Group Actions	**Lead**	**Due date**	**Progress update**
Consultant job plans to be signed off for 2024/25	CDO	Q3 24/25	This is being monitored through the WEC CIC

BAF 8 - Group Strategy				12
There is a risk that the Group Strategy is not effective and does not allow the Group to deliver high quality and sustainable care and that the list of priorities do not align to investments, causing conflict.				
Executive Lead	Group Chief of Strategy & Partnerships	Assurance Committee	Trust Boards in Common	
Executive Group	Strategy	Latest review date	12/09/24	

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	None at present
	To be a good employer					
	To live within our means					
	To work more collaboratively	✓				

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔	3	8
Consequence	4	4				4	
Risk Score	12	12				12	

Controls and Assurance	
Key controls and mitigations	Assurances
• Integrated Care Board meetings • PLACE meetings • Group Structure/Governance • Collaboration of Acute Provider Boards • Humber Cancer Board • Acute and Community Care Collaborative • Health Overview and Scrutiny Committees	**Positive** ● NHSE Assurance and Gateway Reviews. ● OSC Engagement. ● Clinical Senate formal review ● The Consultation Institute (assurance on the engagement process) **Planned** <u>Internal</u>: ● Minutes from Capital and Major Projects Committees in Common ● 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 Reports to Trust Boards in Common <u>External</u>: ● Clinical Senate Reviews. ● Independent Peer Reviews re; service change (ie Royal Colleges) ● Citizens Panel (Humber).

	● The Consultation Institute
Gaps in controls and assurances	
Gaps in Controls: ● A shared vision for the HAS programme is not understood across all staff/patients and partners	**Gaps in Assurance:** ● Feedback from public, patients and staff to be widespread 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

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Leadership at System level and PLACE	Group Chief of Strategy and Partnerships		

BAF 9 - Group Strategic Capital			15
The risk that the Group fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.			
Executive Lead	Group Chief Financial Officer and Group Chief of Strategy & Partnerships	Assurance Committee	Capital and Major Projects Committees in Common
Executive Group	Estates/Strategy	Latest review date	12/09/24

Strategy and Risk Register						
Link to Strategy	To give great care		To provide good leadership		Link to BAF and CRR	None at present
	To be a good employer					
	To live within our means	✓				
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔	3	**15**
Consequence	5	5				5	
Risk Score	15	15				15	

Controls and Assurance	
Key controls and mitigations	**Assurances**
• Group Capital Committee • Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly • Trust Boards in Common • Trust Committees in Common • ICS Strategic Capital Advisory Group	• No strategic plan for all sites • Deteriorating infrastructure 10% per year • No money to fund major changes to sites HUTH £100m required, Scunthorpe £50m required. **Planned** Internal: ● Minutes of Internal Trust Meetings ● Performance, Estates and Finance CIC External: ● NHSE attendance at AAU / ED Programme Board ● CiC Minutes ● PLACE Boards
Gaps in controls and assurances	
Gaps in Controls: ● 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	**Gaps in Assurance:** ● ICS CDEL not sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

eliminate or reduce risk of estates condition in the short term	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies	Group Chief Financial Officer/Group Chief of Strategy and Partnerships		In progress but off track (with mitigation)

BAF 10 - Group Strategic Partnerships and Collaboration				12
There is a risk that the Group does not prioritise actions at PLACE and ICB to fulfill its Anchor role which increases health inequalities, competition and competition in workforce. The Group also fails to work collaboratively to innovate and change pathways.				
Executive Lead	Group Chief of Strategy & Partnerships	Assurance Committee	Trust Boards in Common	
Executive Group	Strategy	Latest review date	12/09/24	

Strategy and Risk Register						
Link to Strategy	To give great care		To provide good leadership		Link to BAF and CRR	None at present
	To be a good employer					
	To live within our means					
	To work more collaboratively	✓				

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔	3	8
Consequence	4	4				4	
Risk Score	12	12				12	

Controls and Assurance	
Key controls and mitigations	Assurances (Positive, Negative and Planned)
● Audit Risk & Governance Committee (ARGC) ● 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 ● Committees in Common ● Acute and Community Collaborative Boards ● Clinical Leaders & Professional Group ● Council of Governors ● Joint Overview & Scrutiny Committees ● MP cabinet and LA senior team briefings ● Primary/Secondary Interface Group (Northbank&Southbank) ● Place Boards	**Positive** ● HAS Governance Framework. ●Clinical Senate review approach and process ● Consultation Institute Review ● Place Boards and Place Working Groups established **Planned** <u>Internal</u>: ● Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, CIB, CoG ● Non-Executive Director Committees in Common Chair Highlight Report to Trust Board ● Executive Director Reports to the Trust Boards in Common

	External: ● 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
Gaps in controls and assurances	
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.

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Collaboration and Leadership within the Group to form strong partnership arrangements	Group Chief of Strategy and Planning		

BAF 3.1	
There is a risk that the quality improvement measures set out in the HUTH Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating.	16

Executive Lead	Group Chief Nurse	Assurance Committee	Quality and Safety Committees in Common
Executive Group	Quality Care	Latest review date	12/09/24

Strategy and Risk Register

Link to Strategy

Honest, caring and accountable culture		Partnership and integrated services		
Well-led, skilled and sufficient workforce		Research and innovation		
High Quality Care	✓	Financial Services		
Great Clinical Services				

Link to BAF and CRR

N3376 - Cardiovascular - A risk to patient outcome due to lack of Vascular Hybrid suite (16)
N4322 - Digestive Diseases - Risk to patients due to the lack of a High observation area (16)
N4294 - Head And Neck - Risk neonates & Paediatrics with hearing conditions will not receive timely care due to Paediatric Audiologist shortfall (16)
N4058 - Head And Neck - Risk to neonates, infants and children with hearing conditions not receiving timely care due to lack of specialist accommodation (16)
N4293 - Head And Neck - Risk neonates & Paediatrics with hearing conditions will not receive timely care due to poor performance in Paediatric Audiology (16)
N4286 - Cardiovascular - Risk to the acute patients due to lack of junior doctor cover. (15)
N1851 - Head And Neck - Shortfall in Capacity within the Ophthalmology Service (15)
N3962 - Specialist Cancer And Support Services - Cardiac CT demand outstripping capacity (15)
N3196 - Specialist Cancer And Support Services - Breast Imaging Service loss of capacity (15)
N3266 - Specialist Cancer And Support Services - Availability of Chaperones for intimate examinations in Radiology (15)

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4	4			↔	4	12
Consequence	4	4				4	
Risk Score	16	16				16	

Controls and Assurance	
Key controls	Assurances (Positive, Negative and Planned)
• Quality committee structure & work-plans; • Health Group Governance Performance Management meetings;; • Patient Safety Specialist role; • Infection Prevention and Control (IPC) arrangements • Safeguarding processes • Fundamental Standards Nursing programme • Quality Strategy/Quality Improvement Plan • Serious Incident Management/ early adopter of PSIRF • Annual Clinical Audit programme • CQC improvement plans, overseen by Executive Check and Challenge process and Maternity Transformation Assurance Committee (MTAC). • External agency register and process • Horizon scanning Integrated Performance Report – BI Reporting • CQC Action Plans in place • Patient Safety Alert process	**Positive Assurances** ***Emergency Department*** • ICB quality team visit report (15 December 2023); • CQC ED engagement visit (non inspection/rating) positive feedback and observations including mental health (9 April 2024). • ED national Patient Safety award for a Quality improvement initiative (November 2023); • Friends and Family (FFT) monthly data demonstrating improvement since November 2023. ***Maternity*** • CQC Maternity action plan progress reported monthly; • Healthwatch HRI 'Big Push' Maternity review concluding "many improvements to patient experience since inspection" (April 2024); • FFT Birth score of 100% (maintained); ***Other prominent external assurances*** • Internal Audit CQC Action Plan Audit (Jan 24) – 35/35 (100%) of actions closed through Executive oversight corroborated to evidence supporting closure. • CQC IR(MER) inspection – report received (October 2023) with no residual actions. *Internal Measures* • Nursing staff (Registered Nurses) recruited to a level 2.5% over budget (April 2024), with turnover reduced to 7.1%, facilitating greater ward staffing. • Falls resulting in both number and rate of moderate or major harm remaining below the mean in 23/24 and Qt1 24/25 (QSC deep dive February 2024). • Pressure Ulcers within control limits and harm reducing (QSC deep dive March 2024). • Backlog of longstanding complaints addressed, quality sustained since August 2023 with limited reopened. • PSII after action reviews established.

	Negative • The Trust is an outlier in HSMR (116 Jan 24) and its SHMI mortality data is higher than expected (having increased to1.15 to Feb 24) • CQC Maternity Year 5 CNST declaration was not full compliance. • Emergency Department failed to deliver the 76% target by end of March 2024 (61%). • Ambulance turnaround times impacting on patients • VTE compliance rate has been below the Trust's 95% target, but starting to demonstrate some improvement Additional QI support is being provided to identify
	improvement actions • Infections due to rise in respiratory, norovirus, measles and diphtheria.
	Planned • CQC ED action plan full delivery; • CQC Maternity action plan full delivery; • Weekly patient safety summit continuation. • Development of the virtual ward and staff to support the falls team; • Delivery of Group wider Quality Priorities for 2024/25 to support consistent delivery across End of Life, Deteriorating patient; Sepsis; Medication safety; and Mental capacity.

Gaps in controls and assurances	
Maternity Leadership Interim reliance. VTE Compliance CQC Maternity Section 31 two conditions	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Delivery of 23/24 CQUIN programme	ADQG	Q4 23/24	Achieved with exception of CQUIN12: Assessment and documentation of pressure ulcer risk and CQUIN1: Flu vaccination.
Implementation of HUTH Patient Safety Incident Response Plan by April 2024	CNO	Q1 23/24	Completed
Deliver Improvements of Fundamental Standards Programme	CNO	Q4 23/24	Improvements noted quarterly.
VTE Quality Improvement Programme	CMO	Q3 24/25	QI team supporting targeted wards.

Mortality Strategy – The implementation of a refreshed Mortality Strategy to direct the work of the Mortality Improvement Group in responding to the Trust's higher than average SHMI.	CMO	Q2 24/25	In progress, targeted work at Castle Hill and against the three condition groups highlighted as an outlier.
Maternity Governance Structure – implement enhanced governance structure to expedite completion of Section 31 (two conditions) and CQC inspection actions	CNO	Q1 24/25	Establish enhanced governance oversight (May 2024)
Quality improvement project initiation in Emergency Department targeting the number of patients outside patient spaces, ambulance handover times and the length of time people are	CDO	Q1 24/25	Commenced 20 May 2024 and updated at the Performance, Estates and Finance CIC
waiting to be seen.			
Development of Group (HUTH and NLAG) consistent Quality priorities for 2024/25 to focus on • End of Life; • Deteriorating patient; • Sepsis; • Medication safety; and • Mental capacity	CNO	Q1 24/25 (approval) – delivery throughout.	24/25 Group Quality Priorities and measures approved – now in delivery.

BAF 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.	20

Executive Lead	Group Chief Medical Officer/Group Chief Nurse	Assurance Committee	Quality and Safety Committees in Common
Executive Group	Patient Care	Latest review date	12/09/24

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture		Partnership and integrated services	✓	Link to BAF and CRR	N4170 - Major Trauma Network - Risk of increased morbidity and mortality for elderly MTC patients due to inadequate DME support for Major Trauma Centre TARN (20) N2244 - Cancer Network - Risk to Overall Performance: Cancer Waiting / Performance Target 62 day (16) N3332 - Head And Neck - Lorenzo Upgrade (16) N3252 - Head And Neck - Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight (15) N3959 - Head And Neck - Risk of patient harm to new and follow-up patients due to delays within glaucoma service (15) N4011 - Head And Neck - Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity (15) N4012 - Head And Neck - Clinical risk to patients referred as new patients into the new wet macular degeneration pathway (15) N4013 - Head And Neck - Clinical risk to patients referred as new patients into new Medical Retina patient assessment clinic due to lack of capacity iss (15)
	Well-led, skilled and sufficient workforce		Research and innovation			
	High Quality Care	✓	Financial Services			
	Great Clinical Services					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4	4			↓	5	16
Consequence	5	5				5	
Risk Score	20	20				25	

Controls and Assurance	
Key controls	Assurances (Positive, Negative and Planned)
• Clinical harm review process • Prioritisation of P1 patients • Fundamental Standards programme • System and Community meetings • Patient Access Team • Weekly Patient Safety Summit • Quality Strategy • Rossmore rehabilitation facility • Emergency Care Standards • Ambulance Handovers waiting over 60 minutes	**Positive** • ICB quality team assurance visit report (15 December 2023); • CQC ED engagement visit (non inspection/rating) positive feedback and observations including mental health (9 April 2024). • ED national Patient Safety award for a Quality improvement initiative (November 2023); • Friends and Family (FFT) monthly data demonstrating improvement since November 2023. • Urgent Treatment Centre opening (Feb 24) and subsequent opening hour extension (April 24) provided additional capacity. • Elective – HUTH removed from NHSE Tiering (April 2024) • Friends and Family (FFT) data for Rapid Diagnostics, Radiology and Day Case all >95% positive responses for 2023/24. Same Day Emergency Care review ongoing • AMU HOB
	Negative • HUTH (and HNY system) remains in NHSE Tier 1 for cancer. • Over crowding in ED • Patients with no criteria to reside is the single largest factor affecting performance with up to 211 patients per day remaining within the hospital who have no medical need for acute services • GP capacity and increased referrals • Ambulance turnaround times – the Trust achieved the revised trajectory for type 1 and 3 performance at 59% (trajectory 50%)

	Planned • Aim to grow the Patient Safety Champion network and number of Learning Response Leads • Discharge to assess model pilot to • Trajectory of achieving zero 78 week waits by March 2024. • 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
Gaps in controls and assurances	
• ED 4 hour performance below 76% March 2024 requirement. • Ambulance handover • Trust failing to achieve all cancer standards with the exception of combined Faster Diagnosis Standard • Patients with No Criteria to Reside • 12 Hour Trolley breaches	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Hull and East Riding MADE event	CDO	Q4 23/24	Held 25 March to 5 April 2024 – actions being taken forward.
Quality improvement project initiation in Emergency Department targeting the number of patients outside patient spaces, ambulance handover times and the length of time people are waiting to be seen.	CDO	Q1 24/25	Commences 20 May 2024.
Embed Group leadership arrangements across the Humber Health Partnership, including: • Site Executives; • Urgent and Emergency Services Care Group leadership model;	CDO	Q2 23/24	New leadership in place effective 1 April 2024 (Site Exec and Care Group level).

BAF 6	12
There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	

Executive Lead	Group Chief Medical Officer	Assurance Committee	Quality and Safety Committees in Common
Executive Group	Research and Innovation	Latest review date	12/09/24

Strategy and Risk Register

Link to Strategy					Link to BAF and CRR	
	Honest, caring and accountable culture		Partnership and integrated services			• None at present
	Well-led, skilled and sufficient workforce		Research and innovation	✓		
	High Quality Care		Financial Services			
	Great Clinical Services					

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔	4	8
	4	4				4	
Risk Score	12	12				16	

Controls and Assurance

Key controls	Assurances
• strengthened partnership with the University of Hull • Infection Research Group • ICS Research Strategy • Health Research Authority	**Positive** • Continued working with HYMS and ICS • Joint working with NLAG • Academic Renal Research team – Lead role for renal studies and currently in the top third of recruiters nationally • GONDOMAR study – unique cohort platform providing data on diagnosis, treatment and outcomes of over 4,000 patients with Crohn's perianal fistula. • HUTH first site to be activated and first to enroll a patient for the AZUR-2 study, which relates to colon cancer. • HUTH is the top recruiting centre for SNAP study. The trial aims to identify which treatment options for Staphylococcus aureus bacteraemia results in the fewest patients dying within the first 90 days after an infection. • HUTH is the top recruiting site for the PACeS study which aims to determine whether the addition of blood thinners to anti-platelet drugs improves treatment outcomes in patients who develop AF after CABG surgery **Negative** • Funding availability • Research capacity hindered by the recovery plan • Demand for IT and Digital innovations are increasing

	Planned • Joint strategy discussions have commenced with the Group Chief Medical Officer and the Group Chief of Strategy and Partnerships
Gaps in controls and assurances	
Reduction in support services due to activity delivery Loss of commercial research income Capital developments will need to ensure research and innovation schemes can be accommodated and staff appropriately housed Demand for IT and Digital innovation is increasing	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Group R&I strategy development	KW	Q3 2024	In development

BAF 1.1				15
The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience				
Executive Lead	Group Chief Medical Officer and Group Chief Nurse	Assurance Committee	Quality & Safety Committees in Common (CiC)	
Executive Group	Patient Care	Latest review date	12/09/24	

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	S3997 - Acute And Emergency Medicine - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E (25) S4285 - Acute And Emergency Medicine - Lack of senior clinical staffing at night is affecting patient safety (20) S3301 - Family Services - Antenatal clinic review capacity (20) S3308 - Family Services - NICU Incubators (20) S3243 - Family Services - Inadequate Consultant Obstetrician cover (20) S2982 - Family Services - Lack of Anaesthetic cover for Under 2's out of hours (20) S3114 - Family Services - Delays in Children being reviewed in DPOW Paediatric Endocrine Service (20) S3325 - Family Services - Delays in Children being reviewed in Cardiac Clinic (20) S4222 - Family Services - Significant clinical risk to patients not being seen in safe and timely manner due to capacity limitations in EPAU/EGU (20) S4284 - Family Services - Risk to patient flow and delayed assessment of paediatric patients due to removal of 2nd consultant for paediatric medicine (20) S4288 - Specialist Medicine - Risk to patients and staff within the Home Ventilation Service (20) SU3217 - Specialist Surgery - Breast Imaging workforce depletion (20) S4201 - Acute And Emergency Medicine - Missed Targets in the First Hour of the Management of Sepsis (16) S4025 - Family Services - Risk of patient harm due to insufficient Medical workforce numbers (Consultant level) (16) S4240 - Specialist Medicine - Staffing resource to support the delivery of the HUTH Specialist Asthma Service (16) S4277 - Specialist Medicine - NCTR / Stranded patients within the MHG acute bed base. (16) S2592 - Specialist Surgery - Risk to Overall Performance: Cancer Waiting / Performance Target 62 day (16) S2245 - Specialist Surgery - Risk to Overall Performance : Non compliance with RTT incomplete target (16) S3161 - Acute And Emergency Medicine - There is a risk of patient deterioration not being recognised and escalated appropriately. (15)
	To be a good employer					
	To live within our means					
	To work more collaboratively					

						S3204 - Family Services - Up to 1 year wait for new referrals to be seen by Consultant Paediatrician (single handed service) into the ADHD post diagnosis support service. (15) S4200 - Family Services - Increased risk of harm to patients and families due to inadequate co-located psychology support to children and young people. (15) S3129 - Family Services - Overdue follow-up and new patients waiting lists for Paediatric patients (Trustwide) (15) S4289 - Specialist Medicine - Risk to patients and staff within the Cystic fibrosis/bronchiectasis service (15) S2347 - Specialist Surgery - Risk to Overall Performance : Overdue Follow-ups (15)

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3	3			↔	3	**15**
Consequence	5	5				5	
Risk Score	15	15				15	

Controls and Assurance	
Key controls	Assurances
● Operational Plan 2024/25 ● Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems ● 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) ● Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group ● Nursing Metric Panel Meeting ● Nursing and Midwifery & AHP Board ● NICE Guidance implementation monitoring and reporting processes ● Learning from deaths process	**Positive** <u>External:</u> ● 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 ● Maternity Birth Rate Plus Review ● Internal Audit - CQC action plan compliance – Significant assurance ● Improved ratings in CQC inspection with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement ● Maternity CNST standards compliance submission ● Health Scrutiny Committees (Local Authority) • Quality and Safety Committees in Common • Risk Management Group • Patient feedback to Council of Governors • SafeCare Live • OPEL Nurse staffing levels and short term staffing SOP • Mortality Improvement Group ● Vulnerabilities Group ● Incident control group chaired by NHSE to support Paediatric Audiology service.
	Planned <u>Internal:</u> ● 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

Controls and Assurance	
Key controls	Assurances
	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
Gaps in controls and assurances	
Gaps in Controls: ● Estate and compliance with IPC requirements B12 – see Estates BAF ● Ward equipment and replacement programme see Estates BAF ● Attracting sufficiently qualified staff - see Workforce BAF ● Funded full time Transition post across the Trust ● Paediatric audiology service	**Gaps in Assurances:** ● 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 BAF 1.2)

Actions planned

Action	Lead	Due date	Progress update
Continue to develop metrics as data quality allows	CMO	Ongoing	On track to deliver
Delivery of deteriorating patient improvement plan	CN	Q4 23/24	Sustained improvements reported in the 2023/24 Quality Account, but this will remain a priority for 2024/25.
Implementation of End of Life Strategy (system-wide strategy)	CMO	Q4 24/25	In progress but off track requiring system input. Improvements reported in the 2023/24 Quality Account, but this will remain a priority for 2024/25.
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	CMO	Q3 23/24	Complete
Review and implement changes to Audiology Service	CMO	Q3 23/24	Update reported at Quality and Safety Committee in June 2024.
15 steps Star Accreditation Programme commenced	CN	Ongoing	Continued application going forward.
Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas.	CMO	Q4 23/24	Improvements reported in the 2023/24 Quality Account, but priorities have been rolled followed to further embed and sustain outcomes on a Group wide basis for 2024/25
Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients	CMO	Q4 23/24	Improvement in all schemes. 8/11 fully delivered, 1 (flu vaccination did not), 2 above minimum
			threshold as reported in June 2024.

Appendix 2
High Level Risks (104) as at 12 September 2024

Risk ID	Risk Opened Date	Risk Type	Risk Title	Risk Handler	Site	Corporate Function/Care Group	Specialty	Risk Rating	Risk Rate Score	Review Date
3439	04/09/2019	Regulatory inc. Health and Safety,Infection Prevention & Control	Crowding in the Emergency Department	Marshall, Victoria	Hull Royal Infirmary	Acute And Emergency Medicine	A and E	High	25	06/09/2024
3325	25/04/2024	Clinical	Delays in Children being reviewed in Cardiac Clinic	Umaima Aboushofa	Scunthorpe General Hospital (SGH)	Family Services	Paediatrics	High	20	31/05/2024
3301	26/02/2024	Clinical	Antenatal clinic review capacity	Lisa Pearce	Trustwide - All Sites (DPoW, SGH & GDH)	Family Services	Obstetrics / Maternity	High	20	29/07/2024
3285	29/01/2024	Operational	Electrical: Age and resilience of the Trust Uninterrupted Power Supply (UPS) - Trustwide	James Lewis	Trustwide - All Sites (DPoW, SGH & GDH)	Estates and Facilities	Estates - Electrical	High	20	23/08/2024
2951	04/08/2021	Buildings, Land and Plant	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide	James Lewis	Trustwide - All Sites (DPoW, SGH & GDH)	Estates and Facilities	Estates - Electrical	High	20	23/08/2024
2959	04/08/2021	Buildings, Land and Plant	Replacement/Repa irs of flat roof - Trustwide	James Lewis	Scunthorpe General Hospital (SGH)	Estates and Facilities	Estates - Buildings	High	20	23/08/2024
2655	12/12/2019	Buildings, Land and Plant	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers	James Lewis	Scunthorpe General Hospital (SGH)	Estates and Facilities	Estates - Heating/Ventilation & Pressure Systems	High	20	23/08/2024
4378	24/07/2024	Workforce (including staffing etc),	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	Colley, Mr Peter	Castle Hill Hospital	Specialist Cancer And Support Services	Radiotherapy	High	20	24/08/2024
4032	21/12/2021	Workforce (including staffing etc),	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	Colley, Mr Peter	Castle Hill Hospital	Specialist Cancer And Support Services	Radiotherapy	High	20	25/08/2024
3983	29/06/2021	Workforce (including staffing etc),	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	Colley, Mr Peter	Castle Hill Hospital	Specialist Cancer And Support Services	Radiotherapy	High	20	25/08/2024
4275	17/11/2023	Financial,	Risk to deliver the financial plan for Medicine	Faruqi, DR Shoaib	Hull Royal Infirmary	Specialist Medicine		High	20	30/08/2024
2562	01/09/2019	Clinical	Failure to meet constitutional targets in ECC	Nicola Glen	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Emergency Care	High	20	31/08/2024
4285	30/11/2023	Patient Safety & Quality of Care,	Lack of senior clinical staffing at night is affecting patient safety	Rayner, Dr Ben	Hull Royal Infirmary	Acute And Emergency Medicine	A and E	High	20	04/09/2024
3162	24/01/2023	Clinical	Quality of Care and Patient Safety based on Nurse Staffing Position	Joanne Foster	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Nursing (All Specialties)	High	20	04/09/2024
3217	29/06/2023	Clinical	Breast Imaging workforce depletion	Mandy Hay	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Cancer And Support Services	Breast Surgery	High	20	13/09/2024
2949	26/07/2021	Operational	Oncology Service	Lisa Pennington	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Cancer And Support Services	Clinical Oncology	High	20	13/09/2024
2982	19/08/2016	Patient Safety & Quality of Care,	Lack of Anaesthetic cover for Under 2's out of hours	Kazmierski, Mr Marcin	Hull Royal Infirmary	Family Services	Paediatric Surgery	High	20	13/09/2024
3232	18/08/2023	Staffing Levels & HR	Speech and Language Therapy Stroke staffing resource	Sarah Scrace	Trustwide - All Sites (DPoW, SGH, GDH & Community)	Community, Frailty & Therapy Services	Speech & Language - Adults	High	20	15/09/2024
4377	24/07/2024	Trust property and environment,	There is a risk that SSU are unable to decontaminate surgical instruments in a clean ventilated environment	Kaye, Neil	Harrow Street Site	Estates, Facilities and Development	Estates Operations (inc grounds and gardens)	High	20	27/09/2024

Risk ID	Risk Opened Date	Risk Type	Risk Title	Risk Handler	Site	Corporate Function/Care Group	Specialty	Risk Rating	Risk Rate Score	Review Date
4389	16/08/2024	Outpatients Risk,	Risk to patient and staff safety due to extreme temperatures within the Chest Clinic at HRI due to lack of ventilation.	Fellowes, Julie	Hull Royal Infirmary	Patient Services	Outpatients (Medical Only)	High	20	30/09/2024
4388	12/08/2024	Patient Safety & Quality of Care,	Risk to patient safety regarding VTE prophylaxis for stroke patients on 13th floor due to lack of use of sequential compression	Nagandran, Dr Yoghini	Hull Royal Infirmary	Community, Frailty & Therapy Services	NCTR Elderly Medicine	High	20	30/09/2024
4401	02/09/2024	Patient Safety & Quality of Care,	There is a risk that adult patients are unable to be discharged on Home Parenteral Nutrition due to National compounding capacit	MacElhinney-West, Mrs Philippa	Trust Wide	Digestive Diseases	Gastroenterology	High	20	02/10/2024
4402	02/09/2024	Patient Safety & Quality of Care,	There is a risk to provide an appropriate level of nursing services to adult patients within the Nutrition Team due to a lack of	MacElhinney-West, Mrs Philippa	Trust Wide	Digestive Diseases	Gastroenterology	High	20	02/10/2024
4403	02/09/2024	Patient Safety & Quality of Care,	There is a risk to the Enteral services being delivered as there is currently no nursing service	MacElhinney-West, Mrs Philippa	Trust Wide	Digestive Diseases	Gastroenterology	High	20	02/10/2024
D - 3219	26/04/2018	Patient Safety & Quality of Care,	Lack of Plastics Theatre Capacity to undertake DIEP procedures for Breast Surgery patients	Last, Sonia	Castle Hill Hospital	Specialist Surgery	Plastics	High	20	06/10/2024
4166	16/01/2023	Patient Safety & Quality of Care,	Risk to patient safety and acheivement of organisational falls strategy.	Ledger, Jo	Trust Wide	Corporate Nursing Directorate		High	20	08/10/2024
4331	19/03/2024	HDigital,	There is a risk that the Switchboard may experience failures in maintaining service due to software that is no longer supported	May, Mr David	Castle Hill Hospital	Estates, Facilities and Development	Switchboard and Telecommunications	High	20	11/10/2024
4327	11/03/2024	Trust property and environment,	Critical ventilation systems will be required to function beyond its 20 year life replacement as detailed in HTM 03 Part B.	Kaye, Neil	Trust Wide	Estates, Facilities and Development	Trustwide	High	20	11/10/2024
2300	07/12/2017	Information Governance	Insufficient processes in place to ensure records management /quality against national guidance	Susan Meakin	Trustwide - All Sites (DPoW, SGH & GDH)	Strategic Development	Information Governance	High	16	27/03/2024
3261	10/11/2023	Clinical	CPAP Drivers	Lisa Pearce	Trustwide - All Sites (DPoW, SGH & GDH)	Family Services	Neonatology (Newborn Intensive Care)	High	16	19/06/2024
4323	01/03/2024	Safeguarding,	Risk of non-compliance with the Mental Capacity Act	Harrison, Mrs Karen	Trust Wide	Corporate Nursing Directorate	Safeguarding Adults	High	16	20/06/2024
4025	24/11/2021	Patient Safety & Quality of Care,	Risk of patient harm due to insufficient Medical workforce numbers (Consultant level)	Allen, Mrs Jane	Hull Royal Infirmary	Family Services	Gynaecology	High	16	24/06/2024
4343	24/04/2024	Patient Safety & Quality of Care,	There is a risk to patient care due to the inability to deliver extension of a regional Mechanical Thrombectomy service	Maliakal, Dr Paul	Hull Royal Infirmary	Specialist Cancer And Support Services	Radiology	High	16	19/07/2024
3164	21/02/2023	Staffing Levels & HR	Nurse Staffing	Maria Briggs	Trustwide - All Sites (DPoW, SGH & GDH)	Corporate Nursing Directorate	Nursing (All Specialties)	High	16	15/08/2024
3331	14/05/2024	Clinical	Lorenzo Upgrade	Joanne Avison	Trustwide - All Sites (DPoW, SGH & GDH)	Digestive Diseases	Endoscopy	High	16	20/08/2024
2905	07/04/2021	Buildings, Land and Plant	Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW	James Lewis	Diana, Princess Of Wales Hospital, Grimsby (DPOWH)	Estates and Facilities	Estates - Electrical	High	16	23/08/2024
2035	22/08/2016	Buildings, Land and Plant	Equality Act 2010 compliance - Trustwide	James Lewis	Trustwide - All Sites (DPoW, SGH & GDH)	Estates and Facilities	Health & Safety	High	16	23/08/2024

Risk ID	Risk Opened Date	Risk Type	Risk Title	Risk Handler	Site	Corporate Function/Care Group	Specialty	Risk Rating	Risk Rate Score	Review Date
1774	05/06/2014	Buildings, Land and Plant	Poor condition of Fuel Oil Storage Tanks - SGH	James Lewis	Scunthorpe General Hospital (SGH)	Estates and Facilities	Estates - Heating/Ventilation & Pressure Systems	High	16	23/08/2024
4379	26/07/2024	Major Trauma Risk,	There is a risk of reduced effective Major Trauma Centre workforce due to the relocation of the Major Trauma Ward	Laws, Lorraine	Hull Royal Infirmary	Major Trauma	Major Trauma	High	16	26/08/2024
4344	25/04/2024	HDigital,	Risk to patient diagnostic/treatment delays due to Information management systems do not meet the requirements of the service	Buxton, Tracie	Castle Hill Hospital	Cardiovascular	Cardiology	High	16	30/08/2024
4169	16/01/2023	Workforce (including staffing etc),	Risk to Continuity of TAVI service due to staffing shortfalls	Magee, Mrs Wendy	Castle Hill Hospital	Cardiovascular	Cardiology	High	16	30/08/2024
3144	08/12/2022	Clinical	Paediatric Audiology Service	Aaron Sykes	Trustwide - All Sites (DPoW, SGH, GDH & Community)	Head And Neck	Audiology	High	16	30/08/2024
2841	12/05/2015	Patient Safety & Quality of Care,	Non achievement of Best Practice for hip fracture patients (BPT)	Moulder, Miss Elizabeth	Hull Royal Infirmary	Specialist Surgery	Orthopaedics (Trauma)	High	16	31/08/2024
2996	17/12/2021	Information Technology	Provision of EMIS eMM standalones in both Pharmacy dispensaries	Paulash Haider	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Cancer And Support Services	Pharmacy	High	16	02/09/2024
3048	13/04/2022	Operational	Challenges to recruitment of acute care physician vacancies in Acute	Rhiannon Wilson	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Acute Medicine	High	16	04/09/2024
3036	17/03/2022	Clinical	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	Simon Buckley	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Emergency Care	High	16	04/09/2024
3918	03/03/2021	Workforce (including staffing etc),Patient Safety & Quality of Care, Financial, Reputation	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	Weeraseker a, Dr Chaminda	Hull Royal Infirmary	Acute And Emergency Medicine	Acute Medicine	High	16	04/09/2024
4148	30/11/2022	Workforce (including staffing etc),	Capacity Shortfalls in DEXA scanning	Aye, Dr Mo	Hull Royal Infirmary	Specialist Medicine	Diabetes and Endocrinology	High	16	05/09/2024
4130	23/11/2022	Workforce (including staffing etc),	Funding provision for 7 day IP DSN Service within Diabetes	Hutton, Mr James	Hull Royal Infirmary	Specialist Medicine	Diabetes and Endocrinology	High	16	05/09/2024
2898	30/03/2021	Staffing Levels & HR	Medical Staff - Mandatory Training Compliance	Victoria Marshall	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Emergency Care	High	16	05/09/2024
3919	03/03/2021	Patient Safety & Quality of Care,	E-Radiology Results System: Results not being Actioned Appropriately	Faruqi, DR Shoaib	Hull Royal Infirmary	Digital Health		High	16	05/09/2024
4201	20/03/2023	Patient Safety & Quality of Care,	Missed Targets in the First Hour of the Management of Sepsis	Smithies, Dr Augustine	Hull Royal Infirmary	Acute And Emergency Medicine	A and E	High	16	06/09/2024
4141	24/11/2022	HDigital,	Network shares (passwords in clear text, sensitive patient data, backups, logs, world writable shares, etc)	Deal, Tony	Trust Wide	Digital Health	Systems and Applications	High	16	07/09/2024
3226	31/07/2023	Operational	Quality and audit monitoring and reporting impacted by information services PAS/Lorenzo development freeze	Fiona Moore	Trustwide - All Sites (DPoW, SGH, GDH & Community)	Chief Medical Officers Directorate	Quality, Evaluation & Audit	High	16	09/09/2024
4367	25/06/2024	Patient Safety & Quality of Care,	There is a clinical risk to patients to receive their medicines & financial risk to the Trust as a result of issues with Lloyds	Ramirez, Mr Antonio	Trust Wide	Specialist Cancer And Support Services	Pharmacy	High	16	12/09/2024
2592	17/09/2019	Clinical	Risk to Overall Performance: Cancer	Jennifer Orton	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Surgery	Cancer Services	High	16	13/09/2024

Risk ID	Risk Opened Date	Risk Type	Risk Title	Risk Handler	Site	Corporate Function/Care Group	Specialty	Risk Rating	Risk Rate Score	Review Date
			Waiting / Performance Target 62 day							
2245	20/06/2017	Clinical	Risk to Overall Performance : Non compliance with RTT incomplete target	Jennifer Orton	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Surgery	General Surgery	High	16	13/09/2024
3044	18/01/2017	Patient Safety & Quality of Care,	Shortage of Breast Pathologist	Wooler, Mr Brendan	Castle Hill Hospital	Specialist Surgery	Breast Surgery	High	16	13/09/2024
2244	20/06/2017	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Neil Rogers	Trustwide - All Sites (DPoW, SGH & GDH)	Cancer Network	Cancer Services	High	16	15/09/2024
4390	20/08/2024	Patient Safety & Quality of Care,	Non Clinical Transfer Risk ICU	Howes , Dr Julian	Hull Royal Infirmary	Theatres, Anaesthetics and Critical Care	Critical Care (ICU & HDU)	High	16	20/09/2024
4392	20/08/2024	Patient Safety & Quality of Care,	Lack of Rehabilitation during critical care admission	Breen, Mrs Ruth	Trust Wide	Theatres, Anaesthetics and Critical Care	Critical Care (ICU & HDU)	High	16	20/09/2024
4395	20/08/2024	Workforce (including staffing etc),	Lack of experienced nursing staff on HUTH intensive care units.	Breen, Mrs Ruth	Trust Wide	Theatres, Anaesthetics and Critical Care	Critical Care (ICU & HDU)	High	16	20/09/2024
4324	07/03/2024	HDigital,Workforce (including staffing etc)	There is a risk of failing our perfusion accreditation due to non-compliance of utilising data management record keeping	Bell, Jill	Castle Hill Hospital	Cardiovascular	Cardiac Surgery	High	16	30/09/2024
4037	19/01/2022	Workforce (including staffing etc),	Lack of Suitably Trained Staff to Perform Cardiac Stress Testing	Mill, Jill	Castle Hill Hospital	Cardiovascular	Cardiology	High	16	30/09/2024
3376	21/03/2019	Patient Safety & Quality of Care,	A risk to patient outcome due to lack of Vascular Hybrid suite	Carradice, Daniel	Hull Royal Infirmary	Cardiovascular	Vascular Surgery	High	16	30/09/2024
4332	25/03/2024	Regulatory inc. Health and Safety,	The inability to meet the bench mark as defined in GPICS2 (Guideline for the provision of Intensive Care services version 2.1 pu	Breen, Mrs Ruth	Trust Wide	Theatres, Anaesthetics and Critical Care	Critical Care (ICU & HDU)	High	16	09/10/2024
4348	30/04/2024	Trust property and environment,	Risk that patients and/or visitors may suffer harm as a result of the inability to undertake important E&F testing & inspections	Tighe, Simon	Trust Wide	Estates, Facilities and Development	Estates Operations (inc grounds and gardens)	High	16	11/10/2024
3129	04/11/2022	Clinical	Overdue follow-up and new patients waiting lists for Paediatric patients (Trustwide)	Paris Willey	Scunthorpe General Hospital (SGH)	Family Services	Paediatrics	High	15	23/04/2024
3279	19/12/2023	Equipment	Lack of enhanced decontamination equipment	Wendy Millard	Trustwide - All Sites (DPoW, SGH & GDH)	Corporate Nursing Directorate	Infection Prevention & Control	High	15	29/05/2024
3204	09/06/2023	Clinical	Up to 1 year wait for new referrals to be seen by Consultant Paediatrician (single handed service) into the ADHD post diagnosis support service.	Umaima Aboushofa	Scunthorpe General Hospital (SGH)	Family Services	Paediatrics	High	15	31/05/2024
3201	02/06/2023	Clinical	Clinical Capacity within Colposcopy	Lisa Pearce	Trustwide - All Sites (DPoW, SGH & GDH)	Family Services	Gynaecology	High	15	19/06/2024
3475	31/10/2019	Workforce (including staffing etc),	Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology	Allen, Mrs Jane	Trust Wide	Family Services	Gynaecology	High	15	24/06/2024
3962	15/06/2021	Patient Safety & Quality of Care,	Cardiac CT demand outstripping capacity	Nutman, Ms Martine	Trust Wide	Specialist Cancer And Support Services	Radiology	High	15	16/08/2024
2036	22/08/2016	Buildings, Land and Plant	Heating, Ventilation and Air Conditioning - (HVAC) - Trustwide	James Lewis	Trustwide - All Sites (DPoW, SGH & GDH)	Estates and Facilities	Estates - Heating/Ventilation & Pressure Systems	High	15	23/08/2024
4368	25/06/2024	Patient Safety & Quality of Care,	There is a risk to patient safety due to Aria operating on outdated hardware	Colley, Mr Peter	Castle Hill Hospital	Specialist Cancer And Support Services	Clinical Oncology	High	15	25/08/2024

Risk ID	Risk Opened Date	Risk Type	Risk Title	Risk Handler	Site	Corporate Function/Care Group	Specialty	Risk Rating	Risk Rate Score	Review Date
2166	28/02/2017	Staffing Levels & HR	Workforce of the imaging team in the Pink Rose Suite	Janet Hendy	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Cancer And Support Services	Breast Diagnostics And Screening	High	15	27/08/2024
3278	15/12/2023	Information Technology	No recurrent revenue to continue the Cynerio IoT Cyber Management System after 3 year contract ends at 07-03-2025	Stephen Mattern	Trustwide - All Sites (DPoW, SGH, GDH & Community)	Digital Services	IT Operations	High	15	28/08/2024
3277	14/12/2023	Information Technology	No recurrent revenue to continue the Imprivata Single SignOn and Fairwarning System	Martin Sykes	Trustwide - All Sites (DPoW, SGH, GDH & Community)	Digital Services	IT Operations	High	15	28/08/2024
3266	16/11/2023	Safeguarding	Availability of Chaperones for intimate examinations in Radiology	Ruth Kent	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Cancer And Support Services	Radiology - Ultrasound	High	15	28/08/2024
4173	06/02/2023	Workforce (including staffing etc),	Nintedanib Change in guidance impacting on clinical capacity to deliver increasing numbers of patients	Hutton, Mr James	Castle Hill Hospital	Specialist Medicine	Chest Medicine	High	15	30/08/2024
3330	08/05/2024	Information Technology	Type 5 ECDS SDEC Activity Reporting	Rhiannon Wilson	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Acute Medicine	High	15	02/09/2024
3329	08/05/2024	Information Technology	Acute Medicine Reporting	Rhiannon Wilson	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Acute Medicine	High	15	04/09/2024
3161	24/01/2023	Clinical	There is a risk of patient deterioration not being recognised and escalated appropriately.	Joanne Foster	Trustwide - All Sites (DPoW, SGH & GDH)	Acute And Emergency Medicine	Nursing (All Specialties)	High	15	04/09/2024
1851	28/04/2015	Clinical	Shortfall in Capacity within the Ophthalmology Service	Tom Foulds	Trustwide - All Sites (DPoW, SGH & GDH)	Head And Neck	Ophthalmology	High	15	04/09/2024
4132	24/11/2022	HDigital,	Cyber Security vulnerabilities	Deal, Tony	Trust Wide	Digital Health	Systems and Applications	High	15	07/09/2024
4363	10/06/2024	Security,	There is a risk that the Mortuary at CHH may experience a security breach for unauthorised / criminal access	May, Mr David	Castle Hill Hospital	Estates, Facilities and Development	Security Services	High	15	10/09/2024
4048	09/03/2022	Equipment,	There is a risk to the continuity of the service due to the ageing Radiotherapy Linac (Bunker 6)	Colley, Mr Peter	Castle Hill Hospital	Specialist Cancer And Support Services	Radiotherapy	High	15	10/09/2024
4200	16/03/2023	Patient Safety & Quality of Care,	Increased risk of harm to patients and families due to inadequate co-located psychology support to children and young people.	Bowen, Theresa	Off site	Family Services	Community Paediatrics	High	15	12/09/2024
3108	11/08/2022	Equipment	Non compliance with MHRA guidance for managing medical devices Jan 21, NatPSA/2023/010 /MHRA and Medical Device Management & Procurement Policy DCP047	Craig Murdock	Trustwide - All Sites (DPoW, SGH, GDH & Community)	Specialist Cancer And Support Services	Medical Engineering	High	15	13/09/2024
4011	12/10/2021	Patient Safety & Quality of Care,	Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity	Cook, Miss Helen	Hull Royal Infirmary	Head And Neck	Ophthalmology	High	15	13/09/2024
4012	12/10/2021	Patient Safety & Quality of Care,	Clinical risk to patients referred as new patients into the new wet macular degeneration pathway	Downey, Ms Louise	Hull Royal Infirmary	Head And Neck	Ophthalmology	High	15	13/09/2024
4013	12/10/2021	Patient Safety & Quality of Care,Outpatients Risk, Reputation	Clinical risk to patients referred as new patients into new Medical Retina patient assessment clinic due to lack of capacity iss	Downey, Ms Louise	Hull Royal Infirmary	Head And Neck	Ophthalmology	High	15	13/09/2024

Risk ID	Risk Opened Date	Risk Type	Risk Title	Risk Handler	Site	Corporate Function/Care Group	Specialty	Risk Rating	Risk Rate Score	Review Date
3959	21/05/2021	Patient Safety & Quality of Care,	Risk of patient harm to new and follow-up patients due to delays within glaucoma service	Downey, Ms Louise	Hull Royal Infirmary	Head And Neck	Ophthalmology	High	15	13/09/2024
3252	06/07/2018	Patient Safety & Quality of Care,	Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight	Cook, Miss Helen	Hull Royal Infirmary	Head And Neck	Ophthalmology	High	15	13/09/2024
2347	21/04/2018	Clinical	Risk to Overall Performance : Overdue Follow-ups	Jennifer Orton	Trustwide - All Sites (DPoW, SGH & GDH)	Specialist Surgery	General Surgery	High	15	13/09/2024
4391	20/08/2024	Patient Safety & Quality of Care,	Lack of Rehabilitation Clinic ICU	Howes , Dr Julian	Trust Wide	Theatres, Anaesthetics and Critical Care	Critical Care (ICU & HDU)	High	15	20/09/2024
4393	20/08/2024	Patient Safety & Quality of Care,	Lack of Critical Care beds ICU CHH	Breen, Mrs Ruth	Castle Hill Hospital	Theatres, Anaesthetics and Critical Care	Critical Care (ICU & HDU)	High	15	20/09/2024
4387	06/08/2024	Financial,	There is a risk that EF&D will fail to achieve the Trust identified CRES target for 2024/25.	Tighe, Simon	Trust Wide	Estates, Facilities and Development	Trustwide	High	15	27/09/2024
4339	12/04/2024	Trust property and environment,	Non-Critical ventilation systems will be required to function beyond its 20 year life replacement as detailed in HTM 03 Part B	Kaye, Neil	Trust Wide	Estates, Facilities and Development	Estates Operations (inc grounds and gardens)	High	15	27/09/2024
4286	14/12/2023	Patient Safety & Quality of Care,	Risk to the acute patients due to lack of junior doctor cover on Cardiology Day Ward, HUTH	Ramlall, Manish	Castle Hill Hospital	Cardiovascular	Cardiology	High	15	30/09/2024
4137	24/11/2022	HDigital,	Accuracy of Data of Business Decision Making	Britchford, George	Trust Wide	Digital Health	Business Intelligence and Information	High	15	02/10/2024
4396	23/08/2024	Patient Safety & Quality of Care,	There is a risk that flooring repairs are needed in the Queens Building due to Trust damage	Appleton, Lee	Castle Hill Hospital	Estates, Facilities and Development	Estates Operations (inc grounds and gardens)	High	15	04/10/2024
4405	11/09/2024	HDigital,	Potential harm to patients due to incorrect recording of a penicillin allergy in Lorenzo, recorded as Penicillamine.	Calladine, Robert	Trust Wide	Digital Health	Systems and Applications	High	15	11/10/2024
3346	29/05/2024	Operational	Clinical capacity within hysteroscopy at DPOW	Lisa Pearce	Diana, Princess Of Wales Hospital, Grimsby (DPOWH)	Family Services	Gynaecology	High	15	/ /

5 - OTHER ITEMS FOR APPROVAL

6 - ITEMS FOR INFORMATION / SUPPORTING PAPERS

REFERENCES

Only PDFs are attached

- BIC(24)184 - Guardian of Safe Working Quarter One Report 2024-25 - HUTH and NLaG.pdf
- BIC(24)196 - Quality & Safety Committees-in-Common Minutes - July 2024.pdf
- BIC(24)197 - Audit Risk and Governance Committee in Common Public Minutes - August and July 2024.pdf
- BIC(24)199 - Infection Control Annual Report.pdf
- BIC(24)200 - Finance, Estates & Performance Committees-in-Common Minutes - July and August 2024.pdf
- BIC(24)201 - Fire Annual Report.pdf
- BIC(24)202 - Security LSMS Annual Report.pdf
- BIC(24)203 - Workforce, Education and Culture Committees-in-Common Minutes - July 2024.pdf
- BIC(24)204 - Capital & Major Projects Committees-in-Common Minutes - February & April 2024.pdf
- BIC(24)206 - Documents Signed Under Seal.pdf
- BIC(24)207 - Trust Boards & Committees Meeting Cycle - 2024 & 2025.pdf
- BIC(24)205 - Integrated Performance Report HUTH - NLaG October 2024.pdf

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)184

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	10 October 2024
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer / Author	Dr Wajiha Arshad, Guardian of Safe Working, HUTH Dr Elizabeth Evans, Guardian of Safe Working, NLaG
Title of Report	Guardian of Safe Working (GosW) Quarter One Report 2024-2025 for HUTH and NLaG
Executive Summary	**HUTH:** Exception reports: There were 98 exception reports this quarter. The highest numbers were submitted by General Medicine (49), Medical Oncology (8) and Paediatric Surgery (7). Within General Medicine, out of the 49 exception reports submitted, 39 were due to hours (overtime), 5 were for educational reasons, 3 were for service support, and 2 for pattern. The majority of exception reports were due to overtime. Fines: 13 fines were issued in total: 5 for Paediatric Surgery, 2 for Cardio-thoracic Surgery, 2 for General Surgery, 2 for Vascular Surgery, 1 for General Medicine, and 1 for Plastic Surgery. 6 of the fines issued within the quarter relate to non-resident on call shifts and trainees remaining on site or returning to site due to a variety of reasons, resulting in breaches of maximum shift length and required rest. eRoster Rollout: The Guardian of Safe Working continues to work with Medical Staffing on the roll out of e-roster across all rotas within the organisation. The standard of rota is determined by the below categories: Gold — Fully Operational (Fully on eRoster and e-Roster main point of truth) Green — Fully functional Blue — Partially Functional Red — Not functional Below table summarises by Health Group current utilisation of e-Roster as at end June 2024, this table shows that 92% of HUTH rotas are now live on eRoster. Over the next quarter, the Medical Staffing team will be focusing their attention on progressing red areas to enable locum management and payment through eRoster. In addition, many of the rotas sat in red and blue are going through HR processes, which enable movement away from current RBG rated red and blue.

	<table><tr><td></td><td>Red</td><td>Blue</td><td>Green</td><td>Gold</td></tr><tr><td>Surgery</td><td>1</td><td>3</td><td>8</td><td>7</td></tr><tr><td>Clinical Support</td><td>0</td><td>2</td><td>5</td><td>2</td></tr><tr><td>Family and Womens</td><td>3</td><td>5</td><td>4</td><td>0</td></tr><tr><td>Medicine</td><td>1</td><td>6</td><td>12</td><td>0</td></tr><tr><td>Emergency Medicine</td><td>0</td><td>0</td><td>5</td><td>0</td></tr><tr><td>Total</td><td>5 (8%)</td><td>16 (25%)</td><td>34 (53%)</td><td>9 (14%)</td></tr><tr><td>Last quarter</td><td>7 (11%)</td><td>16 (25%)</td><td>32 (50%)</td><td>9 (14%)</td></tr></table> <u>Trainee Doctor Fill Rate:</u> Over the quarter, 89.8% of trainee doctor posts were filled, a decrease from 90.2% last quarter. Oral & Maxillofacial Surgery department has highest number of Trainee vacancies with 27.3% fill rate. Emergency Medicine had highest number of locums requested with their trainee fill rate being 74.4%. **<u>NLaG:</u>** There has been a decrease in exception reporting compared with the last quarter. This is an expected finding at this time of year, as this report covers the last three months of the year for doctors in training. The small number of immediate safety concerns is reassuring. The majority of reports concerned breeches in working hours, with a smaller number relating to support during service commitments and loss of educational opportunities.
Background Information and/or Supporting Document(s) (if applicable)	**<u>HUTH:</u>** Whilst the report provides an overview of the last quarter, the data and can be found in the appendices linked at the bottom of the report. **<u>NLaG:</u>** Junior Doctors TCS (Version 11) – https://www.nhsemployers.org/system/files/2023-02/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf
Prior Approval Process	Workforce, Education and Culture Committees-in-Common meeting held on 29 August 2024
Financial Implication(s) (if applicable)	**<u>HUTH:</u>** This report contains information on Guardian of Safe Working fines. £14,231.38 of fines have been issued over the quarter. Paediatric Surgery and Plastic Surgery have continued to have a number of fines issued over several consecutive quarters. **<u>NLaG:</u>** N/A

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Appendix 1

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st April – 30th June 2024

1. Purpose of this Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from January – March 2024.

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	625.7
(establishment)	699
Number of doctors / dentists in training on 2016 TCS (total FTE's):	625.7
Amount of time available in job plan for guardian to do the role:	1 PA (4 hours per week)
Admin support provided to the guardian (if any):	1 WTE
Amount of job-planned time for educational supervisors:	1 WTE 0.25 PAs per trainee (max; varies between health groups)

Information on exception reporting is detailed within the junior doctor's contract (pages 37-39)

Doctors and dentists in training terms and conditions (England) 2016 | NHS Employers

3. Exception Reports

There were a total of 98 exception reports (98 episodes) reported by doctors in training and locally employed doctors for this quarter. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

Appendix A:
Exception reports (episodes) by department 1st April – 30th June 2024

General Medicine, Medical Oncology, and Paediatric Surgery had the highest number of exception reports submitted over the quarter.

Within General Medicine, out of the 49 exception reports submitted, 39 were due to hours (overtime), 5 were for educational reasons, 3 were for service support, and 2 for pattern.

Medical Oncology and Paediatric Surgery had significantly less exception reports submitted.

Out of the 8 exception reports submitted within Medical Oncology, 7 were for hours (overtime) and only 1 exception report related to pattern.

Out of the 7 exception reports submitted for Paediatric Surgery, 4 were for hours (overtime) and 3 were due to pattern.

Appendix B:
Exception reports (episodes) by grade 1st April – 30th June 2024

The highest number of exception reports were submitted by FY1 trainees.
44 exception reports were submitted by FY1 trainees in the quarter, and of those, 40 were for hours (overtime), 2 for pattern, 1 for education, and 1 for service support.

Appendix C:
Exception reports (episodes) by rota 1st April – 30th June 2024

Rota 14 (DME SHO), Rota 4 (Medicine F1 Gastro/Acute/DME) and Rota 18 (Oncology/Chest F1) had the highest number of exception reports within the quarter.

Rota 14 had 8 exception reports due to hours (overtime), 5 due to missed educational opportunities, and 1 due to service support.

Rota 4 had 10 exception reports submitted, all for hours (overtime).

Rota 18 had 9 exception reports submitted, all for hours (overtime).

Appendix D:
Exception reports (episodes) - response time 1st April – 30th June 2024

The 2016 TCS require that the trainer meets with the doctor in training to discuss an exception report within seven days.
It has continually been identified that meting within seven days is often difficult for trainees and supervisors. Guardian of Safe Working continues to educate both junior doctors and supervisors on the importance of exception reporting and meeting in a timely manner.

4. Work Schedule Reviews

The following rotas were under review between 1st April – 30th June 2024; all relevant health groups are aware.

- Oral & Maxillofacial Surgery – Rota 38
- ENT – Rota 34
- Ophthalmology – Rota 36

5. Locum bookings 1st April – 30th June 2024

Appendix E – G:
Bank 1st April – 30th June 2024

The Trust has a number of avenues to fill rota gaps with post gaps filled by doctors working within the Trust initially either as overtime or via our Medical Bank. The bank data details bookings made with doctors working through the Trust's 'Remarkable Bank' and does not include data on any rotational doctors working additional hours/overtime above their base working hours.
The information covers shifts that have been booked by the Medical Staffing Team, Emergency Department and Anesthetics. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Appendix H – J:
Agency 1st April – 30th June 2024

The Trust also uses limited amount of agency staff. All agency bookings are managed by the Medical Staffing team, but are only used when internal and bank routes are exhausted.

Appendix K:
Locum work carried out by doctors in training 1st April – 30th June 2024

This data is collected to help assess whether individual doctors in training are in breach of the WTR and the 2016 TCS, or at significant risk of breaching.

The table represents the top 10 doctors in training that have worked the most extra hours and whether they have opted out of the WTD.

6. **Vacancies:** The below table details the Doctors and Dentists in training establishment and current doctors in training in post as appointed by NHS England (formerly Health Education England).

Hull University Teaching Hospitals NHS Trust - Junior Doctor Trainee Establishment April to June 2024

	Trainee Establishment						Trainee In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Filled June 2024**	% Filled March 2024
Academic, GP, Psych & Community	9	29	0	105	0	143	8	28.5	0	96.9	0	133.4	**93.3%**	93.9%
Acute Medicine	5	7	8	0	9	29	5	6	6.9	0	7.4	25.3	**87.2%**	87.2%
Anaesthetics	5	4	25	0	30	64	5	4	20.7	0	32.8	62.5	**97.7%**	97.3%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	**80.0%**	80.0%
Cardiology	3	1	3	1	10	18	3	1	3	1	10	18	**100.0%**	100.0%
Cardiothroacic Surgery	0	3	0	0	4	7	0	2	0	0	3	5	**71.4%**	85.7%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Colorectal Surgery	9	0	2	0	3	14	8	0	2	0	2	12	**85.7%**	100.0%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	**100.0%**	100.0%
Elderly Medicine	6	3	5	7	6	27	5.8	3	5	7	4.2	25	**92.6%**	97.0%
Emergency Medicine	0	12	12	6	18	48	0	10.6	8.4	5	11.7	35.7	**74.4%**	76.3%
Endocrinology	3	0	2	0	4	9	3	0	1	0	4	8	**88.9%**	97.8%
ENT	2	1	2	3	5	13	2	1	2	3	3.6	11.6	**89.2%**	89.2%
Gastroenterology	3	0	2	0	5	10	3	0	1	0	4.5	8.5	**85.0%**	95.0%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	**100.0%**	0.0%
Haematology	2	2	2	0	4	10	2	2	2	0	3	9	**90.0%**	80.0%
Histopathology	0	0	0	0	7	7	0	0	0	0	6.6	6.6	**94.3%**	94.3%
Immunology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Infectious Diseases	2	1	1	4	6	14	2	1	1	4	6.3	14.3	**102.1%**	102.1%
Neuro-Rehab	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**	100.0%
Neurology	4	3	3	0	5	15	4	3	2.8	0	3.5	13.3	**88.7%**	83.3%
Neurosurgery	1	1	2	0	4	8	1	1	2	0	4	8	**100.0%**	87.5%
Obstetrics & Gynaecology	0	3	7	5	13	28	0	2	7	4.6	12.4	26	**92.9%**	96.4%
Oncology	3	0	2	4	12	21	3	0	1.8	4	12	20.8	**99.0%**	90.5%
Ophthalmology	1	1	0	0	6	8	1	0	0	0	5.8	6.8	**85.0%**	97.5%
Oral & Maxillofacial Surgery	0	0	10	0	1	11	0	0	2	0	1	3	**27.3%**	27.3%
Paediatric Neonatal Medicine	0	0	9	0	7	16	0	0	8.8	0	5.4	14.2	**88.8%**	88.8%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	0	2	**100.0%**	100.0%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**	100.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	6	9	**100.0%**	88.9%
Paediatrics	3	4	4	4	9	24	3	4	3.8	3.2	8.6	22.6	**94.2%**	90.0%
Radiology	0	1	0	0	37	38	0	1	0	0	31.4	32.4	**85.3%**	82.6%
Renal Medicine	2	1	2	0	6	11	2	1	2	0	5	10	**90.9%**	72.7%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8.3	20.3	**101.5%**	96.5%
Rheumatology	0	0	1	2	3	6	0	0	1	2	2.8	5.8	**96.7%**	96.7%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Trauma & Orthopaedics	0	5	3	1	9	18	0	3	2	1	8	14	**77.8%**	94.4%
Upper GI	9	0	2	0	4	15	8	0	1	0	4	13	**86.7%**	93.3%
Urology	1	3	2	0	3	9	1	3	2	0	3	9	**100.0%**	100.0%
Vascular Surgery	6	0	1	0	5	12	5.8	0	0.8	0	2	8.6	**71.7%**	83.1%
TOTAL	**88**	**88**	**120**	**149**	**254**	**699**	**84.6**	**80.1**	**98**	**138.7**	**226.3**	**627.7**	**89.8%**	90.2%

7. Fines

The 2016 Medical and Dental T&C's contract states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.
- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved
- Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine.

Standard rates are outlined in the Terms and Conditions.

Summary of fines issued 1st April – 30th June 2024
Appendix L:

13 fines were issued in total. 5 for Paediatric Surgery, 2 for Cardio-thoracic Surgery, 2 for General Surgery, 2 for Vascular Surgery, 1 for General Medicine, and 1 for Plastic Surgery.

6 of the fines issued within the quarter relate to non-resident on call shifts and trainees remaining on site or returning to site due to a variety of reasons, resulting in breaches of maximum shift length and required rest.

The fines relating to Paediatric Surgery and Plastic Surgery were in relation to non-resident on call shifts where the trainees remained on site for emergency theatre cases, resulting in breaches of 13 hour maximum shift length, 8 hours rest in a 24 hour period, and 5 hours continuous rest.

The fines to Cardio-thoracic Surgery were both in relation to breaches of 13 hour shifts as a result of short staffing over weekends or bank holidays.

The fines issued to Vascular Surgery, General Surgery, and General Medicine were due to breaches of 13 hour shift length as a result of either short staffing or emergencies on the department close to shifts being rostered to end.

<u>Steps taken to resolve issues:</u>

The circumstances resulting in these fines are deemed to be exceptional circumstances due to external factors, Industrial Action and trainees staying on site to maintain patient safety. The trainees have then followed up appropriately by submitting exception reports and escalating the breaches.

The clinical lead in Paediatric Surgery has also produced several business cases to combat rota issues which have resulted in breaches, and the most recent case is still pending financial approval.

8. GOSW Funds Expenditure

Over the quarter there have been several purchases made to benefit the Junior Doctor cohort using Guardian of Safe Working funds, totalling £4,867.
The Guardian of Safe Working funds have been used to provide refreshments at a wide range of junior doctor teaching events over the quarter, and two sofa beds have also been purchased for the Junior Doctor Mess'.
All expenditure from the GOSW Funds is agreed at the Junior Doctors' Forum.

Please see attached appendices containing data referred to above.
Appendix A – L.

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarter One Report 2024-2025

Dr Liz Evans
Guardian of Safe Working
1st July 2024

Contents

1. Executive Summary

Exception reports for the quarter 1st April 2024 to 30th June 2024 saw a decrease from 81 to 59 exception reports. The majority of the exception reports submitted were in connection with working hours, with a smaller number submitted around service support, educational opportunities, and work patterns, which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant divisions/directorates.

There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out for the Educational Supervisors, the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	241.44
Number of Doctors/Dentists in Training (WTE)	200.18
Number of Less than full time (LTFT) Trainees (Headcount)	38
Number of Training post vacancies (WTE)	41.26

Source Finance data

During the period of this quarterly report (1st April 2024 to 30th June 2024) there have been a total of 59 exception reports submitted through the allocate exception reporting system.

This showed a decrease of 22 reports from the last quarter (1st January to 31st March 2024).

Of the 59 exception reports submitted, 45 were linked to hours. This showed a decrease of 16 reports from the previous quarter.

The exception reports for this quarter relating to hours have been compensated by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL). They have mostly been closed successfully. Our policy is to provide TOIL rather than payment to try to reduce burnout and fatigue, unless there is a reason not to (which may include the doctors asking for payment as an alternative, or towards the end of rotations where taking TOIL may not be practical).

The below table is a breakdown of the exception reports over the last quarter (April - June 2024)

Exception Reports Open (ER) between 1st April 2024 – 30th June 2024	
Total number of exception reports received	59
Number relating to hours of work	45
Number relating to pattern of work	2
Number relating to educational opportunities	10
Number relating to service support available to the Doctor	2
Number initially relating to immediate patient safety concerns	2

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support have the option of specifying whether the report constitutes an immediate safety concern (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st April 2024 and 30th June 2024	
Total number of exception reports resolved as at 30/06/24*	60
Total number of exception reports unresolved as at 30/06/24**	17
Total number of exception reports where TOIL was granted	32
Total number of exception reports where overtime was paid	14
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	14
Total number of exception reports resulting in fines	0

"Note:
* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.
* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.
* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded. This may also be because a work schedule review is pending.

2. Immediate Safety Concerns

During this quarter there were 2 exception reports submitted where a Doctor raised an immediate safety concern in addition to a concern around working hours and clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

The immediate safety concerns were both due to the intensity of the work undertaken by the reporting doctors. One was due to the doctors inability to take a safe break during a 12 hour shift, the other due to work intensity meaning the doctors felt unable to safely care for a sick patient. Both of these immediate safety concerns have been escalated and there has been no repetition of these events, which occurred in different

departments. It is encouraging to see that one of these immediate safety concerns was raised by the supervising consultant following a meeting with the reporting doctor, this is a promising sign that the system is being used effectively and is being treated seriously by the educational supervisors.

3. Work Schedule Reviews

During this quarter there were no work schedule reviews required. There were three work schedule reviews which have been open for several months which have not been undertaken despite multiple e-mails to both the reporting doctors, the educational supervisors, and PGME. This has now been escalated to the Medical Director and these reports closed pending further action. The trainees affected have been asked to keep reporting where appropriate, as in at least one of these cases a change to the working pattern is needed.

4. Trend in Exception Reporting

There has been a slight decrease in exception reporting this quarter. This is probably not significant as the difference in numbers is small, but it is in keeping with the trend usually seen at this time of year. It is reassuring to see that despite the number or reports the ratio of Immediate Safety Concerns to exception reports remains low. This Provides evidence that they system is embedded correctly and is being used appropriately. The number of reports for excess hours outstrips the other reasons for exception reporting, which is a consistent finding throughout the year. Improved engagement with the doctors during induction has embedded a culture of exception reporting among the doctors in training, particularly at a foundation level.

5. Fines Levied against Departments this quarter

There have been no fines this quarter.

6. Communication and Engagement

Work continues regarding communication and engagement with our Doctors in Training.

The Junior Doctors Forum has been up and running now for several years, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF is re-discussed at the first JDF of the new academic year to confirm that this time is convenient for the Doctors in Training, and a survey sent out to the doctors to ensure that the time is appropriate.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. This is usually run by the guardian of safe working, but several times a year is a joint session with PGME or the Freedom to Speak Up Guardian.

In addition there is a regular quarterly newsletter which is circulated via e-mail. Information pertaining to the guardians office is available on the HUB, and there is a leaflet which is provided to all doctors in training on joining the trust containing details of the support available. There is also now a regular meeting between the Guardian of Safe Working, the Freedom to Speak up Guardian, and a representative of PGME. This enables the support mechanism for Doctors in Training to establish any common themes and co-ordinate an approach to finding solutions. An exit survey for doctors

leaving the trust has been circulated, with good response. This has shown good engagement and positive feedback for the guardian role, with the overwhelming majority of the doctors in training finding the guardian to be accessible and helpful. Finally a screen saver has been implemented across the trust to remind the Doctors in Training of the exception reporting system. A project to put up posters clarifying the procedure for reporting has been started in conjunction with one of the BMA reps- this is in its early stages but we have noticed a slight increase in reports for missed breaks which is the focus of the campaign.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Chief Medical Officers Directorate.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, commenced in this role in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated a small decrease compared with the previous quarter. This is what we would expect for this time of year. There have been two immediate safety concerns, which have been delt with appropriately.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise. We will ensure that we continue with this work, as it provides real-time information about the situation on the wards, in addition to being a contractual obligation.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one.

Dr Liz Evans - Guardian of Safe Working

Date: 1st July 2024

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)196

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday 10 October 2024
Director Lead	Sue Liburd, Committee Chair of Quality & Safety CIC David Sulch, Committee Chair of Quality & Safety CIC
Contact Officer / Author	Sue Liburd, Committee Chair of Quality & Safety CIC David Sulch, Committee Chair of Quality & Safety CIC
Title of Report	Quality & Safety Committees in Common Minutes – July 2024
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 31/07/24
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 29/08/24
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 ü Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday 31 July 2024, 9.00 - 12.30 in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director NLAG (chair)
David Sulch	Non-Executive Director HUTH
Tony Curry	Non-Executive Director
Amanda Stanford	Group Chief Nurse
Kate Wood	Group Chief Medical Officer
Paul Bytheway	Group Chief Delivery Officer

In Attendance:

Pete Sedman	Deputy Group Chief Medical Officer
Rob Chidlow	Interim Group Director of Quality Governance
Melanie Sharp	Deputy Chief Nurse NLAG
Richard Dickinson	Associate Director of Quality Governance NLAG
Rebecca Thompson	Deputy Director of Assurance (Minutes)
Michela Littlewood	Associate Director of Quality HUTH
Yvonne McGrath	Group Director of Midwifery
Vicky Thersby	Head of Safeguarding NLAG
Corrin Manaley	Public Governor (observer)
Marie Stern	Patient Representative HUTH
Linda Jackson	Vice Chair
Jonathan Lofthouse	Group Chief Executive Officer
Lesley Heelbeck	NHSE Maternity Support Team

KEY

HUTH – Hull University Teaching Hospitals NHS Trust
NLAG – Northern Lincolnshire & Goole NHS Foundation Trust
CiC – Committees in Common

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting. Apologies were noted from David Sharif, Kate Truscott and Ashok Pathak.

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items. Linda Jackson offered a declaration to item 1.6 as she had members of her family affected by industrial action.

1.3 To approve the minutes of the meeting held on 26 June 2024

The minutes of the meeting were accepted as a true and accurate record.

1.4 Matters Arising

The CIC chair invited committee members to raise any matters requiring discussion not captured on the agenda. None were raised.

1.5 Committees-in-Common Action Tracker

The action tracker was updated prior to the meeting.
The neonatal action was closed as it was captured on the agenda.
The Children and Young People's action relating to medication errors to remain on the tracker and picked up in the next iteration of the report in the usual cycle. The action was amber and on track.

1.6 Operational pressures update

Paul Bytheway advised there were well tested plans now during the strike action and it was noted the action would probably end due to the settlement reached regarding Junior Doctors' pay.

Paul reported there were still challenges in Urgent Care with long waits in both ED departments and an urgent care plan was being developed ahead of winter.

There were no 65 week waits recorded at the end of June 2024.

Amanda Stanford advised the midwifery support workers at Diana Princess of Wales Hospital had gone on strike due to Band 3 back pay issues. Lengthy meetings had taken place with Unison but the Trust was constrained by the national position. Jonathan Lofthouse advised it was unfortunate the Unions did not want to settle but the Trust had reached the ceiling on the offer. Sue Liburd asked if there would be any further Industrial Action and Amanda advised that it was possible.

Amanda also reported she was keeping a close watch on the number of Covid cases as some organisations were being impacted and reverting to PPE measures.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported there were no matters referred.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

Rebecca Thompson presented the Quality and Safety BAF risks and highlighted that the high level quality and safety risks are now included in the report.

There had been a discussion at the Group Cabinet Risk and Assurance Committee around the risk rating levels for the Quality risks and whether they were too low.

Amanda Stanford advised further work was required and that she and Kate Wood would review the ratings and make sure the risks were appropriately completed. Kate Wood added the risk ratings were to low due to the front door, flow, the inadequate for safety and the Section 31 notice. Work was required to reassess and realign with evidence to underpin the changes.

David Sulch suggested that the risk ratings should be reviewed with the other risks at the Boards in Common to ensure the risk ratings were appropriate. Jonathan Lofthouse added that there had been a strong debate regarding the finance risk rating of 25 and how this compared to the lower quality risks. Linda Jackson asked how long this piece of work would take and Jonathan replied that the Executive Team were having a time out at the end of August so the changes would be ready for October 2024.

Action: Quality and Safety risk ratings to be reviewed at the October 2024 meeting.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Integrated Performance Report (IPR): quality & safety metrics

Rob Chidlow presented the report and advised that it still required a manual work up each month. He added that the Single Oversight Framework was changing which would mean further amendments.

Key areas included:

VTE performance which had been re-introduced to the metrics and NLAG had seen reporting issues due to the Lorenzo switch. Kate Wood advised data validation was being carried out to bring this into line. Richard Dickinson advised that Lorenzo was not picking up all the data and the EPMA system was more reliable. Once the issues were fully understood the team would report back to the CIC.

HUTH was still an outlier with regards to the SHMI and HSMR but NLAG were on target. Pete Sedman added there was now a Group wide Mortality Group and work was ongoing to align good practice with a view to improve performance. There was targeted focus around Fractured Neck of Femur, Sepsis and Secondary Malignancies.

Action: A report highlighting Fracture Neck of Femur performance, action plans and improvements to be received at the November 2024 meeting.

Venous Thromboembolism (VTE) performance at NLAG had dipped due to mapping and coding changes as a result of Lorenzo being introduced. Work was ongoing to review this.

Duty of Candour performance was not where it needed to be on the North Bank. Verbal apologies were being made but there was a lack of written letters to patients. Remedial actions were in place to address and there had not been an increase in complaints or PALS in this area. This was being monitored at the Quality Governance Group.
IPC in particular C Difficile was an issue and Amanda Stanford advised the IPC Team were scrutinising each case and tracking the issues. This was being monitored at the operational and strategic IPC meetings.

4.1.1 Update on Quality IPR Time Out

Amanda Stanford presented the item and advised the Quality Team had met with Care Groups and discussed the work required regarding the quality metrics as the work was complex and not currently in a good format. She advised that each Care Group would have a Quality and Safety scorecard which would include Ward accreditations and this would build a bottom-up way of understanding the quality and safety of care in the organisation.

Rob Chidlow advised the core metrics had been shared with Business Intelligence (BI) and benchmarking had taken place with other large Group organisations.

The CIC agreed limited assurance for the IPR as although there was work ongoing no outputs had been received. The CIC wanted to acknowledge the work ongoing and the progress being made.

Linda Jackson expressed her concern regarding the assurance ratings and agreed to discuss the ratings outside of the meeting as she was not sure the levels were right.

4.2 CQC Oversight Report

Amanda Stanford advised that due to CIC members not being assured regarding progress on the CQC actions she had met with governance and clinical colleagues and reviewed all of the actions and their rag ratings. This had resulted in a shift in the number of must dos and a paper would be brought to the CIC setting out the agreed new principles.

RAG ratings are now based on evidence supplied and take into account moving target dates. Amanda gave a couple of examples as to changes in escalation which were the diagnostic and outpatient actions are now monitored at the Cancer Delivery Board and backlogs of patients that are overdue news or follow ups would be monitored at the Planned Care Board. Minutes from these meetings would be fed back to the CQC.

Amanda advised a small number of the must dos were not achievable and would discuss these further with the CQC. Amanda advised there were a few more core services to tackle then a paper would be brought back to the CIC to explain the changes.

Action: A CQC action update paper to be received at the October CIC.

4.3 Nursing Assurance Report

NLAG – Melanie Sharp presented the report and advised the vacancy position for Registered Nurses had slightly increased but the Trust had recruited a total of 104 whole time equivalent Registered Nurses that would commence in September and

October. The recruitment of international nurses had been put on hold until such time the vacancy position changed again. The unregistered position had not improved and mass recruitment days had been put into place.

The fill rate was below 85% in 3 areas in particular NICU and Disney wards at Grimsby but robust measures were in place for capacity and demand with staff being redeployed if necessary.

There had been an increase in red flags and the key issues was a red flag highlighting less than 50% substantive staff on a ward. Proactive work was ongoing to ensure staff were moved when necessary to maintain safe staffing levels and care.

Melanie presented the falls performance and there had been an increase reported. There had been 13 in April and 7 in May and 3 of these had resulted in patient harm. She advised that the patients had complex issues and SWARM huddles had taken place immediately with robust risk assessments also taking place. There had been no new learning from the events.

NLAG saw a reduction in pressure ulcers in the acute process but an increase in the Community. Changes had been made within the Community teams to review all patients in care homes. Mel added there had been no stage 4 pressure ulcers reported.

Linda Jackson asked what the Trust was doing regarding the 116 unregistered vacancies and Mel advised that mass recruitment was ongoing and 26 had been recruited from this process. Linda added that retaining the recruits was key. Melanie advised teams were being very clear about roles and responsibilities and weekend working requirements. Health Care Assistant 'buddies' were now in place too. Amanda Stanford added the situation was not isolated to NLAG and was a national problem mainly due to the low pay issue. Learning from the North would be replicated in the South as the North was in a stronger position. Jonathan Lofthouse queried whether mass recruitment was the answer as the low pay was the main driver and he stated that a better solution needed to be found.

Tony Curry suggested that HCA support worker's pay and retention should be discussed further at the Workforce, Education and Culture CIC.

Sue Liburd queried the Community pressure ulcer activity and the very high numbers of unplanned and cancelled visits. Mel advised that the numbers were a mixture of the individual planned visits and cancelled visits. The visits were reviewed daily by the system.

Sue also queried whether any of the patient falls had resulted in family complaints. Melanie advised they had not but advised that 2 of the SWARMs included family members and this had worked well.

Amanda Stanford presented the HUTH report and highlighted that there was less of an issue regarding HCAs and the apprenticeship programmes had been hugely successful. There had been a total of 220 students recruited both North and South. Amanda added the challenge was how the Trusts invest in the newly qualified nurses, share opportunities and make sure they had a positive experience when they come to work.

Amanda reported that she wanted to focus on the nutritional standards at HUTH as part of the new accreditation programme to ensure patients were getting good nutritional care. David Sulch asked about the IPC ratings and that performance had not changed since March. Amanda advised there were fundamental issues, such as appropriate use of PPE and staff not being bare below the elbows which needed addressing. Amanda added antibiotic prescribing would also be revisited.

A new approach to fundamental standards was being developed for the Group using the Salford model in which IPC would be key. Ownership of the standards would fall to the matrons and sisters and they would be held accountable for their wards. Amanda added that the IPC BAF would be presented at the August CIC.

Linda Jackson asked if there would be opportunities for the NEDs and Governors to be included in the new fundamental standard approach as this would help with Board visibility. Amanda welcomed the additional support from the NEDs/Governors.

The CIC agreed limited assurance for the NLAG report due to concerns around recruitment of non-registered nurses and falls.

The CIC agreed limited assurance for the HUTH report due to IPC issues but noted that there were good processes in place regarding recruitment which would be replicated on the South bank.

4.4 Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI, MTAC)

Yvonne McGrath presented the NLAG report and advised the CNST safety actions were being monitored and work was ongoing regarding safety action 6 around capacity and demand but otherwise the Trust was in a good position.

Training was on track and the Trust would shortly be going for gold in the sustainability award for Baby Friendly. This showed good collaboration work with the Local Authority colleagues.

Level 3 Safeguarding training compliance was poor but this was because more staff had been asked to complete it. Work was ongoing to ensure the compliance levels were in a better place by October.

Sue Liburd thanked Yvonne for the report which was a much easier read than before. She highlighted the CNST MIS year 6 10 steps to safety and stated that she was struggling with the RAG ratings. Yvonne advised the difference was around should do actions and must do actions. The should do actions did not count towards compliance.

The HUTH report was presented and the greatest risk was around safety action 5 and this related to workforce issues around co-ordinators. There was a 0.49 vacancy position meaning only one co-ordinator was available per shift and there should be two. The Trust was in the process of having another Birth Rate Plus review and a robust action plan was being developed.

A temporary Band 7 Maternity Compliance and Audit manager had been appointed to review compliance and reviewing documenting evidence on BadgerNet. Work

was ongoing with Lesley Heelbeck from NHSE to work through the Maternity Support Team exit criteria.

The Trust had 18.5 WTE vacancies which included maternity leave and the service had recruited 22 newly qualified midwives.

Amanda Stanford advised a paper had been presented at Cabinet highlighting the risks to the Hull site regarding workforce and leadership. Culture was still an issue with reports of bullying and harassment and other poor behaviours. Preceptorships were lasting 2 weeks in some cases and programmes should be at least a year. Jonathan Lofthouse advised the investment required was £2m and this would need to be presented at the Boards in Common for discussion and approval. Jonathan added if the money was approved the plan had to be delivered within 18 months due to the ongoing issues being highlighted.

Lesley Heelbeck added the concept paper was key as concerns around staffing and culture had been raised with her also as part of the Maternity Safety Support Programme. She added that the programme had been in place for nearly a year and many improvements had been made but now a review and reset was required with revised targets.

Sue Liburd cautioned the report being submitted to the Board in its current state as there was potentially patient identifiable data included in it.

The CIC discussed the report format and Linda Jackson suggested a shorter report with the detail attached at an appendix which would make it easier to read.

Yvonne added work around culture was now being picked up in a specific workstream and she now sat on the MNVP (Maternity & Neonatal Voices Partnership) and working on the Governance aspects of the maternity workstreams.

The CIC agreed reasonable assurance for NLAG and limited assurance for HUTH as there was more work to do and investment to be made.

4.4.1 Neonatal Deaths Report

The HUTH neonatal death review was picked up as the MBBRACE perinatal surveillance report had shown the Trust to be an outlier. This was a snapshot view and there were no signs of any themes from a workforce point of view and the Head of Midwifery had arrangements in place to mitigate any risks.

Paul Bytheway left the meeting at 11am.

4.5 PSIRF/Serious Incidents (including Duty of Candour and Lessons Learned)

Richard Dickinson presented the report and advised there had been some traction and progress on some of the investigations but there had been others that were taking longer to review. He used case 8658 as an example as anesthetic input was required as part of the investigation which took longer than anticipated.

Other issues were around Quad review and governance cycles within Care Group meaning timescales were extended.

David Sulch requested assurance around the action plans and whether actions were being delivered in a timely way. Richard advised the Governance Team had weekly reports showing action progress and these would be reviewed at the Quality Governance Group. Amanda Stanford added the next report will show action plan movements and that it would be reviewed at the September Q&S time out.

Michela Littlewood added that the Quality Governance Teams were targeting the overdue actions with the Care Groups and these were being reviewed at Governance meetings. She added that the methodology was different and much more targeted. A thematic review was underway relating to stroke care which showed not just individual learning but service involvement and learning would be shared. There had been one Patient Safety Incident Investigation closed in month and again the learning would be shared widely.

Michela advised that a Never Event had been declared in July 2024 relating to a wrong site anesthetic injection. The WHO checklist was followed but there were other factors that impacted on the error. Kate Wood advised immediate escalation to the Executives was key so support could be offered to the teams. Michela added that Duty of Candour had taken place and the Governance Team were supporting the staff involved.

The CIC agreed limited assurance for this item across the Group as there was further work to be done.

4.6 Patient Experience Report (including learning from complaints)

Rob Chidlow presented the report which summarised the significant amount of work that had been carried out to bring the two teams together into a Group position. Work is ongoing to review themes and trends coming out of complaints and PALS with the clinical operational teams to prevent the issues reoccurring.

There was more work to be done regarding the PALS teams in both Trusts as compliance regarding the 60 day turnaround target was poor. There were plans in place to respond to patient concerns on mass where appropriate, for example ophthalmology appointment issues and patient property.

The new Group Patient Experience Group would be commencing in September and the Inpatient Survey results would be presented at that first meeting. Friends and Family data was also being shared with the Care Group nurse directors.

Linda Jackson asked about the 50% compliance for HUTH complaints and Rob advised that work was ongoing to clear the backlog so the teams were tolerating the 60 day turnaround rather than the 40 compliance in place. Once the backlog was cleared a Group target and position would be reported.

Sue Liburd asked if the complaints were responded to by the Group or sovereign organisation. Rob advised that Jonathan Lofthouse signed off every complaint on behalf of the Group.

4.7 Register of External Agency Visits

Rob Chidlow presented the report which highlighted the External Agency visits for the Group.

Sue Liburd asked that where there were long standing open items (more than 2 years old) that action plans were in place and the CIC could see progress in future reports.

Amanda Stanford advised the visits were being worked through with the owners and was an improving picture.

4.8 Safeguarding including MCA & DOLs

Victoria Thersby presented the report and highlighted training compliance differences at HUTH and NLAG and how the teams are working together to align processes and agree best practice. The restructure of the teams had been now been agreed and good relationships were being formed.

Kate Wood asked if there were any plans for enhancing the Sudden and Unexpected Deaths in Infants (SUDIC) process across the Group. Vicky advised it was in the workplan.

Amanda Stanford advised the two Safeguarding Teams were now working as one and posts had been maintained for any nuanced requirements with the Local Authorities. Streamlining with the Teams would take place where this was appropriate.

Linda Jackson asked about the dementia post that had been vacant for nine months. Vicky advised a matron had been acting up so once the Head of Safeguarding post was filled this situation should be resolved.

Sue Liburd expressed her concern regarding the Domestic Abuse Coordinator funding only being available for a year. This post not only worked with patients but staff also. Vicky agreed but stated that the post should be equitable across both Trusts.

Action: The CIC referred the Domestic Abuse Coordinator future funding issues to the Workforce, Education and Culture Committees in Common.

4.9 Clinical Effectiveness Report (including Clinical Audit, NICE Compliance and Deviations, PROMS)

Richard Dickinson presented the report which was now aligned as a Group Head of Audit had been appointed.

The National audit of dementia had shown HUTH to be an outlier and there was a plan in place to ensure improvements in this areas were made.

Sentinel Stroke Nation Audit Programme (SSNAP) scores were discussed weekly and the HUTH performance had been up and down whereas NLAG data was static. The SSNAP data was managed by a central team at NLAG where at HUTH it was more devolved. David Sulch asked about speech therapy and asked if the establishment was low. Richard advised it was resource related. He added one of the benefits of the Group arrangement was the Care Groups could work together to offer a solution.

David Sulch also asked why the Clinicians had not been adding their data onto the national system for percutaneous coronary interventions and Kate Wood advised that the Cardiology Team were reviewing this. Kate added the same team was working across North and South so the procedures should be the same.

Linda Jackson asked if there had been a data collection issues because of the Lorenzo switch and Richard advised the Teams had to push to get the data which was causing timing issues. Steps were being taken to manage this.

The AMAT system was now available for Care Groups and it was not always clear who the audit leads were due to the changes in the teams. Richard advised that if any clarity was require the Triumvirates were contacted.

The CIC agreed reasonable assurance for this item.

Amanda Stanford left the meeting

4.10 Clinical Audit Annual Report

Richard Dickinson presented the report and highlighted the differences in ways of working across both Trusts, this was particularly the case for CQUINs and CAS alerts.

The CIC agreed reasonable assurance for this item.

5. ITEMS FOR INFORMATION

5.1 EQIA Policy and Terms of Reference

Kate Wood presented the new Group policy and Terms of Reference relating to the EQIA process. Kate advised that this had not been tested yet but was being presented for information.

Rob Chidlow advised that the policy would be tested in relation to the Quality Governance £350k cost improvement programme.

6. ANY OTHER URGENT BUSINESS

There was no other urgent business discussed.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

The CIC referred future recruitment and funding issues relating to the Domestic Abuse Co-ordinator to the Workforce, Education and Culture CIC

7.2 Matters to be escalated to the Trust Boards including any proposed changes to the BAFs

There were no changes proposed to the BAF risk ratings at this meeting but there would be a review of the quality risks to be presented to the October 2024 meeting.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Quality and Safety CiC meeting:

Thursday 29 August 2024, 09.00 – 12.30 in the Boardroom, Hull Royal Infirmary

Cumulative Record of Attendance 2024

Core Members									
Sue Liburd	SL	Non-Executive Director NLAG							
David Sulch	DS	Non-Executive Director HUTH							
Ashok Pathak	AP	Associate Non-Executive Director HUTH							
Kate Truscott	KT	Non-Executive Director NLAG							
Tony Curry	TC	Non-Executive Director HUTH							
Kate Wood	KW	Group Chief Medical Officer							
Shaun Stacey	SS	Group Chief Delivery Officer							
Paul Bytheway	PB	Interim Group Chief Officer							
Amanda Stanford	AS	Group Chief Nurse Officer							

Attended	Apologies/Deputy sent	DNA

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)197

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	10 October 2024
Director Lead	Simon Parkes & Jane Hawkard – Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Simon Parkes / Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Minutes – July 2024 & NLAG Audit, Risk and Governance Committee – August 2024 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 25 July 2024, approved at the ARG CiC meeting on 1 October 2024. Minutes of the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Audit, Risk and Governance Committee meeting held on 6 August 2024, approved at the ARG CiC meeting on 1 October 2024. This NLAG only meeting was for the audited 2023/24 annual accounts and reports.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 25 July 2024. NLAG ARG Committee agenda papers – 6 August 2024
Prior Approval Process	ARG CiC meeting – 1 October 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:

AUDIT, RISK AND GOVERNANCE COMMITTEES-IN-COMMON (ARG CIC)

Minutes of the meeting held on Thursday 25 July 2024 at 9am to 12.30pm via MS Teams

For the purpose of transacting the business set out below:

Present:
Core members:

Simon Parkes	Chair of ARG CiC (NLAG) / Non-Executive Director
Jane Hawkard	Chair of ARG CiC (HUTH) / Non-Executive Director
Sue Liburd	Non-Executive Director (NLAG)
Tony Curry	Non-Executive Director (HUTH)
Linda Jackson	Trust Vice Chair / Non-Executive Director (NLAG)

In Attendance:

Lee Bond	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Sally Stevenson	Assistant DoF – Compliance & Counter Fraud - Group
Nicki Foley	Local Counter Fraud Specialist – Group
Rebecca Thompson	Deputy Director of Assurance - HUTH
Ellie Horsley	Audit Manager, Forvis Mazars – External Audit – HUTH (to item 17)
Asam Hussain	Head of Internal Audit (RSM) – HUTH (to item 25)
Robert Knowles	Assistant Manager (RSM) – HUTH (to item 25)
Helen Higgs	Managing Director, Audit Yorkshire – NLAG (from item 10)
Chris Boyne	Director, Audit Yorkshire – NLAG (from item 10)
Mark Rowntree	Senior Internal Auditor, Audit Yorkshire – NLAG (from item 10 - observer)
Jason McCallion	Associate Director, SumerNI, External Audit – NLAG (from item 10)
Robert Chidlow	Group Interim Director of Quality Governance (item 17.2 – 17.5)
Paul Bytheway	Group Chief Delivery Officer (item 17.6)
Matt Overton	Group Operations Director EPRR (item 17.6)
Sue Meakin	Group Data Protection Officer and Lead for Information Governance (item 17.7)
Edd James	Director of Procurement (item 17.8)
Steve Mattern	Group Director of IT Performance & Operations (item 21.1)
Karen Green	Governor Observer – NLAG (from item 10)

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

The meeting was recorded, and the recording will be deleted once the draft minutes are approved as correct.

Part One – HUTH Business Items – All NED members plus HUTH only attendees in attendance

1. Welcome and apologies for absence

Apologies were received for Gill Ponder Non-Executive Director, Kate Truscott, Non-Executive Director, James Collins (Forvis Mazars), Louise Stables (Forvis Mazars), Brian Clerkin (SumerNI) and Andy Haywood, Group Chief Digital Officer (item 21.1).

It was noted that Linda Jackson and Sue Liburd were in attendance to ensure the meeting was quorate.

2. Declarations of Interest

Jane Hawkard asked for any declarations of interest and none were made.

3. Minutes of the Previous HUTH ARG Committee Meeting on 21 June 2024

The minutes were approved as a true and accurate record of the meeting.

4. External Audit (Forvis Mazars)

4.1 HUTH Auditors Annual Report 2023/24

Ellie Horsley took the paper as read but drew out the key points advising that it covered the work for the year ended 31 March 2024 and confirmed that an unqualified audit opinion had been given on the Trusts financial statements. Their work on the Trust's value for money (VfM) arrangements was complete and summarised within the report and, as previously communicated to the Committee in the Audit Completion Report, there was one significant weakness in arrangements relating to the Care Quality Commission (CQC) report and a recommendation in relation to the achievement of the 2024/25 efficiency target. Ellie Horsley also advised that, in line with National Audit Office (NAO) requirements, they had reported on 26 June 2024 that the Trust consolidation schedules were consistent with the Trusts audited financial statements. Audit fees were also detailed within the report and had been agreed with management.

Jane Hawkard referred to the stock adjustment extrapolation figure and Ellie Horsley explained how this was calculated.

David Sharif referred to page 6 of the report and the narrative in the table around the Annual Governance Statement (AGS) asked if the External Auditors could amplify that all appropriate arrangements were in place and that policies had been followed. Lee Bond pointed out that the narrative was a positive statement and asked what further information he was looking for. David Sharif responded that he would like to see a more positive expansion of the narrative in terms of the Trust producing a balanced, reasonable AGS and more assurance around that. Ellie Horsley agreed to speak to James Collins about this.

Action: Ellie Horsley

4.2 HUTH External Audit Recommendations Action Plan

Lee Bond presented the report and advised that four recommendations had been made, three relating to inventory and the other to the backing documentation around accruals. The Finance team had been given clear instructions on the latter one (backing documents for accruals) and that this was to be enacted each month end, not just at year-end, and the team are doing far more analytical review of the balance sheet each month anyway because of the financial position. Lee Bond stated that he did not envisage this to be an issue next year.

Lee Bond advised that inventory issue was slightly more difficult as there had been confusion regarding consignment stock but this will be identified more clearly in future as to what and what isn't included in stocktakes going forward i.e. consignment stock would not be. Lee Bond added that he did not see it as a high risk but it was an area where better housekeeping was needed.

Jane Hawkard asked who took responsibility for the stock takes and Lee Bond advised that it should be individual departments but it defaulted to Finance and therefore he was responsible for stock levels in all areas. Lee Bond referred to investment being made in the last few years around an inventory management system in the form of Scan for Safety, and this year wanted to ensure the integrity of that system to get an accurate system generated stock value which could then be simply validated at year end. Given the discussions at the Performance, Estates and Finance (PEF) CiC the previous day it was not top of the agenda however. Stock management and stock prices were confirmed as a Procurement issue, part of Lee Bonds remit.

5. Internal Audit (RSM)

5.1 HUTH Summary of Final IA Reports for 2023/24

Part of this item minuted as a private minute.

Robert Knowles presented the final two reports from the 2023/24 Internal Audit Plan which were the Capital Benefits Realisation Report and the annual Data Security Protection Toolkit (DSPT) Report. The reports were taken as read with a couple of key points highlighted.

The Capital Planning benefits realisation report specifically covered the Castle Hill Day Surgery scheme and the Acute Medical Unit (AMU) at Hull Royal Infirmary. A review of the business cases had taken place to ensure key performance indicators (KPIs) were underpinned by assumptions based on robust and valid data, and that delivery of the schemes was being monitored and the evaluation of the achievement of expected benefits.

Recommendations were in place for both schemes particularly around availability of documentation and delivery timeframes of the KPIs, although it was a historic scheme and acknowledged the issues associated with Covid-19. At the time of the audit there was no evidence of evaluation of the schemes and these had agreed to be done in Q3 of 2024/25. The report had been given reasonable assurance.
Lee Bond advised that the AMU case had fallen short on the revenue side due to the Trust not managing to recruit acute physicians and having to use a

work around, so not surprisingly some of the intended benefits were not delivered.

Jane Hawkard requested that the Capital Planning Benefits Realisation report was received by the Capital and Major Projects CiC.

Action: Sally Stevenson

Jane Hawkard also asked about EQI assessments for all projects and how it would be demonstrated that these had been completed. Lee Bond advised that this was business as usual so should be undertaken with every new project.

5.2 HUTH Annual Internal Audit Report 2023/24 Final

Jane Hawkard asked if there were any particular comments or questions in relation to this, and none were raised. Asam Hussain reiterated it was a positive Head of Internal Audit Opinion (HoIAO) and they had looked at some challenging areas during the year. The draft HoIAO had been seen at an earlier meeting and this was the final version of their Annual Report 2023/24 containing the HoIAO.

The Committees noted the final version of the HUTH Annual Internal Audit Report and HoIAO 2023/24.

6. HUTH Private Agenda Items

There were no private items.

7. Any Other Urgent HUTH Business

There were no urgent items of business raised.

8. Matters for Escalation to the HUTH Trust Board (Public/Private)

Matters to be included in the escalation report included the year end stock issues action plan.

9. Matters to Highlight to other Trust Board CiC

There were no matters highlighted.

Part Two - Joint Business Items – NLAG attendees to join the meeting as necessary

10. Welcome and Apologies for absence for NLAG attendees joining the meeting

There were no further apologies to those given at the start of the meeting.

11. Declarations of Interest for NLAG attendees

Jane Hawkard asked for any declarations of interest from NLAG attendees joining the meeting and none were made.

12. Minutes of the previous ARG CiC Meeting on 25 April 2024

12.1 Public Minutes

The minutes were approved as a true and accurate record of the meeting.

12.2 Private Minutes

The minutes were approved as a true and accurate record of the meeting.

13. Matters Arising

There were no matters arising.

14. Review of ARG CiC Action Tracker

The following updates were given in relation to items on the action tracker:

- Lee Bond advised that Finance team consultation had been ongoing since March 2024 and was due to be completed in the next few weeks. This would give clear lines of accountability between the Finance Business Partners and the new Care Groups. Lee Bond also stated that there was a plan to revisit the HFMA checklist in the Autumn, but this might be superseded due to intervention from the national team depending on future period financial results which would focus on grip and control.

- Asam Hussain confirmed the CQC Action Plan recommendations had been completed and signed off on the tracker. Action closed.

- Simon Parkes confirmed he had written to Andy Haywood recently regarding Lorenzo and the subject access request issues asking when this would be resolved. Contained within DSPT paper. Action closed.

- Simon Parkes had also written to Dr Kate Wood and Shaun Stacey regarding out of date documents that had been flagged by the Document Control team. He had been advised that there was no risk to patient safety and work was ongoing to bring them up to date. Action closed. Will review when next routine report received by the ARG CiC.

- Adjustments to the ARG CiC Terms of Reference following review of the HFMA NHS Audit Committee Handbook in April 2024 had been undertaken, but further amendments made by David Sharif and on the agenda for discussion. Action closed.

- High level risk management process – agenda item at the meeting. Action closed.

All actions were confirmed as closed. David Sharif added that the Group Governance document action was closed but wanted to confirm that the governance structure wiring diagram was forming part of the Risk Management Strategy work which was a huge piece of work being undertaken by himself, Rob Chidlow and Amanda Stanford. This did not change the closed status of the action however.

15. Internal Audit – Group (Audit Yorkshire and RSM)

15.1 Group Internal Audit Progress Report 24/25 YTD

Asam Hussain reported that the Group Internal Audit progress report included one finalised report which was the Fit and Proper Person Framework and one report in draft which related to Access Management. Six of the seven actions on the Fit and Proper Person Framework report were now complete and the final action would be completed by the date of the next return. The report highlighted when the rest of the planned audit reports would be shared with the ARG CiC.

Jane Hawkard commented that it was good to see a joint report. Chris Boyne added that the two audit teams were working well together and had a good relationship. Simon Parkes acknowledged the work undertaken by the two Internal Audit teams to work together this year.

15.2 Group IA Recommendations Status Report

Asam Hussain presented the new consolidated report and highlighted eight overdue actions for HUTH and 30 overdue actions for NLAG. In terms of the first joint report issued this year six of the seven actions had been implemented and one is not yet due.

Lee Bond informed the ARG CiC that the Group Cabinet Risk and Assurance Committee (GRAC), chaired by the CEO and attended by Stuart Hall from the Non-Executives, had reviewed the outstanding actions and the Executives had been given actions to review their areas with a view to closing actions down before the next meeting. There was therefore an expectation that the position would be markedly improved by the time of the next GRAC meeting.

Lee Bond asked if there were any delays with the auditors updating actions and Chris Boyne advised that he was not aware of any delays in this regard. Chris Boyne commented that it was unusual for NLAG historically to have a high level of outstanding recommendations, but was pleased to hear about the increased focus from the Executive team.

Jane Hawkard asked if herself and Simon Parkes could be supplied with details of overdue recommendations at the time of the next GRAC meeting report, rather than wait until the October 2024 ARG CiC meeting.

Action: Sally Stevenson

Counter Fraud – Group

16.

16.1 Group LCFS Progress Report

Nicki Foley took the paper as read but highlighted a couple of items, advising that a further £21k had been recovered from the National Fraud Initiative (NFI) at HUTH. Nicki Foley also advised that she had attempted to reduce the size of the progress report and had managed to do so for quite a few of the standing items in the report however some of the topics coming to the Committees at this meeting had warranted more detail (staff fraud awareness survey results and counter fraud functional return), so the report didn't actually appear to be any smaller.

Sue Liburd referred to the staff fraud awareness survey results and asked about the 42% of staff that did not use the approved channel to report fraud concerns and asked whether this was staff not reporting or just reporting via non-approved channels. Nicki Foley advised that approved channels are to herself, the Group Chief Financial Officer, the NHS Counter Fraud Authority, etc. however many staff will still report through their line managers directly and it is then up to the manager to pass it on to Nicki Foley. It is possible that this may not always happen, but the good news was that staff are reporting fraud.

Jane Hawkard queried information about the fraud risk assessment (FRA) component three amber rating and the ongoing development of the FRA with

the HUTH Risk Manager and asked David Sharif if he was aware of this. He confirmed that he was. Nicki Foley explained that the ongoing exercise to complete the FRA had stalled due to absence of the Risk Manager at HUTH.

16.2 Group Annual LCFS Report 2023/24

Nicki Foley advised that the Group LCFS Annual Report 2023/24 was a summary from all the quarterly reports that had been received by the ARG Committee's during 2023/24, and included a couple of new year end charts showing overall number of referrals, etc.

Lee Bond stated that Nicki Foley worked really hard in her LCFS role and he worries sometimes that the counter fraud service is taken for granted and the true value and benefit of it is not realised, in terms of the unquantifiable benefit of having the LCFS in place and serving as a deterrent effect.

Jane Hawkard stated it was a prevention strategy and if we have no fraud it's a really good thing, adding only a small minority of staff commit fraud and that most people do the right thing. Jane Hawkard thanked Nicki Foley for her continued hard work and good reports.

Ellie Horsley left the meeting. Rob Chidlow joined the meeting.

Management Reports for Assurance

17.

17.1 Annual Review of Adequacy and Effectiveness of the system for devising and monitoring the BAF

David Sharif presented the report and advised that the report was in two parts reflecting the Group development over 2023/24 and the subsequent impact on the risk reporting into the Board Assurance Framework (BAF) as part of the harmonisation process that began in December 2023 / January 2024 with the formation of the Group CiCs.

The BAF design had been changed midway through 2023/24 and David Sharif stated he was conscious that in April 2024 the CiC raised concerns regarding lack of oversight of the risk registers. Work was still in progress to harmonise the BAF and would continue up to at least September / October 2024. The report contained an assessment that the BAFs have been presented to CiCs during the year, the GRAC continues its work to oversee the BAF and wider risk management issues. The content of the BAF contains key controls and assurances and to a degree the action plans and areas of concern, and a discussion was held about risk scoring at the PEF CiC the previous day. David Sharif had some frustration around the strategy refresh and its impact on the BAF and also around two different systems feeding the risk registers. A number of manual processes and assumptions were still in place and a new Group Risk Register is imminent this year, but will ultimately lead to some disruption of the process again.

Linda Jackson asked if all the risks rated 15 and above were now captured in the BAF and David Sharif replied that he was 99.9% confident around the completeness of high risk reporting through the BAF through to each CiC and to the Board, but could not give such high assurance of mapping of all risks through to the appropriate CiC. He advised it was broadly about right but that

further work was required to make sure those risks were sat within the right CiCs.

Linda Jackson queried the intention to get one system across both Trusts within the Group. David Sharif confirmed the plan was to have one system in place. Linda Jackson queried the timescales for a new solution given where we are in the year and said that any change must be mapped properly to ensure it was implemented effectively. Rob Chidlow advised that the tender process was underway with risk management system providers, as the Group plan was to have one supplier rather than two. He added that there were contingencies in place with the Procurement team to extend the current contracts if required, and he was taking their advice accordingly.

Jane Hawkard asked for further clarification on the 64 risks and asked if they were mapped to the BAF's seen by the CiCs. In response, David Sharif stated the answer was a bit of a mix with some risks covered by other risks reported through the BAF. David Sharif also clarified that in terms of his 99.9% confidence level he was referring to quality governance risks (which covered a huge amount of the Trust's risk profile) but for other areas, e.g. Estates and Facilities, he was yet to dovetail those systems into the same process and therefore could not provide the same level of confidence as yet. Those conversations are ongoing.

Jane Hawkard stated she did not feel assured that they were where they needed to be yet in terms of mapping risks to the BAF. David Sharif stated that the BAF was a top down view of risk, and assists with reviewing high level scoring risks. However further work could be done to strengthen the bottom up approach.

Simon Parkes advised that it was key that the high level risks lined up with the strategic risks and that the CiCs were assured that risks were being managed appropriately. He added that it was not for the ARG CiC to review all the high level risks it was their responsibility to be confident that things joined up, to be cognisant of the organisations major risks on the BAF and be assured that they were being managed appropriately.

17.2 Annual Review of Adequacy and Effectiveness of the system for the management and monitoring of Risk

Rob Chidlow took the paper as read but gave an outline to the structure of the paper, stating that he wished to stress that essentially both Trusts had delivered their risk management processes and policies as they were designed in the legacy organisations up to the end of March 2024.

However the starting points were quite different. He advised that the majority of the high risks had now been reviewed by the Care Groups. NLAG had started their current risk journey and strategy in 2019 and midway through had some support from NHSE/I and HUTH had been subjected to a risk maturity review in 2021 which had highlighted that the Trust was developing in its risk maturity. So HUTH were at an earlier stage of development than NLAG. Rob Chidlow discussed the scoring of risks and the view that some of the scoring was a little high.

Check and challenge was underway with the Care Groups and a monthly Risk Management Group was being established (re-established at NLAG). The plan was to allow risk managers to manage their risks appropriately rather than just closing risks, and these meetings would be Executive lead with himself, David Sharif, Amanda Stanford and Paul Bytheway in attendance.

Linda Jackson thanked Rob Chidlow for the excellent update and asked about the Group Quality Governance map of meetings and when they would be commencing. Rob Chidlow advised that some of the meetings were already in place and others would be starting in September 2024.

The ARG CiC agreed they could take assurance from this item and the extensive amount of work being done. Jane Hawkard thanked Rob Chidlow for the update.

17.3 Annual Review of Risk Management Strategy – Group Update
David Sharif provided a verbal update in respect of this item and advised that the Risk Management Strategy was in draft and was waiting for the risk appetite section to be added following the work conducted as a Board.

Jane Hawkard referred to references within the NHS Audit Committee Handbook about system wide risks and collaborative management of these, and suggested these should be included in the Group Risk Management Strategy document. David Sharif advised they would reflect on what the Risk Management Strategy says around the wider issue of the management of system risks.

Action: David Sharif

17.4 Review of Legal Fees and External Consultancy Fees – Group
The paper was taken as read, however David Sharif highlighted that court of protection cases had been taken back in house and they would also be doing so for inquest work given the rate of improvement that had been seen around that. David Sharif also placed on record his thanks to the Finance team for their support in producing the paper.

Lee Bond added that there had been a loss of key personnel in the past in HUTH involved in this and as a result had relied more heavily on external support but now more work is being managed in house.

Jane Hawkard thanked David Sharif for the report.

Matt Overton joined the meeting.
17.5 Annual Claims Report 2023/24 – Group
Rob Chidlow took the paper as read, and acknowledged the work of Gerard Curren, Group Head of Legal Services in preparing the data within report.

Rob Chidlow advised that it had been through the Quality CiC in May 2024 and highlighted that there were a large number of outstanding inquests that were being managed, explaining some of the issues associated with this. The CNST premium had broadly increased by 13% (circa £3m) for HUTH in 2024/25, with only a negligible increase at NLAG. The themes coming out of the completed cases were being triangulated in the background and learning

was being shared quickly to improve points of care. Increases in nursing headcount was also highlighted which should contribute to improvements.

The Group were now using Capsticks to service all falls inquests and close contact was kept with the Coroner particularly in notifying that the eleven falls per 1,000 bed days in 2022 had now reduced to around six falls per 1,000 bed days. The HUTH Coroner was now satisfied with this progress and therefore some of the inquest work would be stepped down.

Jane Hawkard stated it was a very good report and was assured by the update. Jane Hawkard asked if it would be useful to include peer data in the report for further benchmarking and Rob Chidlow confirmed that this could be done.

Action: Rob Chidlow

The ARG CiC agreed assurance had been received for this item as processes and plans were in place.

Rob Chidlow left the meeting. Paul Bytheway joined the meeting.

17.6 Annual EPRR and Business Continuity Report inc. Medical Testing Oversight – Group

The paper was taken as read and Matt Overton highlighted some key items included in the 2023/24 Annual Report, namely the Group approach to EPRR and training and exercises, the number of Emergency Preparedness, Resilience and Response (EPRR) incidents, a recap on the core standards and the top Local Health Resilience Partnership (LHRP) risks and also reassurance regarding the medical oxygen delivery systems.

Jane Hawkard asked about the drop in compliance to 18% at HUTH. Matt Overton advised the ARG CiC that it was due to NHS England changing the annual EPRR core standards assurance process last year. The North of England took a different approach last year to the rest of the country which involved increased requirements and as a result there was significant dip in compliance across the region, with HUTH and NLAG dropping from 91% down to 18% (HUTH) and 40% (NLAG). In the December 2023 report NHSE advised that this did not indicate a significant change in the organisations ability to respond to incidents.

Matt Overton advised the Committees that they were moving back to being in line with the rest of the country for this years core standards assessment, the submission of which would be seen by the Committees in the coming months and would show a very different percentage to last years.

Paul Bytheway asked Matt Overton to clarify the report going to the August 2024 Trust Board and Matt Overton stated that it was being moved from August to December 2024 Trust Board so that it related to this years core standards submission, which was due for national submission in December 2024.

Tony Curry asked how the Trusts got full coverage of training and exercises and how it was decided when and how these would be carried out. Matt Overton advised that there were two aspects to it. There is a minimum

training schedule on both live and table top exercises, and they also look at top LHRP risks and take a multi-agency approach to it. So not every Trust does an evacuation exercise in the same year, they would be staggered but all Trusts would learn lessons from the Trust undertaking the live exercise. The requirement for a live test is one every three years and is rotated around the Trusts. In May 2024 a live Chemical, Biological, Radiological and Nuclear (CBRN) exercise was conducted at HRI, a future exercise is planned at SGH and followed by another exercise at DPoWH. Tony Curry clarified that Matt Overton was confirming the required number of exercises had been conducted and Matt Overton confirmed this was correct, in fact had exceeded it.

The Committees discussed their concerns around the 2023/24 EPRR core standard compliance percentages and further assurance was requested at its meeting on 1 October 2024 to provide the ARG CiC with assurance that the action plans, developed to address the areas of non-compliance at each Trust and reduce any potential risks, were progressing and to ensure improvement in meeting the standards in 2024/25.

Jane Hawkard and Sue Liburd questioned the existence of a workplan and who owned it, as the Committees had not seen it.

Paul Bytheway agreed with the Committees comments and suggested bringing an overview of the work done and the current position to provide assurance that it had moved on. Jane Hawkard accepted this suggestion with a view to seeing what the areas were which got us the 18% and 40% compliance rates.

Action: Paul Bytheway / Matt Overton

Matt Overton confirmed that this year's core standards initial submission would be in September 2024 with the final submission going to the Trust Board in December 2024.

Paul Bytheway and Matt Overton left the meeting and the ARG CiC took a short break.

The ARG CiC meeting resumed and the agenda was taken out of order to await the arrival of a scheduled attendee.

19.1 NLAG ARG Committee Annual Report to Trust Board 20234/24

Simon Parkes advised he would take the paper as read, thanked Sally Stevenson for preparing the report and asked for any questions or comments, of which there were none.
The NLAG ARG Committee approved it being submitted to the Boards-in-Common meeting and the NLAG Council of Governors for information and assurance.

Action: Sally Stevenson

Sue Meakin joined the meeting and the ARC CiC returned to the sequence of the agenda.

17.7 Group IG Highlight Report inc. Annual IG Toolkit Returns

Sue Meakin advised that the report included the submission of the DSP Toolkit and the fact that a brand new toolkit would be launched in September 2024 which would be all around the cyber security assurance framework. Incidents were contained within the report and were currently being reported on two separate reporting systems and the ICO was providing feedback on how the Group was handling issues, and feedback received was that they were satisfied with how the Trusts were handling their investigations. Lots of staff communications are planned imminently around inappropriate access to systems. Sue Meakin stated that there were lots of things going on but there is a big focus on the move to the new Toolkit given its cyber security focus.

Simon Parkes asked for Sue Meakin's thoughts on progress with the DSPT action plans. Sue Meakin responded to advise that NLAG had met the standards of the current toolkit and the Information Governance (IG) team was working with Education and Development to develop a robust Group training module following a training needs analysis. Face to face corporate inductions had recently been introduced again and Sue Meakin stated this was positive as IG had a slot on this training for new starters which added extra robustness to the training by allowing them to really get the message across about key issues coming out of incidents.

Edd James arrived in the meeting.

Sue Meakin also advised that they were working with Edd James around the Procurement Hub, because there are a number of actions that link to procurement risks within the new DSPT.

Sue Meakin updated on the DSPT improvement plans and also advised that a new reporting structure was under review and there would be a new Group IG Committee from October 2024, as well as a dedicated DSPT working group which the Trusts have not had in recent years. Sue Meakin advised that DSPT action plans would be reviewed and monitored closely at that group and then fed up to the IG Committee.

Simon Parkes commented that progress was being made on Subject Access Requests (SARs) and Sue Meakin confirmed this to be the case.

Linda Jackson asked why IG incidents had doubled in number compared to the same quarter last year with certain areas standing out and asked if some context could be given as to this. Sue Meakin advised that staff were reporting more, and records management issues were being flagged given the big push on this and will continue to see a focus on over the next six months for both clinical and corporate records management.
Sue Liburd asked if there were any particular insights or trends Sue Meakin could share with the Committee in relation to inappropriate access to systems and whether on the increase. Sue Meakin updated the Committee on this and advised that staff seemed more comfortable reporting such issues, including them coming through the Freedom to Speak Up Guardian, and gave some examples of issues reported. Sue Meakin also reminded the Committee that it was a criminal offence for staff to look at records if they had no valid reason to do so in line with their job role and if an organisation had put in place all measures to protect that information, and the offence would be against the individual member of staff. Future Group wide communications on this

subject will consider using the Information Commissioners Office (ICO) wording on this.

Jane Hawkard thanked Sue Meakin for a good report and asked if the DSPT action plan could be brought back to the next meeting in October 2024 so that the Committee could see that progress is still happening.

Action: Sue Meakin

Sue Meakin left the meeting.

17.8 Position Statement on Expired Contracts

Edd James advised that he had been asked to prepare a paper on the position with expired contracts, explaining that this was the result of contracting work being placed on hold during the Covid-19 pandemic in order to focus on getting clinical supplies into the Trust, as other Trusts also did.

Procurement now has a single contract repository called Atamis which was issued by the national team, and all contracts are now in one place and gives visibility of contracts when coming up for renewal, their values, etc. in order to build plans for how to address the issue. Edd James added that they were looking at a couple of solutions to get back on top of expired contracts without additional cost to the Trust, and this involved external support to increase capacity. In the meantime expired contracts were being prioritised due to financial and clinical risk and some contracts had been extended past their original term where appropriate to do so.

As at July 2024, 18% of all Group contracts held had expired, and 15% of renewals were in progress of which some would have also expired. The Group has a total of 1,568 contracts.

Jane Hawkard observed there was no timetable included in the paper and Edd James advised there was a lot of data quality work to be completed to understand the baseline position, and his teams were working on this at the moment. Any timetable would also depend on getting approval for the external support to allow the work to be accelerated.

Linda Jackson commented on the size of the task and added that with an 18% vacancy rate in the team at present it was important that the ARG CiC supported the use of additional external support to assist in making significant progress. It was noted that maintenance contracts were often separate to the capital equipment contract and that combining the two would result in a significant reduction in the number of contracts to maintain. Jane Hawkard reiterated her view that there should be a timetable to show how the organisations would get back on an even keel. Jane Hawkard also asked if there was any way the appropriate Committee could approve contract extensions in bulk to speed up the process.

Lee Bond stated that he had asked Edd James to bring the paper to the Committee to provide the context to the issue, but importantly for people to understand that there was no risk to delayed contract renewals. He added that the team were working diligently to reduce the number of expired contracts but suggested that the timescale would be years to get things back

on track. In terms of risk appetite, Lee Bond stated this was not the biggest risk to the Trust.

Simon Parkes acknowledged that it may take a while to do this, but felt there was a need for a plan and timetable to show how the organisations would achieve up to date contracts and then keep them up to date. Lee Bond responded to say the team would continue to work on them and the position was improving but it had been a problem since Covid and he had to consider procurement priorities, so an accurate timescale would be difficult but could bring back an annual update to the Committee.

Asam Hussain referred to the potential for added challenges from the new Procurement Act coming in later in the year and Edd James concurred that the Procurement Act changes, expected from October 2024, would be even more challenging and would create more work. He added that any contract over £20m would need Cabinet Office approval, which would add another level of delay and require processes to commence even earlier internally to factor in external approval requirements.

Following discussion, the Committee asked for additional assurance on how the backlog of expired contracts would be addressed and by when, and that this should be brought back to the January 2025 meeting. The Committees also acknowledged the level of work already undertaken by the Procurement team as part of the recovery plan. Jane Hawkard suggested any contracts that could be agreed in bulk, the appropriate CiC would be happy to review.

18. **Action:** Edd James

Policies for Review/Approval

18.1 Draft Group Standing Financial Instructions
18.2 Draft Group Scheme of Delegation and Powers Reserved for the Boards in Common

These two agenda items were taken together.
Jane Hawkard thanked Lee Bond for sending out the documents early for comments, it had been useful. Lee Bond thanked Sally Stevenson for the work undertaken to initially review and update the existing Standing Financial Instructions (SFI's), and the Scheme of Delegation (SoD) at 18.2, and then combine the two organisations documents into one Group set. Lee Bond added that there were some small differences to reflect the existence of the Council of Governors at NLAG as a Foundation Trust for example, but otherwise they were essentially the same governance framework. He was therefore proposing that these Group documents be adopted by the Committee.

Lee Bond advised that he had taken a lot of input from Edd James to ensure they reflected up to date procurement practice, etc. The Scheme of Delegation had been updated to reflect the new Care Groups, although this was presenting some difficulties. The documents had been circulated to various people for comment and any comments received had been reflected in the draft presented to the Committee for approval.

The Committees-in-Common approved both the draft Group Standing Financial Instructions and the draft Group Scheme of Delegation and Powers Reserved for the Trust Board prior to submission to the August 2024 Trust Boards-in-Common meeting for final ratification.

Action: Sally Stevenson

19. The Committees thanked Sally Stevenson for her work on producing these draft governance documents.

ARG CiC Governance Items

19.2 NLAG ARG CiC Terms of Reference (ToR) Changes
19.3 HUTH ARG CiC Terms of Reference (ToR) Changes
These two items were taken together.

The proposed amendments to the NLAG ARG CiC ToR and HUTH ARG CiC ToR were approved by the ARG CiC. It was also agreed that the BAF would be received at each meeting of the ARG CiC, apart from the audited annual accounts meeting. The ToR would be submitted to the August 2024 Trust Boards-in-Common for ratification.

Action: Sally Stevenson

20. **19.4 Schedule of ARG CiC Meetings 2025**
To be confirmed and circulated in due course.

Highlight Reports and Action Logs from Board Sub-Committees-in-Common
20.1 Performance, Estates and Finance CiC
20.2 Capital and Major Projects CiC
20.3 Quality and Safety CiC
20.4 Workforce, Education and Culture CiC
20.5 Health Tree Foundation Committee NLAG

21. The above highlight reports and action logs were received for information. There were no issues raised.

Private Agenda Items

22. **21.1 Annual Review of Group Cyber Security Arrangements – Confidential**
This item was minuted under a private agenda item.

23. **Any Other Urgent Joint Business**
There were no urgent items of joint business discussed.

Matters for Escalation to the Trust Boards-in-Common
The following joint items were agreed to be highlighted to the Trust Boards-in-Common:

- Annual EPRR Report 2023/24 compliance rates.
- DSPT Action Plan.
- Position statement on expired contracts.
- High level risks aligned to the BAF.

- NLAG AR Committee Annual Report to the Trust Board 2023/24.
- Draft Group SFIs and SoD.
- NLAG and HUTH ARG CiC Membership and ToR changes.

24.

25. Matters to Highlight to other Trust Board CiC
There were no matters to highlight to other Trust Board CiCs.

Review of the Meeting
The review of the meeting was positive as a very large agenda had been managed appropriately with good discussion. Linda Jackson highlighted a point of accuracy regarding the use of the term Group Trust Board, when it should be Trust Boards-in-Common.

26. Part Three – NLAG Business Items – HUTH attendees left the meeting. All NED members and NLAG only attendees remained.

External Audit (Sumer NI formerly ASM)

26.1 Progress Update
Jason McCallion advised that ASM had been rebranded to SumerNI as part of a wider group collaboration. He added that there would be no impact on the day to day working with NLAG.

27. Jason McCallion added that the External Audit work was now complete and the Trust would receive a positive audit opinion without any issues raised at the scheduled NLAG ARG Committee meeting on 6 August 2024.

Internal Audit

27.1 NLAG Summary of Final Reports for 2023/24
The report was taken as read with Chris Boyne advising that apart from a number of reports awaiting final management sign off, the annual audit plan 2023/24 was now complete and he was not expecting any of the reviews draft opinions to change at this stage.

David Sharif advised that all audit scopes would be reviewed by all the Executives going forward at the monthly Group Cabinet Risk and Assurance (GRAC) meetings. This would ensure they were all sighted on forthcoming audits and the associated scope of work was agreed and clear. Chris Boyne agreed that there was a need to ensure that audit scopes were very clear for each audit to ensure that it delivered its intended aim.

The ARG CiC noted the report.

27.2 Draft NLAG Head of Internal Audit Opinion 2023/24
Helen Higgs advised that this provided their overall Head of Internal Audit Opinion (HoIAO) on the programme of internal audit work throughout the year. The HoIAO gave a 'significant' audit opinion, but Helen Higgs drew the Committees attention to the high level of overdue recommendations and the need to ensure these were actioned.

Simon Parkes stated he was not surprised at the overall assurance given, and commented that it was not the normal level of overdue recommendations

28. for NLAG but assurance had been given by the CEO that these were being monitored closely at the GRAC meetings to ensure they were dealt with.

29. NLAG Private Agenda Items
There were no private items discussed.

30. Any Other Urgent NLAG Business
There were no urgent items of business.

31. Matters for Escalation to the Trust Boards-in-Common
There were no further actions to escalate.

32. Matters to Highlight to other Trust Board CiC
There were no further actions to highlight.

33. ARG CiC Workplan
The workplan was presented for information.

Review of the Overall Meeting
Simon Parkes advised that there were fewer items in the separate NLAG and HUTH sections and more items falling into the Group section of the ARG CiC meeting and this was welcomed. He thanked the attendees for their hard work in achieving this.

At this point the Internal and External Auditors left the meeting to allow for a
34. *private discussion around the future provision of the Internal Audit service at both Trusts.*

Internal Audit Contract – NLAG and HUTH Future Provision

34.1 Internal Audit Contracts NLAG and HUTH
Lee Bond outlined the current position with both contracts and a view that a single Internal Audit provider for the Group should be sought for 2025/26. RSM and Audit Yorkshire had worked together this year to provide a Group plan as far as possible.

Lee Bond advised that the ARG CiC would have the opportunity to review the tender specification before it was issued in the Autumn.

Action: Sally Stevenson

An evaluation panel was also needed and following discussion it was agreed it would include the two ARG CiC Chairs, the Group CFO and the Group Director of Assurance. Jane Hawkard suggested that Helen Wright may also be interested in being on the evaluation panel. *Post meeting note: Helen Wright was contacted and agreed to sit on the panel.*

35. Date of the next meeting:
The next meeting of the NLAG Audit, Risk and Governance Committee would be held on Tuesday 6 August 2024 at 9am to 10.30am via MS Teams only (NLAG Audited Annual Accounts to be presented - NLAG NEDs / Attendees only).

The next full meeting of the Audit, Risk and Governance Committees-in – Common would be held on Tuesday 1 October 2024 at 9am to 12.30pm in the Boardroom, HRI and via MS Teams.

NLAG AUDIT, RISK AND GOVERNANCE COMMITTEE (ARGC)

Minutes of the meeting held on Tuesday 6 August 2024 at 9am to 10.30am via MS Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

Simon Parkes	Chair of ARGC (NLAG) / Non-Executive Director
Linda Jackson	Trust Vice Chair (NLAG) / Non-Executive Director

In Attendance:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Lee Bond	Group Chief Financial Officer
Nicola Parker	Assistant DoF – Planning and Control – Group
Sally Stevenson	Assistant DoF – Compliance and Counter Fraud - Group
Alison Hurley	Deputy Director of Assurance (NLAG)
Adrian Beddow	Group Deputy Director of Communications
Brian Clerkin	Managing Director, Sumer NI – External Audit
Helen Higgs	Managing Director, Audit Yorkshire – Internal Audit
Danielle Hodson	Asst. Internal Audit Manager, Audit Yorkshire – Internal Audit
Rebecca Thompson	Deputy Director of Assurance (Minutes)

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

1. **Welcome and Apologies for Absence**
   Simon Parkes welcomed those present to the meeting. Apologies for absence were received from Gill Ponder, Non-Executive Director, Kate Truscott, Non-Executive Director and David Sharif, Group Director of Assurance. Alison Hurley, Deputy Director of Assurance (NLAG) was in attendance to deputise for David Sharif.

2. **Declarations of Interest**
   Simon Parkes asked for any declarations of interest in relation to any agenda items and none were made.

3. **Minutes of the Previous ARG CiC meeting on 25 July 2024 / Matters Arising / Action Tracker**
   Deferred to the next full meeting of the Audit, Risk and Governance Committees-in-Common (ARG CiC) on 1 October 2024.

4. Public Disclosure Documents

4.1 NLAG Audited Annual Accounts 2023/24

Simon Parkes introduced the item and advised that the accounts had been through the external audit process since the draft accounts had been received at the April 2024 ARG CiC meeting. A list detailing a limited number of changes made since the draft accounts were seen by the Committee, had been provided with the paper which Nicola Parker ran through as follows:

- Page 10 – narrative adjustment in relation to accounting policies note 5 in relation to revenue from NHS contracts to now read… 'Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts, with CQUIN for both elective and non-elective considered to be variable'.
- Page 20 - Community services income for 2022/23, £22,389k moved from the API fixed element to Community Services API contracts.
- Page 20 - Additional narrative regarding the reporting of high cost drugs income had been included – only NHSE income for high cost drugs is shown separately.
- Page 25 - Auditors liability is limited to 125% of the annual fee.

Simon Parkes thanked Nicola Parker for outlining the limited number of changes on the audited accounts and invited questions. There were no questions or comments.

Simon Parkes advised that before asking the Committee to recommend adoption of the Trust's audited annual accounts for 2023/24 to the Trust Board, he would take the other items on the agenda and then return to this decision.

4.2 NLAG Audit Completion Report / Management Letter of Representation, 2023/24

Brian Clerkin presented the Audit Completion Report which informs the Committee's decision to recommend approval of the annual audited accounts to the NLAG Trust Board. The report included the summarised outcome of the audit work throughout the year and is an internal document only (not public facing).

Brian Clerkin wished to place on record his thanks to the Finance team, in particular Nicola Parker, Paul Marchant and Sally Stevenson for their assistance during the year end audit process. The close out meeting had taken place on 22 July 2024 with the Finance team and Brian Clerkin stated that there were no material issues preventing the signing of the audit opinion, adding that there were no significant audit risks only minor issues and none of these had materialised or impacted on the audit opinion. There were no issues regarding the Trust's Going Concern status.

Brian Clerkin referred to the need to ask the Committee if there were any fraud related matters that they were aware of. Brian Clerkin confirmed figures in the accounts had not changed and there were no unadjusted statements requiring attention.

Brian Clerkin went on to highlight three recommended internal control improvements; firstly relating to IFRS16 leases and the need for continuing to update any lease agreements that are out of date/expired/do not contain sufficient

information. Agreements are in place to reflect assumptions based on invoiced amounts, terms, operational knowledge and need. These reasonable assumptions did not impact on the accounts. It was acknowledged that this was not a unique issue to NLAG. Lee Bond advised that this was an area that the Trust was still getting to grips with the documentation and requirements of, and was a minor housekeeping issue.

Brian Clerkin also highlighted that some of the Remuneration Report disclosures did not agree with the supporting information provided, resulting in some changes to the disclosures in the report. It had been agreed that the Trust would ensure that the Remuneration Report agreed to the source documentation before being released to the external auditors in future, and that a meeting of all internal parties involved in this process would take place. Sean Lyons asked about the issue with the Remuneration Report and Brian Clerkin responded that the supporting information was correct but the report disclosures were not up to date, so there was a gap in the process to ensure all information agreed. Lee Bond advised that due to the complicated nature of the Remuneration Report and the amount of changes in the last year there had been a little slip in attention to detail, but he was content that the information was now correct.

Brian Clerkin also highlighted that from their testing there were a two Service Level Agreements that needed updating.

The External Auditors had agreed actions with management to address these three minor matters.

Brian Clerkin referred to the Management Letter of Representation contained within the report and reminded the Committee that this was a letter from the Trust to the External Auditor and they needed to be comfortable with signing it.

Simon Parkes asked the Committee if they were aware of any issues of fraud that needed to be raised with the External Auditor and there were no issues raised.

Simon Parkes added that he would return to the decision on the Management Letter of Representation once all remaining agenda items had been taken.

4.3 NLAG Audit Opinion and Certificate 2023/24

Brian Clerkin reported a ‘clean audit opinion’ (unqualified audit opinion) with no issues regarding the Trust’s Going Concern status and no issues relating to other information, the Remuneration and staff reports. He advised that the audited Annual Accounts would be signed following approval at the Trust Board meeting on Thursday 8 August 2024.

The Committee noted the Audit Opinion and Certificate 2023/24.

4.4 NLAG Consistency Opinion 2023/24

Brian Clerkin advised that the statement provided confirmation that the consolidation schedules were consistent the audited financial statements on which they had issued an unqualified opinion, and were in line with NHSE Foundation Trust guidance.

The Committee noted the Consistency Opinion 20234/24.

4.5 NLAG Annual Auditor Report 2023/24

Brian Clerkin presented the report and noted the requirements (under the Audit Code) for reporting on the Trusts value for money (VfM) arrangements at the same time as reporting on the truthfulness of the annual accounts. He advised that the Auditors Annual Report was a public facing document which summarised their audit findings. The draft version had been discussed with management and the final version would be issued the following week for publishing by the Trust.

The Trust had appropriate arrangements in place to monitor sustainability, governance, efficiency, financial sustainability, controls to monitor budgets and risk management processes including the Board Assurance Framework.

Brian Clerkin advised that there would be further scrutiny in the coming year relating to the Group structure after it had been in place for a full year, and also cost improvement plan achievements. He added that NLAG had been removed from the financial recovery support programme in May 2023 and this prior year recommendation had now been closed and no new significant weaknesses had been identified.

Brian Clerkin invited any further comments from the Committee for inclusion in the final version of the report. There were no comments or questions raised.

The Committee noted the Annual Auditor Report 2023/24.

4.6 NLAG Annual Governance Statement 2023/24

Alison Hurley presented the Annual Governance Statement (AGS) 2023/24 on behalf of David Sharif, and referred to three areas which had been updated from earlier drafts, namely; section 3.3 relating to learning lessons and patient safety incidents; the mortuary incident had been added; and the conclusion had been updated in relation to finance and performance. Alison Hurley stated that comments from the Auditors had been incorporated.

Lee Bond expressed his concern that the AGS for NLAG was not consistent with the HUTH AGS in relation to significant gaps in controls. He added that the finance and performance issues at HUTH had been captured as risks to the organisation which were being managed and considered that the two Trusts be consistent in their messaging given their Group status. Linda Jackson and Simon Parkes both agreed with Lee Bond regarding the finance and performance issues.

The Committee also discussed the inclusion of the mortuary issue, which was unique to NLAG, as a significant gap in control. Jonathan Lofthouse agreed that the matter needed to be disclosed within the AGS. Simon Parkes suggested that the final decision to align the two AGS statements and keep the mortuary statement as a significant gap in control should be made by the Trust Boards on 8 August 2024.

Action: To be discussed at Trust Boards-in-Common on 8 August 2024.

Brian Clerkin advised that from an auditors perspective he was comfortable either way but that there should be an appropriate section in the AGS highlighting the risks mentioned above.

4.7 NLAG Annual Internal Audit Report and Head of Internal Audit Opinion 2023/24

Danielle Hodson advised that there had been 23 audits carried out in 2023/24, 18 had received 'significant assurance' and 5 'limited assurance'. The limited assurance audit report recommendations would be revisited during 2024/25 and monitored through the Audit, Risk and Governance Committees-in-Common as normal.

The number of overdue audit recommendations remained high at 22 and the Lorenzo and Care Group changes had impacted on them being completed in a timely manner. Jonathan Lofthouse advised that these outstanding recommendations would also continue to be assessed by the Group Cabinet Risk and Assurance Committee, at which he and Stuart Hall, Non-Executive Director were present, and at the Group Executive Team.

Helen Higgs reported that annual Head of Internal Audit Opinion had resulted in the following level of assurance: '*Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently*'.

Simon Parkes thanked the Audit Yorkshire for their work over the last twelve months.

The Committee noted the Annual Internal Audit Report and Head of Internal Audit Opinion 20234/24.

4.8 NLAG Trust Annual Report 2023/24

Adrian Beddow presented the Trust's Annual Report for 2023/24 and advised that two areas had required more detail this year and these were Health Inequalities and the Green Agenda. Adrian Beddow added that, following earlier discussions around the AGS, any changes made to the AGS would need to be reflected in the Annual Report.

Sean Lyons commented that the Annual Report was a good read and presented a huge body of good work and was well written, adding that it shows the huge effort from thousands of people the Trust employs. The Annual Report reflected both the good work going on as well as the challenges faced by the Trust.

Simon Parkes thanked Adrian Beddow for producing the report and commented that there had been much progress during the year and there was a great deal to be proud of.

The Audit, Risk and Governance Committee approved the substantial draft of the Trust's Annual Report 2023/24 subject to any final minor changes.

Following the completion of all scheduled agenda items, Simon Parkes returned to the earlier items deferred for decisions and the following was agreed by the Committee:

- ***The NLAG ARG Committee recommended the adoption of the Trust's audited Annual Accounts for 2023/24, the Annual Governance***

Statement and the Trust's Annual Report to the NLAG Trust Board subject to the approval of the AGS final changes.

- ***The NLAG ARG Committee approved the signing of the Letter of Representation 2023/24 and agreed it would be sent following the Board meeting on 8 August 2024.***

Simon Parkes thanked Nicola Parker for the Annual Accounts, Alison Hurley for her work on the AGS and Adrian Beddow for the Trust's Annual Report. He also thanked both sets of Auditors for their work with the Trust. Simon concluded that it had been a team effort in the production of all the year end documents.

5. Private Agenda Items

There were no private items to note.

6. Any Other Urgent Business

There were no urgent items of business raised.

At this point Simon Parkes thanked Lee Bond, as this was his last Audit, Risk and Governance Committee meeting before leaving the Trust. Simon Parkes thanked Lee Bond for his stewardship, his direct and candid advice and for his leadership of his teams and his support to colleagues over the years, and wished him well in his new role.

7. Matters for Escalation to the NLAG Trust Board (Public/Private)

The following items of business were agreed to be highlighted verbally to the NLAG Trust Board meeting on 8 August 2024:

- Recommendation to adopt the audited Annual Accounts 2023/24 and Management Letter of Representation.
- Endorsement of the Annual Governance Statement 2023/24 subject to further discussion at the Trust Board meeting.
- Endorsement of the NLAG Annual Report 2023/24, subject to any revisions to the AGS.

8. Matters to Highlight to other Trust Board CIC

None.

9. Date of the next meeting:

The next full meeting of the Audit, Risk and Governance Committees-in-Common will be held on Tuesday 1 October 2024 at 9am to 12.30pm in the Boardroom, HRI and via MS Teams.

The meeting ended at 10am.

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)199

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10 October 2024
Director Lead	Amanda Stanford, Group Chief Nurse
Contact Officer / Author	Dr Debbie Wearmouth, ICD/Greta Johnson now retired from Trust
Title of Report	Infection Prevention and Control Annual Report 2023 - 2024
Executive Summary	Included in report
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Not yet circulated for approval – presented at Strategic Infection Reduction Committee in September
Financial Implication(s) (if applicable)	Nil direct Recommendations include supporting a business plan, and potential savings if care improvements can be attained.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ü Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST (HUTHT)

INFECTION PREVENTION AND CONTROL (IPC)

ANNUAL REPORT 2023-24

1 Executive summary

2 Contents

1 EXECUTIVE SUMMARY

The Infection Prevention and Control (IPC) Annual Report reports on infection prevention and control activities within Hull University Teaching Hospitals NHS Trust from April 2023 to March 2024. During 2023-24 the Infection Prevention and Control team (IPCT) have continued to work to re-establish the structures, functions and delivery of infection prevention and control moving out of the pandemic.

Key highlights of the year's achievements include the maintenance of *Clostridioides difficile* infection rates below threshold, a continued year on year reduction in the use of broad spectrum antibiotics and the successful full introduction of the national standards of cleanliness. The IPCT have successfully piloted innovative, in situ IPC simulation training with excellent feedback. A FFP3 mask fit testing service has been established to ensure the Trust is compliant with health and safety legislation and protecting staff.

However, there are a number of areas in which there is significant concern around performance that need to be the focus for improvements. The Trust is a significant outlier for the rates of all gram negative blood stream infections, in particular E coli which is estimated to be contributing to an excess of 60 deaths and over ¾ million pounds in excess costs annually. Mandatory surgical site surveillance of fracture neck of femur repairs, total hip and total knee replacements have shown that the trust is a high outlier for all 3 metrics. Following the CQC findings in 2022-2023 it is disappointing that audits including the fundamental standards, PLACE inspections and IPC enhanced audits have all shown that infection control basics such as hand hygiene and personal protective equipment (PPE) use remain inconsistent, despite a focus on back to basics.

Nationally, new education and training frameworks for infection prevention and control have been published. The IPCT are working with the required learning steering group to move towards compliance with the new recommendations, as improved understanding of the role of infection control in patient safety will help compliance and infection rates. The new Humber Health Partnership brings with it opportunities for joint improvement work in areas where there are common concerns. That said, there is the challenge of re-establishing communications and the working relationships with care groups that are required to bring about change that needs the engagement of all from ward to board.

The recommendations for 2024-25 are focussed on reducing harm to patients from preventable healthcare acquired infections. The board is requested to take note of this report and consider the recommendations.

2.1 INTRODUCTION AND PURPOSE OF THE REPORT

Effective infection prevention & control is fundamental to the delivery of high quality, safe and effective patient care. This remains a significant priority for the Trust with an objective for engagement and ownership of infection prevention & control throughout the organisation at all levels from ward to board.

The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance and Care Quality Committee (CQC) regulations requires that the Board of Directors have a Board-level agreement outlining the Boards' collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks. A requirement of the Act is the production of a Director of Infection Prevention & Control Annual Report.

This annual report provides an overview of the work done with respect to all aspects of IPC within the Trust and in accordance with the Infection Prevention and Control Board Assurance Framework (IPC BAF) during the financial year 2023-24.

2.2 GOVERNANCE ARRANGEMENTS

2.2.1 Team structure

Greta Johnson is the Trust **Director of Infection Prevention and Control (DIPC)** and was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan during 2023-24. Jo Ledger, Acting Chief Nursing Officer, had executive responsibility for infection prevention and control during 2023-24. During 2023-24 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist. The remaining infection control team structure is shown in appendix 1, along with further details of the IPC arrangements including the committee structure diagram.

2.2.2 Infection Prevention, Control and Decontamination Committee Structure

The infection team has a robust set of meetings to ensure that the Trust is meeting it's mandatory and statutory requirements for IPC. There are the strategic and operational infection reduction committees, which report via the Quality committee ultimately to the Trust board. There are a number of supporting committees and meetings which feed into Operation infection reduction committee (OIRC), including the antimicrobial stewardship committee (ACAT), water safety, ventilation safety and the decontamination committee.

2.2.3 Reporting to the Trust Board and board assurance framework (IPC BAF)

The IPCT has maintained an excellent relationship with the Trust board, and when there are issues of concern that require escalation have been given the opportunity to raise these in appropriate committees. Both the DIPC and the ICD regularly meet and update the chief nurse and chief medical officer. The IPC BAF is maintained as a live document, with action

plans to support improvements where gaps in compliance or risks have been identified. An update on progress of the BAF was presented to the board in a development session in October 2023.

2.2.4 Policy and Procedures

There has been a full review and refresh of all the IPC policies and procedures that has been completed in 2023, such that policies are now in date and aligned with current national guidance where applicable. Some policies that have included significant changes that impact clinical teams are in the process of being operationalised, to ensure compliance.

2.2.5 Infection Control Risk Register

There is an established risk register which highlights risks held directly by the IPCT, but also reflects risks owned by other departments which are relevant to IPC. These are reviewed regularly with the risk management team, and discussed at Operational Infection Reduction Committee and escalated to strategic IRC as and when appropriate. Key risks include those around the aging environment including the ventilation and water systems, isolation room capacity, healthcare acquired infections and multi-drug resistant organism transmission.

2.2.6 External inspections / visits

There have been no external inspections or assessments specific to IPC during 2023-2024. There were actions from the Care Quality Commission (CQC) visit in November 2022 which resulted in an action plan to address the recommendations. This action plan was closed, with actions either completed or transferred to the operational infection reduction committee.

2.3 OVERVIEW OF INFECTION CONTROL ACTIVITIES DURING 2023-24

The IPCT has a significant and broad remit. The team has developed a work plan, to ensure that they focus on key priorities. Much of the work of the IPCT is reactive, including

- providing advice to the clinical teams on the management of individual patients to prevent onward spread of transmissible infections
- managing outbreaks of infection
- investigating healthcare acquired infections

However, the team plays a more critical role in the proactive prevention of infection and moving forward, this needs to be the greater focus. This work includes, but isn't limited to

- supporting estates to ensure the environment is safe and fit for purpose, in particular in relation to water safety and ventilation
- advising capital on aspects of new builds related to IPC
- working closely with facilities to maintain the cleanliness of the environment

working with the microbiology department to ensure effective screening of patients at risk of multi-drug resistant organisms

improving antimicrobial stewardship to reduce antimicrobial resistance

education and training of staff in all aspects of IPC

The remaining report will highlight in more detail some key aspects of this work.

2.3.1 HEALTHCARE ASSOCIATED INFECTIONS (HCAI'S)

2.3.1.1 Surveillance organisms

2.3.1.1.1 Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI)

Over the last ten years the Department of Health & Social Care have monitored Trust apportioned MRSA BSI against a policy of 'zero tolerance of avoidable infection'. It was accepted that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum'. National figures support this contention (Figure 1). The numbers of total and hospital onset MRSA BSI diagnosed in the Trust for the last 3 years are shown in Figure 2.

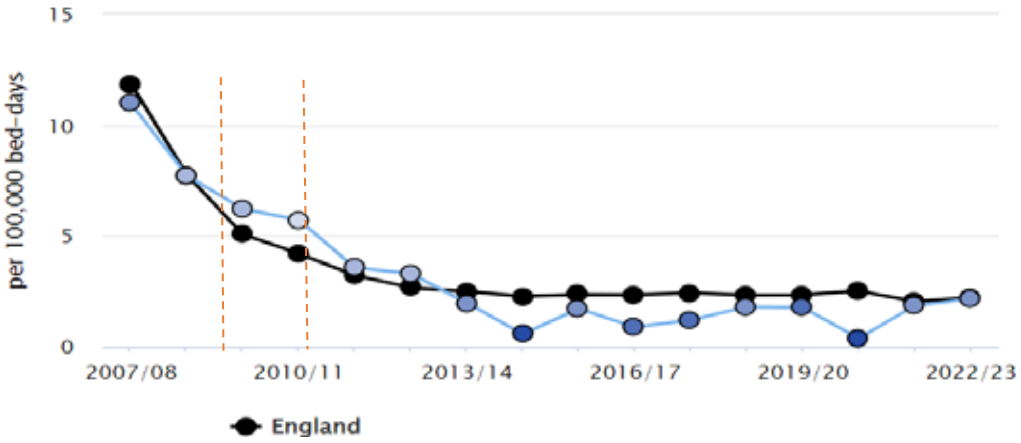
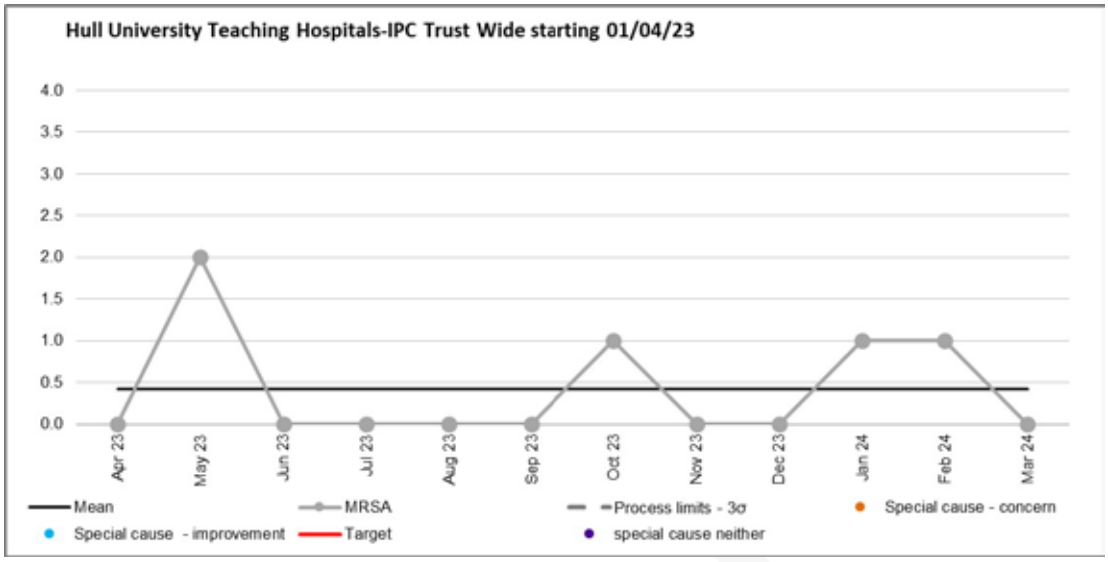


Figure 1. MRSA bacteraemia all rates by reporting acute trust and financial year in England 2007-2023 in comparison with Hull University Teaching Hospitals NHS Trust (red lines indicate introduction of universal screening)

During 2023-24, five hospital onset, healthcare associated (HOHA) cases were reported, two in May 2023, one in October 2023, one in January 2024 and a further case in February 2024.



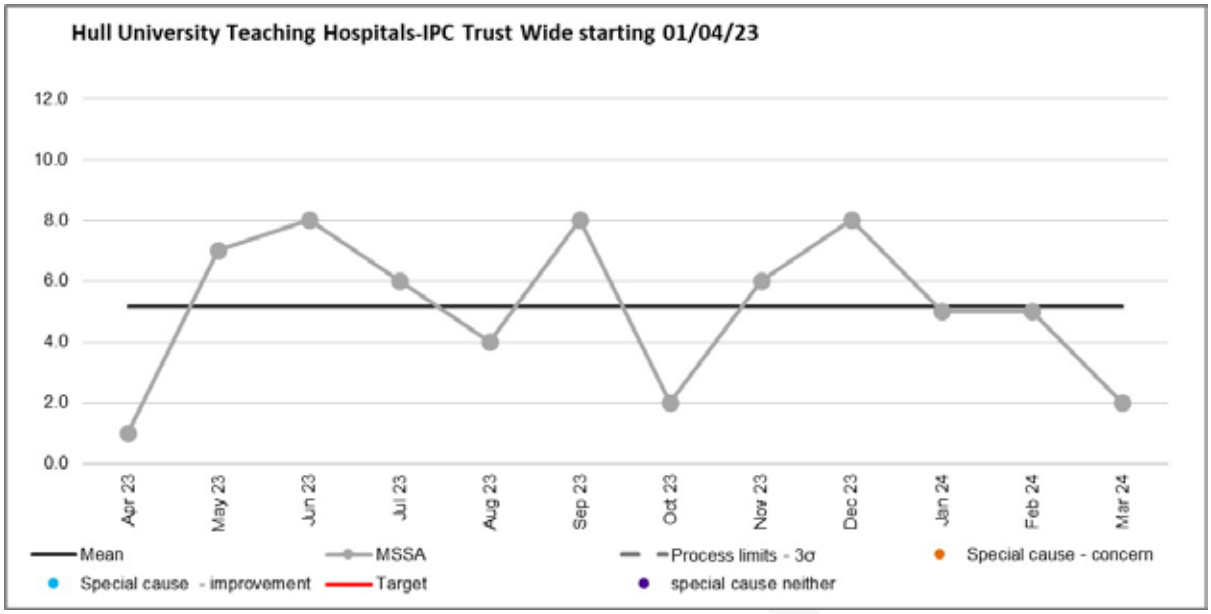
All five cases were investigated via Post Infection Reviews (PIR) by both the Trust and System Partners. One community onset community associated (COCA) case was reported in April 2023. 3/5 were reported in the Medicine Health Group, 1 case in Surgery Health Group and latterly 1 case in Clinical Support Health Group with no reported cases in Families & Women's Health Group. There were no reported outbreaks of healthcare acquired MRSA infections.

Of the five reported HOHA MRSA bacteraemia cases all represent patients with complex past medical histories and multiple comorbidities. The majority of the cases had a history of MRSA colonisation and/or previous infection. All five cases were investigated via PIR and all five cases agreed as unavoidable with no significant lapses in care identified when discussed in a joint review meeting with system partners. The cases did highlight that compliance with the MRSA policy could be improved, and the planned update in

The hospital-onset rate at Hull University Teaching Hospitals NHS Trust is 1.6 per 100,000 bed-days compared to the England hospital-onset rate of 0.8 per 100,000 bed-days (2022-23 available data). Therefore, there is room for improvement as the Trust is a negative outlier in comparison to the English average. This is a focus of some the improvement work planning for the coming year.

2.3.1.1.2 Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infection (BSI)

Currently there is no national threshold for MSSA bacteraemia but as a Trust, a local threshold was agreed with system partners of sixty HOHA cases which was breached by 3 cases during 2023-24. This demonstrates an improvement on the previous years reported numbers of 80, however time is required to see if this decrease is sustained.



The reasons for this improvement are likely to be multifactorial and may include the introduction of an extension set to cannulas which reduce the risk of trauma and subsequent infection around the cannula site. There needs to be an ongoing focus on vascular device insertion and management with an aim of creating a vascular access service, which is currently at the business case stage.

Most reportable cases, 46% were reported in the Medicine Health Group, with the same percentage in Surgery Health Group, 4% in Clinical Support, and latterly 4% in Families & Women's Health Group. Thematic analysis identifies the most common risk factors as a previous history of MSSA, presence of an invasive device such as a cannula and or central venous catheter and skin and soft tissue infections. There were no reported outbreaks of MSSA during 2023-24.

During 2023-24, NHSE were concerned about the rise in MSSA BSIs across England and requested NHSE regional teams to further investigate MSSA BSI, and as a result the Trust completed and submitted a survey in January 2024. Results of the survey across the North of England, mirrored that of the Trust with risk factors associated with chronic wounds and wound care, intravenous devices and management, people who injection drugs (PWID's), skin colonisation and diabetic patients being at greater risk. Reduction strategies are centred on intravenous devices insertion and management, Aseptic Non-Touch Technique (ANTT), screening and decolonisation protocols, effective documentation and education. During 2024-25, a regional workshop on preventing MSSA BSI is being scheduled with any consequent recommendations forming part of any Trust MSSA BSI reduction strategy.

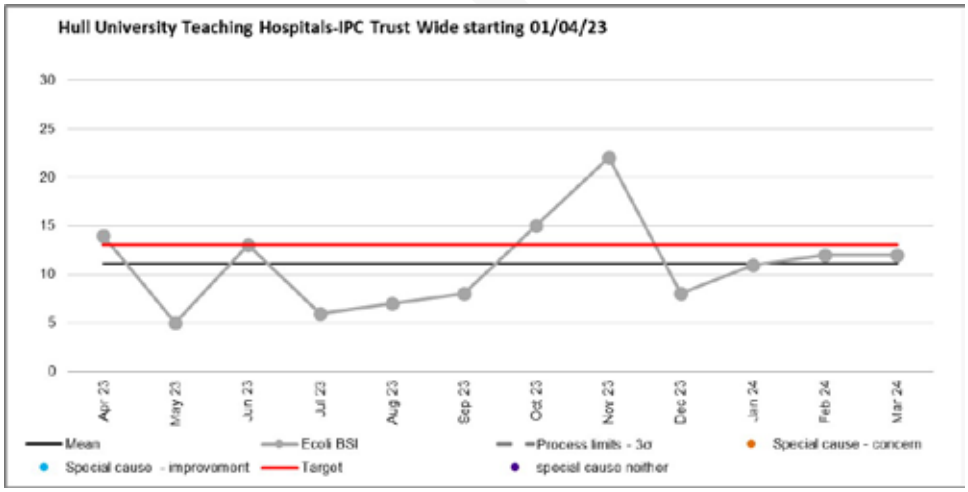
2.3.1.1.3 Gram negative organism blood stream infections (GNBSIs)

For the operational period 1st April 2023 to 31st March 2024, UKHSA and NHS England required NHS Trusts to continue to report cases of bloodstream infections due to E coli, Klebsiella species and *Pseudomonas aeruginosa (P. aeruginosa)*. On the 26th May 2023, NHS England published NHS Standard Contract 2023/24 - Minimising Clostridioides difficile and Gram-negative bloodstream infections (GNBSIs). Trusts were required under the NHS Standard Contract 2023/24 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so reported hospital onset, healthcare associated (HOHA)* and community onset healthcare associated (COHA)* cases are no higher than the threshold levels set by NHS England. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 50% reduction by 2024-2025, inclusive of E. coli, Klebsiella and *Pseudomonas aeruginosa* bacteraemia.

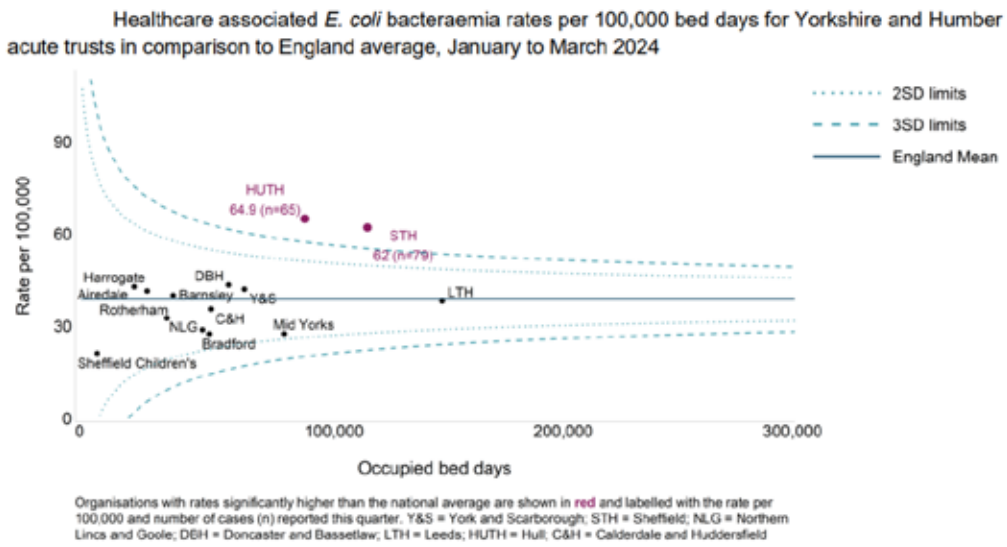
Blood stream infection	**2023-2024 upper threshold as per standard contract (HOHA* & COHA* cases combined)**	**Year end actual reported case total (HOHA* & COHA* cases combined)**	**Performance**
E coli	157	224	Exceeded threshold 142%
Klebsiella species	64	89	Exceeded threshold 139%
Pseudomonas aeruginosa	25	38	Exceeded threshold 152%

*See appendix for definitions

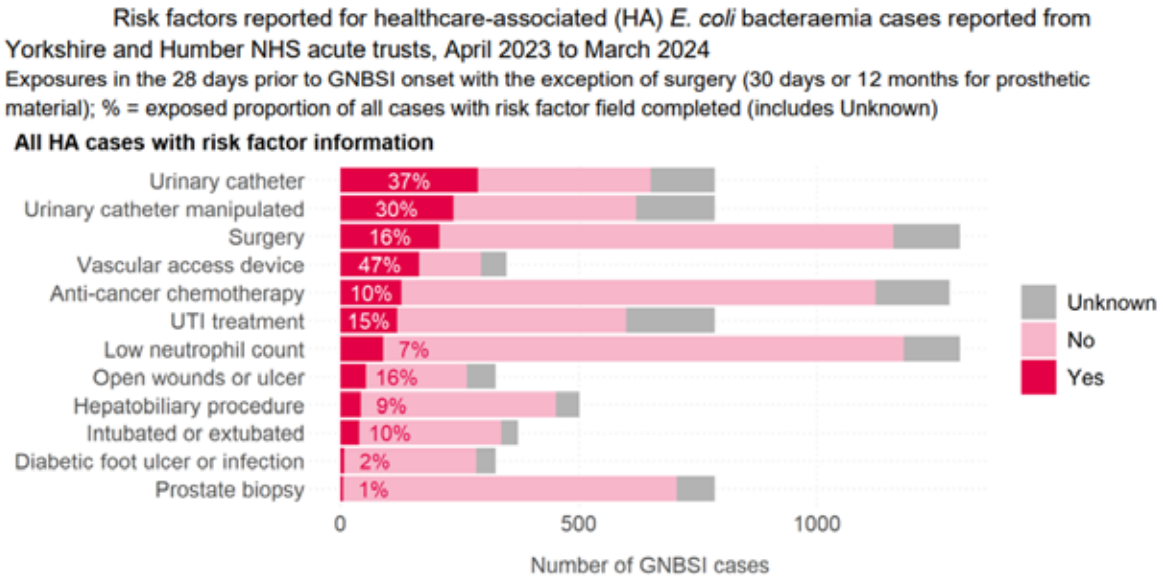
E.Coli bloodstream infections



The hospital-onset rate at Hull University Teaching Hospitals NHS Trust is 35.2 per 100 000 bed-days compared to the England hospital-onset rate of 22.2 per 100,000 bed-days (UKHSA Fingertips, 2022-23 available data). As such, the Trust is a significant outlier, and an ongoing focus on improvement is required as this trend has continued throughout 2023-24, see below the final quarter figures showing that HUTH is above the 3rd standard deviation.

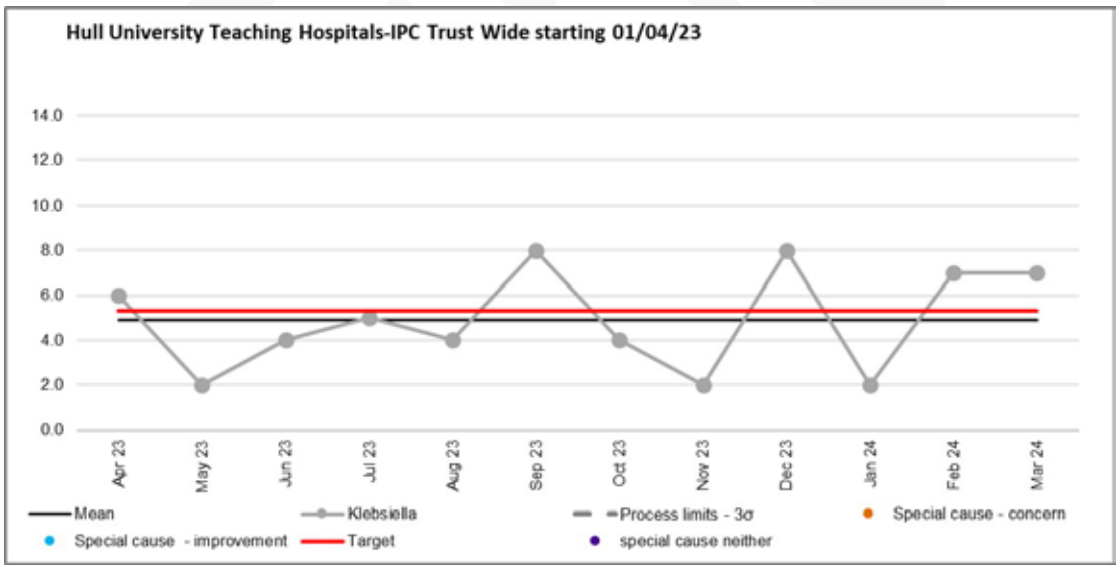


Of the 224 cases in 2023-24, 42% were reported in the Medicine Health Group, 33% in Surgery Health Group, 21% in Clinical Support, and 4% in Families & Women's Health Group. During 2023-24, NHSE focused on reducing healthcare associated *E. coli* bloodstream infections because they represent 55% of all Gram-negative BSIs. As approximately three-quarters of E. coli BSIs occur before people are admitted to hospital, reduction requires a whole health economy approach. To commence this key work stream the IPCT completed a GNBSI self-assessment intended to assist organisations or systems to produce a focused and effective action plan for reducing E. coli BSIs. To effectively reduce the number of E coli BSIs, there will need to be coordinated work across the Trust looking at improvements in patient hydration, the use and care of urinary catheters and reduced delays in infection source control eg delayed interventional procedures, such as endoscopic retrograde cholangiopancreatography (ERCPs).



This should be considered a priority area, as not only will patient outcomes significantly improve, with reduced morbidity and mortality from sepsis, but there are significant cost savings in terms of excess bed days and emergency department admissions. A tool to analyse the mortality and excess costs of shows that E. coli blood stream infections result in an estimated 60 excess deaths and at least £780,000 in excess costs at HUTH annually, based on 2022-23 data (see appendix 3 for full analysis).

<u>Klebsiella species bloodstream infections</u>

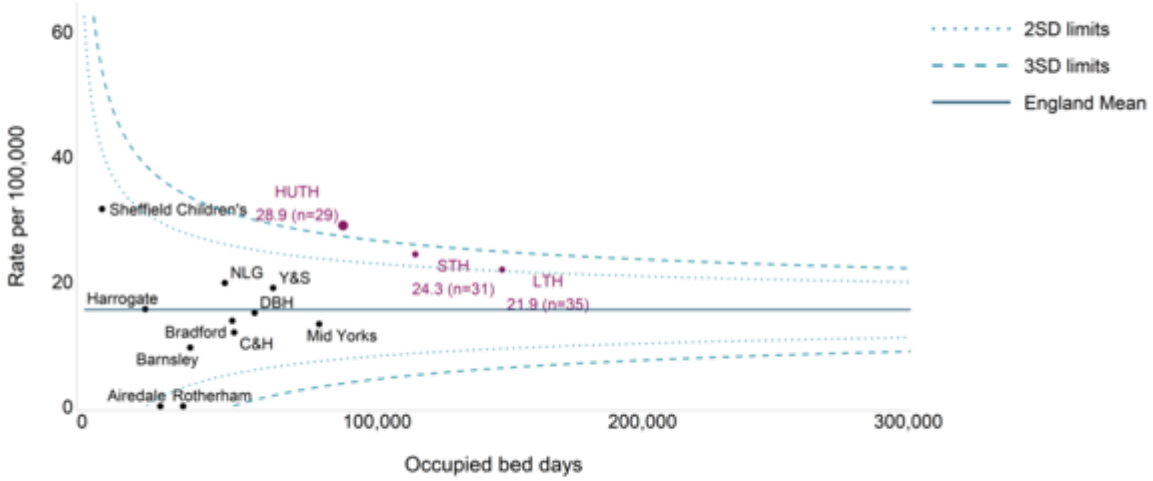


The split of cases by health group are similar to that seen for the other GNBSIs, 44% in SHG, 34% in MHG, 18% in CSHG and 4% in F&WHG.

The same trends and risk factors apply for Klebsiella as per E coli, ie most infections are of urinary or intra-abdominal focus and although some are unpreventable, improvements in

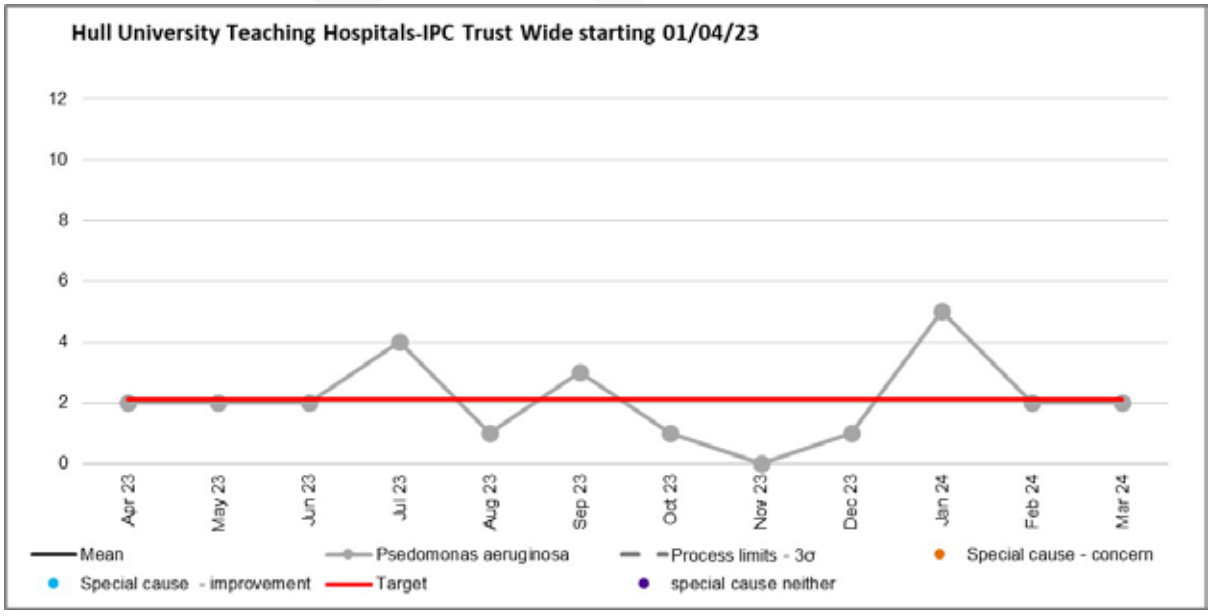
hydration, catheter care and surgical source control are all likely to have a beneficial improvement.

Healthcare associated *Klebsiella* spp. bacteraemia rates per 100,000 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2024

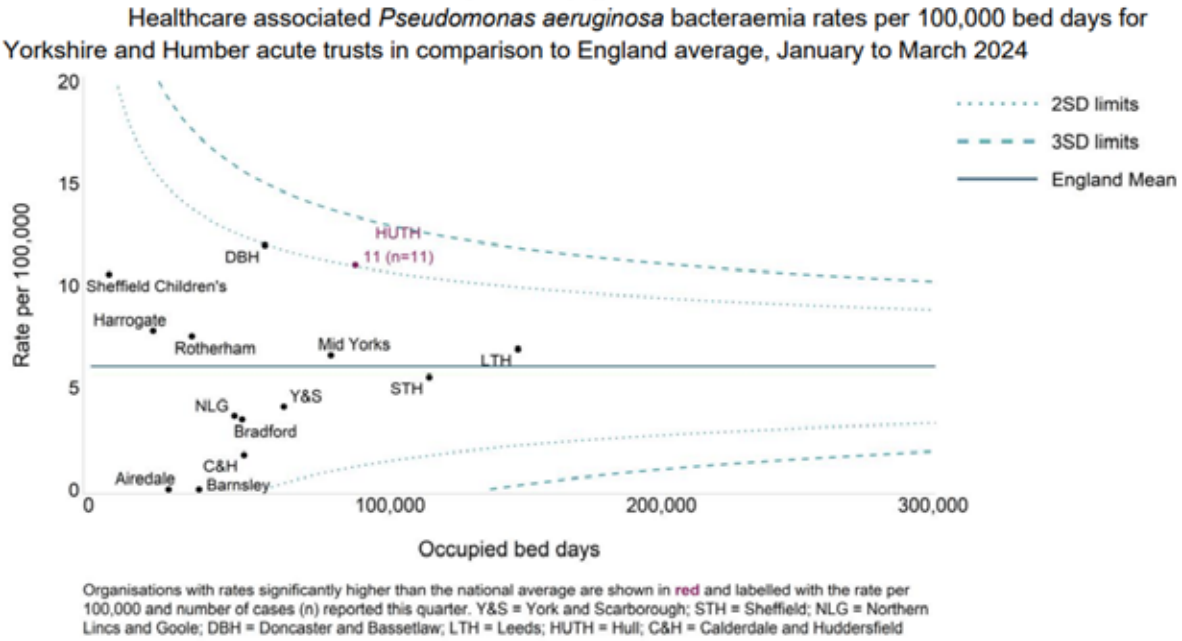


Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. Y&S = York and Scarborough; STH = Sheffield; NLG = Northern Lincs and Goole; DBH = Doncaster and Bassetlaw; LTH = Leeds; HUTH = Hull; C&H = Calderdale and Huddersfield

<u>Pseudomonas aeruginosa bloodstream infections</u>

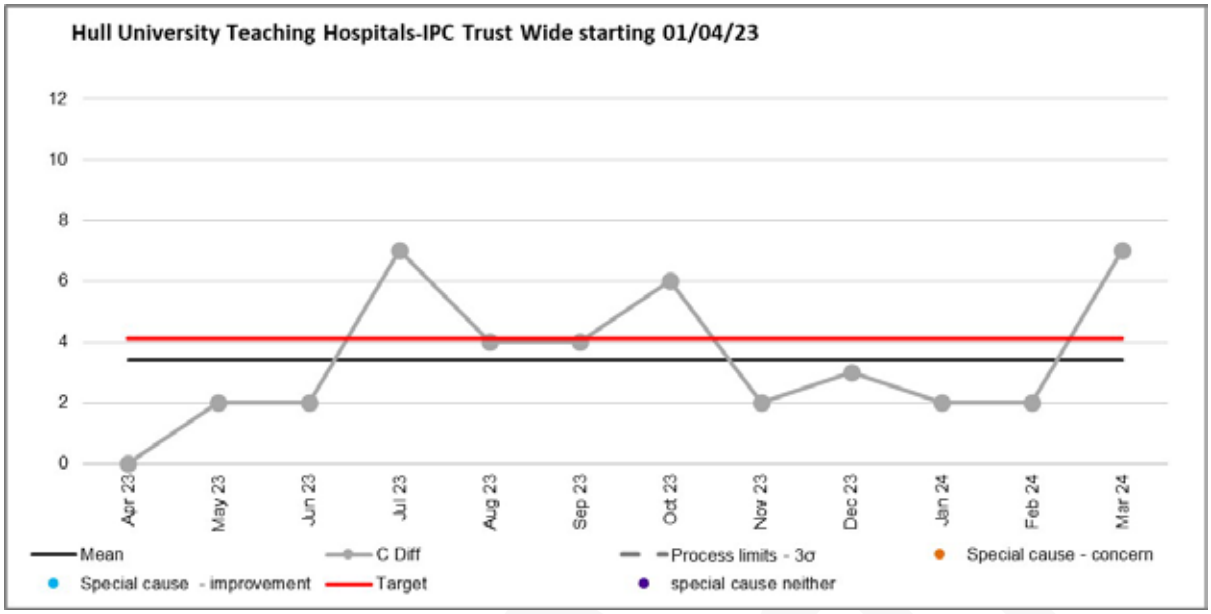


During 2023-24, the Trust remained an outlier across Yorkshire and the Humber with regards *Pseudomonas aeruginosa* BSI rates.



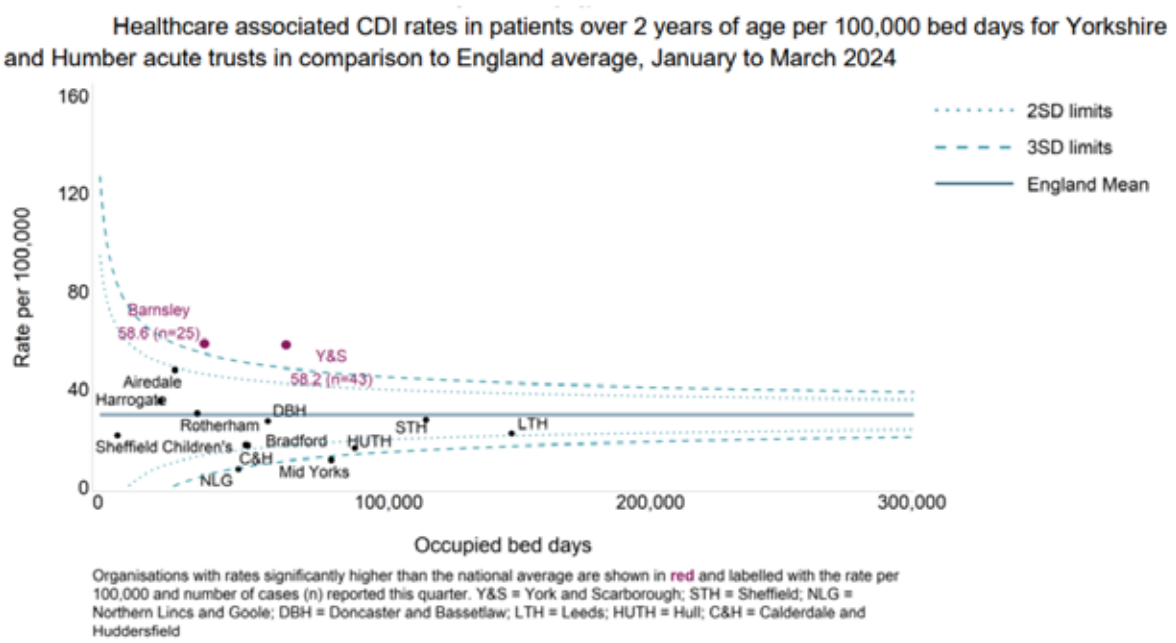
The majority of reportable cases, 42% were reported in the Medicine Health Group, 32% in Surgery Health Group, 21% in Clinical Support, and 5% in Families & Women's Health Group.
There were no reported outbreaks of Pseudomonas aeruginosa BSI, although monitoring of cases in augmented care areas continued during 2023-24 due to the risk correlation associated with the environment, especially water.
Overall, a Trust reduction in Pseudomonas aeruginosa BSI were reported during 2023-24, compared to the previous financial year.
Causation was associated with hospital, community and/or ventilator associated pneumonia, skin and soft tissue infections, biliary and neutropenic sepsis.
There was a national incident raised by UKHSA due to an increase in Pseudomonal infections and the Trust helped support the investigation of this. Babies on the neonatal intensive care unit (NICU), are routinely screened for Pseudomonas carriage due to the significant risk of infection in this group and new isolates are sent to the reference laboratory for typing. The outbreak strain was identified in a number of the babies in the Trust, along with a number of other organisations. Investigation of potential source was undertaken but the source was not identified and the incident is now closed. The unit continue to be vigilant with regards to *P aeruginosa*.

2.3.1.1.4 *Clostridioides difficile* associated diarrhoea (CDAD)



The Trust has maintained its performance with regards to not exceeding the threshold set once again for C difficile. There have been no outbreaks of C difficile during the year, and as expected the majority of the cases were reported in the MHG (57%), with the other cases distributed between the remaining HGs (20% CSHG, 18% SHG and 5% in F&WHG).

The Trust continued to perform RCAs on C difficile for the year 2023-24, and found that in virtually all cases the infection was deemed unavoidable, with similar themes and learning as over previous years.



2.3.1.2 Multi-drug resistant organisms (CPE, VRE)

Carbapenemase producing Enterobacterales (CPE)

Following the successful work of 2022-23 to allow the Trust to move towards compliance with the National Framework of Actions to Contain CPE, screening for CPE commenced for patients managed in the Queens Centre. This ongoing proactive screening has so far identified single cases of CPE who have been managed in accordance with Trust policy and did not result in onward transmission. Screening outside of the Queen's centre has resulted in the identification of a small cluster of cases on the vascular ward at Hull Royal infirmary, and although some patients had CPE infection treated, there were no cases of direct mortality associated with this outbreak.

Vancomycin Resistant Enterococci (VRE)

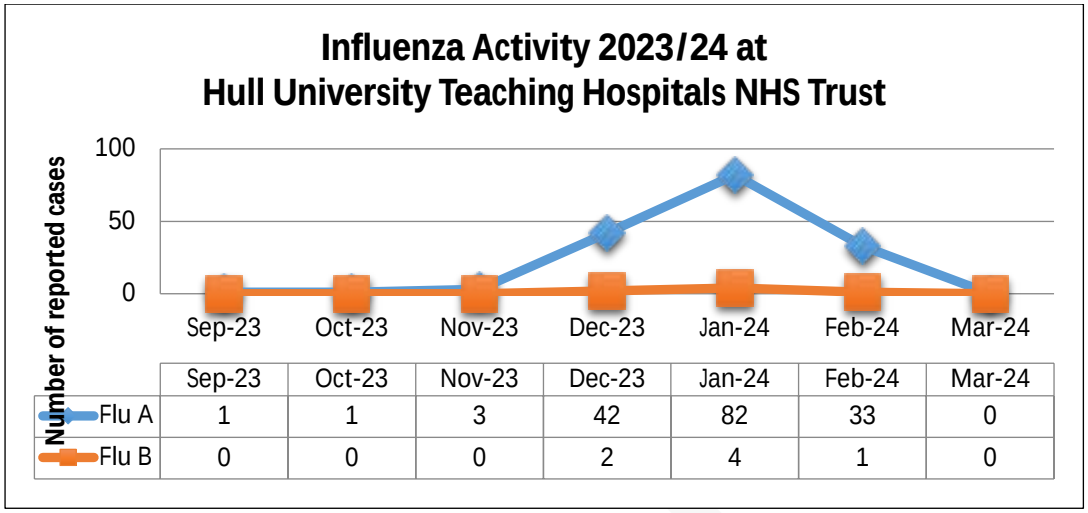
During 2022-23 & 2023-24 a marked increase in VRE cases was reported, predominantly in the Surgery Health Group. Cases were initially reported across a number of surgical areas including both intensive care units on the Hull Royal Infirmary site, neurosurgery and vascular wards. These areas were able to control the outbreak rapidly with standard enhanced precautions instituted by the outbreak control group. The largest single outbreak centred on the trauma and orthopaedic wards at the Trust, commencing in the Winter 2022-23. For Trauma & Orthopaedics the outbreak was protracted with a number of urgent actions taken to mitigate the ongoing risk of transmission. There was significant morbidity and mortality associated with this outbreak, both directly from wound infections and indirectly due to the impact of ward restrictions and patient movement.

Following investigation initial cases were found to be linked to time and place, with multiple patient moves providing transmission opportunities. In all cases, the outbreaks commenced with a cluster of clinical infections, mainly wound infections. Clinical isolates were sent for typing to UKHSA which confirmed indistinguishable VRE infection in at least two clusters. Reactive and proactive screening for VRE was initiated, as was appropriate isolation and cohorting. Rectal screening identified community cases with patients positive for VRE on admission. Incident meetings were convened and held with System Partners, UKHSA and NHS England. The IPCT worked closely with the clinical teams to support during this time, and significant lessons have been learnt about the difficulties of an entrenched outbreak with multi-drug resistant organisms. The outbreak was only successfully brought under control once all positive patients had been discharged / transferred.
No further clusters have been reported since August 2023.

2.3.1.3 Respiratory viruses

Influenza

Cases of Influenza were reported from September 2023, peaking in January 2024. During January 2024, there was the expected increase of Influenza A cases. These predominantly were amongst patients acquiring infection in the community but unfortunately did result in some transmission in ward areas. The rise in Influenza A was comparable with other acute Trusts regionally and nationally.
The Trust saw a low number of Influenza B infections matching the national picture of cases of Influenza B were reported in low numbers, peaking in March 2024.
Patients were tested for influenza, along with COVID-19, on admission on the basis of symptoms compatible with respiratory viral symptoms, in line with national guidance. Key admission areas including ED, MAU and paediatrics performed viral testing by Point of Care Tests, allowing for timely accurate diagnosis and subsequent isolation and management.
The IPCT are keen to support the ongoing use of POCT respiratory virus testing, supplemented by the laboratory diagnostic service provided by Microbiology and Virology.
In order to appropriately manage patients presenting with infective respiratory conditions, maintenance of up to date face mask fit testing by staff is vital to enable them to use appropriate PPE. Please also see section….



	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Flu A	1	1	3	42	82	33	0
Flu B	0	0	0	2	4	1	0

Figure 20. Represents influenza activity at the Trust during 2023-24

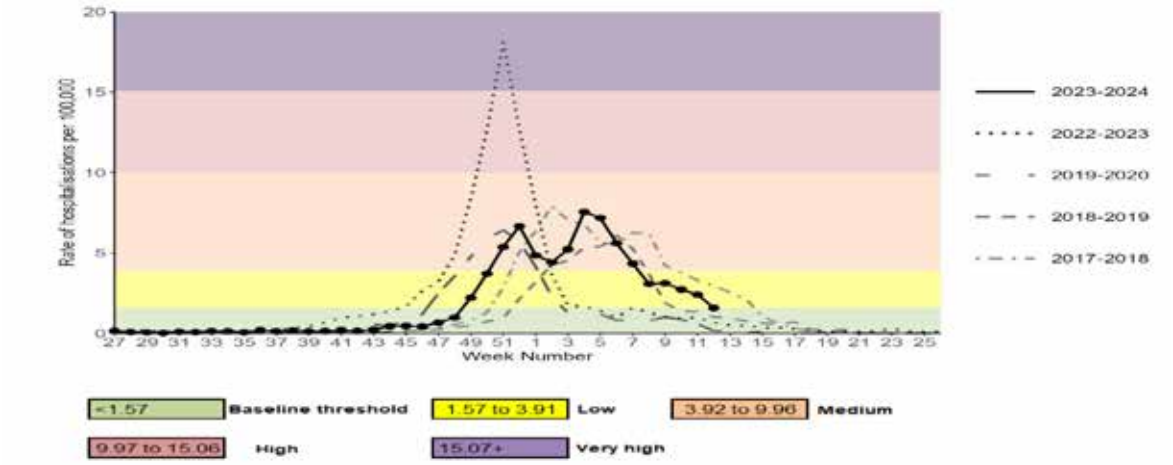


Figure 21. Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England

COVID-19

During 2023-24, COVID-19 continued to be a challenge for the organisation, resulting in ongoing small outbreaks and bay closures. The Trust continues to follow national guidance for the management of respiratory viruses, including Covid-19.

Cases of COVID-19 during 2023-24 were due to different COVID-19 variants which resulted in peaks and troughs of infections. At times of high prevalence and incidence within the community we continued to see subsequent increases in hospital admissions and resulting outbreaks of infection.

During 2023-24, the Infection Prevention & Control team responded to updates in guidance providing a pragmatic approach to the management of patients and staff across the Trust. When rates of infection increased additional measures were introduced such as clinical staff wearing respiratory protection, additional enhanced cleaning and cohort areas being created to manage patients safely. Asymptomatic screening to facilitate discharge to social

care remained in place during 203-24 and in some cases identified asymptomatic carriage of COVID19 and as such reported as hospital onset cases due to the patient length of stay. In the absence of asymptomatic testing, it was difficult to illicit if COVID-19 occurred prior to admission and the patient remained asymptomatic throughout.
The ongoing impact of COVID-19 vaccination and associated boosters resulted in patients being affected by COVID-19 differently, fewer patients required escalation of treatment or supportive treatment. Clinical management and specific Covid-19 therapies continued to be prescribed as per Trust Guideline for the Clinical Management of Proven / Suspected COVID-19 in Adults.
Outbreaks of COVID-19 resulted incident meetings being convened to improve decision making and escalation locally, regionally and nationally via reporting routes. To improve communication further a daily IPC report continued to be circulated to ensure clinical and site teams were apprised of IPC recommendations with regards bay and ward closures along with IPC advice.

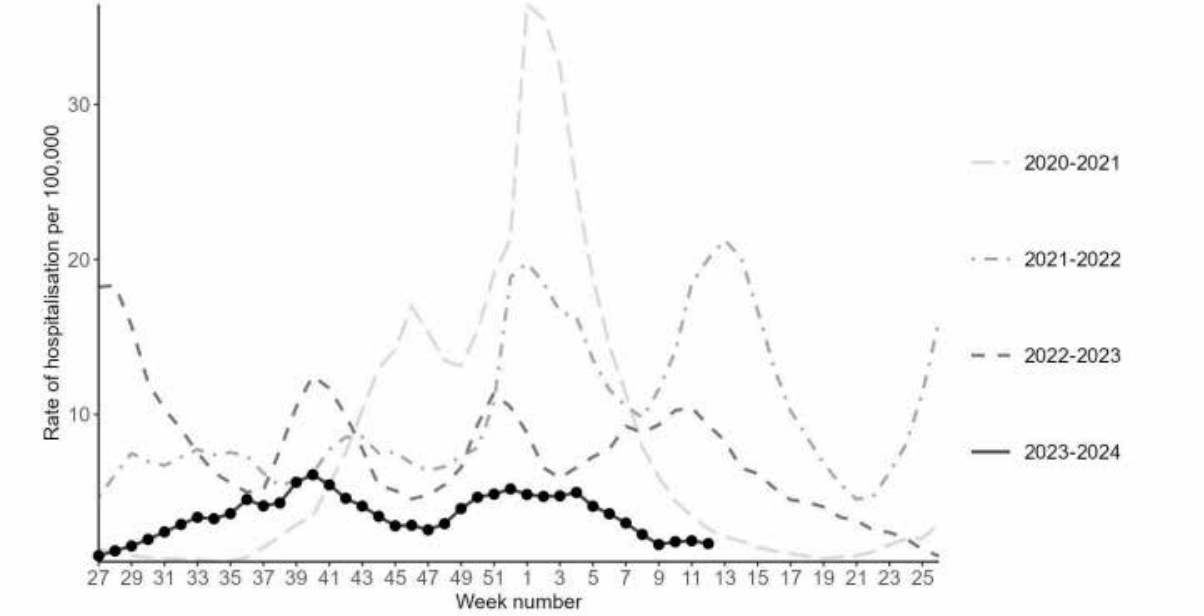


Figure 24. Weekly overall COVID-19 hospital admission rates per 100,000 trust catchment population, reported through SARI Watch mandatory surveillance, England
COVID-19 hospital admission rate based on 81 NHS trusts for week 12. SARI Watch data is provisional and subject to retrospective updates.

Other outbreaks and infections of note

Norovirus

During 2023-24 Quarter 3 and Quarter 4, outbreaks of Norovirus occurred on wards on the HRI site. The outbreaks were promptly identified but affected both patients and staff, and in general were short lived in duration with incident meetings held to discuss control measures. All wards were cleaned and reopened following advice taken from the IPCT.

During 2023-24, other outbreaks of diarrhoea & vomiting (D&V), mainly affecting general medical & medical elderly wards were also reported. In the majority of cases, only bays were affected and following applied control measures and sampling, closures were short-lived.
In accordance with national guidance hospital outbreaks of D&V/ Norovirus were managed with partial restrictions but some complete ward closures were necessary.

Measles

In Autumn 2023, NHS England in conjunction with UKHSA communicated with Trusts regarding an evolving picture of rising cases of measles in the community not just in the UK but across Europe and globally. The Trust responded by alerting relevant departments whilst Occupational Health pre-emptively reviewed staff in high-risk areas for MMR vaccine uptake and/or a history of measles.
During November 2023, the first local measles incident occurred. A patient presented to ED with an illness following recent travel to Eastern Europe to visit family. Measles was not initially suspected, and the patient was therefore not isolated immediately. Tests (PCR) subsequently confirmed measles resulting in a contact tracing exercise of both staff and patients. Incident meetings were convened and held with System Partners, UKHSA and NHS England. Contacts were risk assessed and immunocompromised patient contacts were identified and followed up both in the Trust and in the community. All other contacts were provided with a 'warn and inform' text message as per national measles guidance.
Subsequent to this case, in the spring of 2024, further measles cases resulted in large contact tracing exercises (over 180 patients and staff), with onward transmission of infection to at least 2 patients and one member of staff. Once the cases were identified, the rapid actions taken with the support of multiple teams ensured that the impact was minimised.
These cases experienced in Trust were indicative of a larger national increase in Measles cases, predominantly in London, The Midlands and the North West. By the 28th March 2024, 868 measles cases had been confirmed since the 1st October 2023, compared to just 54 confirmed cases reported in 2022-23 and by year end most English counties had reported confirmed cases.
Resurgence in vaccine preventable diseases poses a significant threat to healthcare as demonstrated by the examples previously given, compounded by overcrowding and increased length of stay in ED departments and remains a current priority for UKHSA and the DoH.

Tuberculosis

During 2023-24, the identification of Tuberculosis (TB) in inpatients, resulting in contact tracing of both staff and patients continued. The infection prevention and control team have

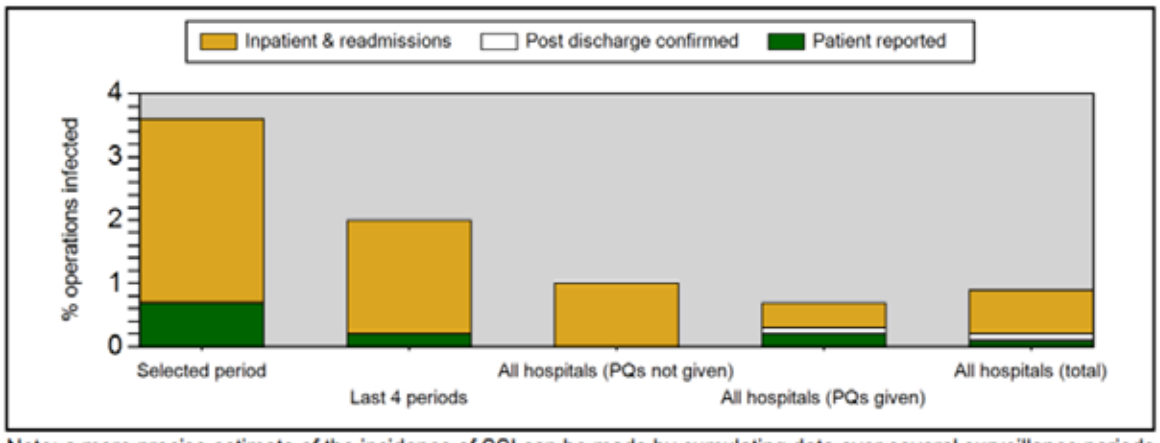
worked closely with the community TB nursing team, infectious diseases consultants, respiratory consultants and UKHSA to reduce ongoing risks to patients and staff. These incidences have provided the opportunity to reinforce the importance of appropriate isolation of 'at risk' patients, use of appropriate personal protective equipment (PPE) e.g. FFP3 facemasks and also communication of cases and incidents to local System Partners both on the North & South Bank.

During 2023-24, the Infectious Diseases team managed a complex patient with XDRTB at the request of NHS England. The patient was treated in conjunction with the cardiothoracic surgeons and managed on ward C7. The patient was successfully treated with NHS England commending the team for their input and treatment pathway. The patient was discharged with follow up arranged via their respective community TB team. It served as a positive example of joint system partner working.

2.3.1.5 Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2022/23 this included orthopaedic surveillance (fractured neck of femurs) which showed that the Trust was a high outlier. Following this a group was convened to look at potential improvements to reduce the infection rate. Surveillance for fractured neck of femur fracture patients was completed during January – March 2024, to allow direct comparison with the previous year. One hundred and twenty seven repair of fractured neck of femur operations were surveyed, results showed that four patients developed a surgical site wound infection providing the percentage of surgical site infections (SSIs) at the Trust at 3.1%, a rise on the previous year and well above the national hospital SSI rate. The department has been contacted to look again at the infection rates.

Rates of SSI by inpatient/readmission, post-discharge confirmed and patient reported SSIs for the selected period (Jan-Mar 2023) and last 4 periods compared to all hospitals* for the previous 5 years available (Apr-Jun 2018 to Jan-Mar 2023).



Note: a more precise estimate of the incidence of SSI can be made by cumulating data over several surveillance periods

At the request of the T&O team, the IPCT also supported surveillance for total hip replacements (THR) and total knee replacements (TKR). This surveillance had not been completed for some years, so there is not recent local comparator data but once again the Trust is shown to be a high outlier for post-operative skin and soft tissue infections. The data showed that the Trust had an infection risk of 0.8% for THR above the 90th percentile nationally and similarly for inpatient and readmission SSI risk is above the national 90th percentile in for TKR with a risk of 2.0%.
Further work to look at this has been requested of the care group by the IPCT, and will be support by the IPCT.

2.3.2 INFECTIOUS DISEASES AND PUBLIC HEALTH

The Trust continues to work closely with UKHSA and the local health protection teams. There is a monthly infection control and antimicrobial stewardship collaborative forum which discusses healthcare acquired infections themes, trends and required actions. The Trust ICD is a member of the Humber & North Yorkshire ICS Antimicrobial Stewardship steering group and is a member of the ICS AMR and IPC Programme Board.

Locally there have been cases of diphtheria in the migrant population which the Trust have played an integral part in diagnosing, managing and supporting the wider public health actions. The Trust supports UKHSA in urgent actions required to protect patients and the public from infectious diseases, for example supporting the supply and delivery of urgent interventions such as immunoglobulins for post exposure prophylaxis.

2.3.3 BUILT ENVIRONMENT

2.3.3.1 Isolation facilities

There have been, for many years, concerns about the Trust's isolation capacity and facilities. Like many other NHS trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution.
Compliant isolation facilities on intensive care units across the Trust expanded on the opening of the ICU on the HRI site in 2021 resulting in increased accessibility for patients requiring isolation and improving care for patients nursed in intensive care.
In January 2023 new paediatric facilities opened following reconfiguration of existing hospital estate on the HRI site. This provided a new paediatric inpatient, high dependency unit and outpatient facility. Improved isolation capacity and smaller bedded areas e.g. 2 bedded bays enable appropriate management of paediatric patients and minimise the risk

but not totally exclude the transmission of infections. Parental and family facilities were also improved as part of the scheme.
The Neonatal Intensive Care Unit (NICU), a tertiary level 3 unit, previously experienced incidents and outbreaks with the environment cited as being a contributory factor and significant work has been undertaken on the unit to mitigate risks. During 2023-24, the remaining reconfiguration of the environment, including the 'blue room' and special care areas were completed with input from the clinical teams, IPCT, Apleona and contractors. The lack of a decant facility to enable a proactive, rolling deep clean programme and the flexibility with which to close a ward in the event of an outbreak is also an issue for the organisation and must be considered alongside the requirement to increase isolation facilities.

2.3.3.2 Other issues

There are some areas in the Trust that are being used for purposes other than their original design, which poses potential risks to patients and staff. The ventilation committee is in the process of identifying which areas of the Trust should be identified as critical ventilation, and this has highlighted some issues. The IPCT will be raising these issues as risks with the relevant services, so that mitigations and alternative plans can be made. An example is the acute hand trauma service is using a room as a theatre that does not meet the relevant standards for ventilation for a clinical area.

2.3.4 WATER SAFETY

As per national guidance on water safety Health Technical Memorandum 0401 (HTM0401), during 2023-24, water safety was monitored by the Water Safety Group (WSG), reporting to OIRC & SIRC, as and when required. The Trust has a Water Safety Plan (WSP) which provides a risk-management approach to the safety of water and establishes good practices in local water usage, distribution and supply.
The Estates team continue a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients. Any positive water samples culturing Legionella and/ or Pseudomonas are reported by UKHSA to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.
During 2023-24, the Estates team invested in recruiting an experienced Senior Water Technician whose duties that are solely focussed on water safety, and the evident improvements to patient safety this has brought, including the review of asset lists and schematic drawings all of which contribute to a better understanding of water systems and better management of risks, as well as fulfilling the Trust's requirement to keep its LRAs up to date.

There has been a systematic approach to risk minimisation and multiple preventative actions have been taken as recommended by the Authorising Engineer (AE) with respect to water safety over several years. In addition, there is good awareness of the primary water safety issues through the recently set up internal water management subgroup meetings, crucial to the implementation of successful policies and procedures.
Flushing of infrequently used outlets, a requirement of HTM 04-01 is now firmly established on both hospital sites, with improved compliance now seen. The Estates department utilise a software database to record flushing. This improved the ease with which clinical staff recorded flushing in real time. The system creates compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system. The system continues to be embedded by the Estates Department and respective Health Groups and is reliant on contemporaneous contact details of key team members and reliance on paper records is markedly reduced.
A clinical wash hand basin task & finish group was convened during 2023 with the purpose of ensuring all reasonable steps are taken to minimise/ mitigate risks from wash-hand basins, providing assurance for patient and staff safety. This has seen the introduction of improvements such as designated mobile wash basin trolleys, allowing patients to safely wash in their bedspace.

2.3.5 VENTILATION SAFETY

The Trust now has a well established ventilation safety committee, which is chaired by the estates team and supported by the IPCT, an external Authorising Engineer (AE) and other relevant services. The group is working towards understanding where the Trust is complaint with the relevant HTMs, whilst recognising there are significant risks due to the aging estate and ventilation plants.

2.3.6 DECONTAMINATION OF MEDICAL DEVICES AND EQUIPMENT

The decontamination committee met during 2023-2024 to provide assurance of the processes in place across the Trust in ensuring appropriate decontamination of re-useable medical devices, surgical instruments and endoscopes. The Trust Decontamination Committee was chaired by the Surgical Health Group and met quarterly. The Trust endoscopy users, sterile services department and theatre report into this group and during 2023-24, escalation of concerns has been reported via the IPCT and Surgical Health Group to OIRC.
A continued focus has been the development of an asset register to document patient care equipment and the required decontamination including responsibility, process, frequency and traceability. An asset register will need to encompass all patient care equipment where decontamination is required and as such during 2023-24 it was evident decontamination of

patient care equipment was taking place across the Trust by multiple teams and differing disciplines. An asset register, methods of decontamination and audit of processes and practices will form the basis of the committee's direction for 2024-25 and as such will remain a priority.
Cleanliness audits of patient care equipment such as blood glucose monitors is undertaken by the Trust and manufacturers with results fed back to the wards and departments with immediate effect should equipment found to be contaminated – in some cases individual nurses and clinicians who last used the equipment can be identified with appropriate training and education provided. This is facilitated by the Point of Care Team with support from the IPCT and completed at regular intervals during the year, the last audit undertaken was in March 2024.
During 2023-24, an Endoscopy User Group (EUG) met bimonthly with input from the infection prevention & control team. This input is pertinent given the challenges of there being no onsite decontamination for endoscopes on the HRI site. The Trust is reliant on CSSD to provide a timely turnaround of scopes. IPC continue to provide advice and support for the requirements for the new endoscopy suites under development within the Allam Digestive Health Building. Estates in conjunction with CSSD have started the replacement of older endoscopy washers with new models, the programme should be complete in Summer 2024. This should improve the resilience of the washer disinfectors. The Endoscopy service is working towards JAG accreditation.

Central Sterile Services Department (CSSD) continues to meet the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008.
For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only).
Clinical teams complete DATIX reports should sterile equipment fall short of the required standards and investigated by CSSD accordingly.
During 2023-24, embedded support for CSSD, theatres and endoscopy by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments and scopes has continued with the additional development of an Standard Operating Procedure.

2.3.7 FACILITIES

2.3.7.1 Cleaning

Hull University Teaching Hospitals NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2023-24, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for Hull University Teaching Hospitals NHS Trust. Healthcare demand post pandemic and a rise in reported resistant organisms has brought challenges with regards cleaning services, especially during surges of infection. Enhanced cleaning with additional hours needed and an increased staffing resource over and above the existing Trust contract has been required, in addition an increase of post-infection (Amber) cleans have been required along with specialist cleans involving Hydrogen Peroxide Vapours (HPV).

During the financial year the IPCT attended operational meetings to share information with regards risk and/or issues related to respiratory infections, HCAIs and outbreaks but also to acquire assurance that hospital cleanliness remained a priority.

National Standards of Healthcare Cleanliness (2021) apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations and good practice. The standards incorporate significant changes such as the "percentage scoring" system which was not clear to patients/visitors, replaced with cleanliness ratings from zero – 5, similar as seen in the hospitality industry. A zero-star rating equates to "urgent improvement necessary" while a 5-star rating confirms the cleanliness in the area concerned as "very good".

Environmental auditing remains a priority for both the Trust Facility Team, OCS and IPCT to ensure the Trust remains compliant with the standards. All clinical areas display 'Our Commitment to Cleanliness Charter' and cleaning ratings. Efficacy auditing is required if a ward / department scores 3 or below and during 2023-24 this occurred in two clinical areas with remedial action taken to improve the ratings.

During 2023-24, due to an increase in resistant infections affecting patients both at Hull Royal Infirmary and Castle Hill Hospital, additional specialist cleaning and decontamination processes were required. These processes involved primarily the use of HPV and were delivered on an ad hoc call out basis by Sanondaf, who have facilitated this since January 2023. There is a significant cost burden associated with this, regardless of provider which year on year has increased as per table below.

Company Name	**Dates**	**Cost**
Inivos	From April 2022 – January 2023	£220,000
Sanondaf	From 1ST April 2023 – 31st March 2024	£134,629 (ex. VAT)

At the time of writing this annual report an options appraisal paper was drafted to scope acquiring a Trust HPV decontamination service, enabling reactive and proactive decontamination. Consideration given to Facilities, Hotel Services, OCS and the financial burden resulted in a delay in this been given the traction it required. Issues about preferred suppliers and suppliers being on the NHS supplies framework, alongside cost efficiency and effective delivery of a service were also factors in the delay.

2.3.7.2 Linen

During 2023-24, Synergy Linen Management Services has been responsible for providing linen services for the Trust from the 1st of August 2021. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained.
During 2023-24 ongoing construction work at both HRI and CHH, resulted in the need for prudent pest control by both the IPCT, Estates & Facilities teams and external pest control contractors and this will be monitored as ongoing construction continues into 2024-25.

2.3.8 AUDIT PROGRAMME

2.3.8.1 Place inspections

The annual PLACE programme was suspended in 2020 and 2021 during the pandemic and replaced with PLACE-Lite but was reintroduced in 2022. The 2023 PLACE assessments were undertaken at Castle Hill Hospital between 6th October and 19th October 2023 and at Hull Royal Infirmary between 24th October and 17th November 2023 by a multidisciplinary Trust Team and trained patient assessors. The two pertinent PLACE inspection elements to include within the DIPC Annual Report are Cleanliness and Condition, Appearance and Maintenance. For Cleanliness the national and regional average score is 98.1%, the Trust scored below the national average (97.64%). For Condition, Appearance and Maintenance the national average score is 95.9%, with the regional score being 96.5%, the Trust scored below the national and regional average (93.61%). These scores are a concern and demonstrate a deterioration in previous PLACE results but reflect the ongoing challenges of maintaining and cleaning an aged estate none more so than on the HRI site.

2.3.8.2 Fundamental standards

An annual programme of audit is agreed as part of the annual IPC/ Fundamental Standards programme. The audit programme is a combination of policy and general IPC audits carried out as part of an unannounced visit schedule. Audits of both practice and environment are

also undertaken following incidents/outbreaks of infection. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. During 2023-24 audits were presented to the respective Infection Reduction Committees by the reporting Health Group, summarising all of the audit activity and high-level findings.
During 2023-24, the IPCT focused on the timely completion of IPC Fundamental Standards audits and audit documentation with an updated audit form to reflect introduced electronic nursing records. By year end IPC Fundamental Standards were up to date in spite of ongoing challenges faced with the reactive nature of the service, dealing with outbreaks and incidents.
Thematic audit analysis is a regular element and highlights an improvement in audit compliance and associated scoring with exceptions including lack of storage facilities resulting in cluttered environments, gaps in cleaning checklists especially at weekends/ bank holidays, lack of compliance with effective hand hygiene/use of PPE and gaps in electronic nurse documentation.
At ward / departmental level audit processes utilised an updated audit format and audit schedule via MyAssurance alongside a live dashboard, thereby allowing Health Groups and the IPCT to identify trends and required action to improve compliance and practice. Audit processes were slow to embed at ward level. Self-assessment can result in positive scoring

2.3.9 EDUCATION AND TRAINING

A new Infection Prevention and Control (IPC) education framework was published in March 2023 by NHS England. It sets out a vision for design and delivery of IPC education and sets core requirements for clinical and non-clinical staff working in healthcare settings in 6 core standards:

Standard: 1. IPC Practitioners must inform the development of IPC learning and practice development

Standard: 2. Applying standard IPC Precautions (SICPs) and evidence-based practice for preventing HCAI associated with invasive devices and procedures will be incorporated into all health and social care related education programmes

Standard: 3. Antimicrobial resistance (AMR) and Antimicrobial Stewardship (AMS) is an integral part of education programmes.

Standard: 4. Transmission based IPC precautions (TBPs), screening programmes, Hierarchy of controls (HOC) and IPC risk assessment will be incorporated into relevant education programmes

Standard: 5. IPC will be appropriately incorporated into all health and social care related education programmes in a contextually relevant approach. This will support the promotion of appropriate IPC in the delivery of care.

Standard: 6. Management, maintenance and planning of the built environment is incorporated into related education programmes.

The overall aim is to strengthen IPC knowledge, skills and behaviours, and to provide a standardised approach to IPC education. Once fully implemented, the framework will deliver clear individual objectives for IPC learning and development; strong IPC leadership at Board and Executive level; IPC training developed with IPC experts. A new introduction is Levels 1, 2 & 3 (previously only known as level 1 & 2); Level 1 is for everyone working in health and social care setting; Level 2 is for all staff working directly with/ providing care to patients and / or who work in the patient environment; and Level 3 is for all staff who are responsible for an area of care.

The IPC team are currently undertaking a piece of work as part of the annual IPC work-plan, to update the training and delivery for IPC across the Trust. A gap analysis has been developed and work to move towards compliance with the framework is underway.

The Trust is currently undertaking a Learning Needs Analysis Task and Finish Group (LNA) through education and development, IPC are linking in as part of this, to confirm the minimum requirement for IPC throughout the Trust. The Trust is also undertaking a Training Needs Analysis Task and Finish Group (TNA) through education and development for the Trust, reviewing what mandatory / statutory training is being undertaken currently and what training needs reviewing, so that IPC aligned to the new standards. Support to ensure all staff groups are enabled to fulfil their mandatory IPC training requirements will be required.

The IPC team have been delivering face to face training as well as Skills for Health continuing online through HEY24/7. The face-to-face training is currently aimed at non-registered staff new to the Trust and working in clinical areas, newly qualified nurses and apprentices. The IPCT have delivered to over 450 staff face to face since commencing in August 2022, the IPCT would like to see continued support for this through clinical unit managers encouraging their staff to attend. The IPCT have delivered an IPC link day last year and plan to arrange a link day for later this year. Members of the IPCT have further face to face training booked with ward Housekeepers and Hygienists planned for July and November 2023, and the IPCT are linking in with OCS in relation to the education of the new NHS cleaning standards. The overall plan is to continue to expand this work in the coming twelve months.

During 2022-23, training and educational opportunities were offered regionally and nationally by NHS England & UKHSA inclusive of IPC practices, tackling GNBSIs, CPE and antimicrobial stewardship. The National IPC Team funded places for the Rosalind Franklin Programme with the Senior Matron IPCT successfully completing the programme. Non-registered staff at the Trust also benefitted from a bespoke IPC course again funded by the national team, places were limited regionally but at least two non-registered staff completed the course and found the content helpful and clinically applicable.

2.3.10 ANTIMICROBIAL STEWARDSHIP

This section of the report provides an overview of antimicrobial usage and antimicrobial stewardship work within HUTH during 2023 to 2024.

2.3.10.1 National Contract Reduction in Watch & Reserve Agents

The National Contract target reductions were re-instated from 2022/23 onwards. For 2022/23 the target set was a 4.5% reduction in Watch & Reserve (broad-spectrum) agents (measured as defined daily doses (DDDs) per 1000 admissions), compared to a 2018 baseline. HUTH achieved an 8.4% reduction (based on local data). For 2023/24 the target set was a 10% reduction in Watch & Reserve agents (measured as DDDs per 1000 admissions), compared to a 2017 baseline. Based on this new baseline year, HUTH ended 2022/23 using 5.4% less Watch & Reserve agents. At the end of 2023/24 HUTH achieved a 5.9% reduction (based on local data). Thus, although the target was not reached for 2023/24, a sustained reduction in Watch & Reserve agents was seen during the year.

2.3.10.2 CQUIN Improvements

Commissioning for Quality and Innovation (CQUIN) improvements were re-instated for the 2022/23 financial year. In 2023/24, the antimicrobial CQUIN focussed on intravenous (IV) to oral antibiotic switches (IVOS) and switching patients as soon as they met the criteria to switch. HUTH met the CQUIN requirements throughout 2023/24.

2.3.10.3 Total Antimicrobial Usage (DDD data/ 1000 admissions)

ALL agents

HUTH overall antimicrobial usage was steady throughout 2023/24, and was within the mid-range for usage within the Yorkshire & Humber region. At ICB level, HUTH was one of the highest users during the year although usage was relatively constant. Other trusts within the ICB increased their usage towards the end of 23/24, and HUTH ended the year benchmarking favourably with only one trust using less antimicrobials.

Antimicrobial Usage (DDD data/ 1000 admissions).

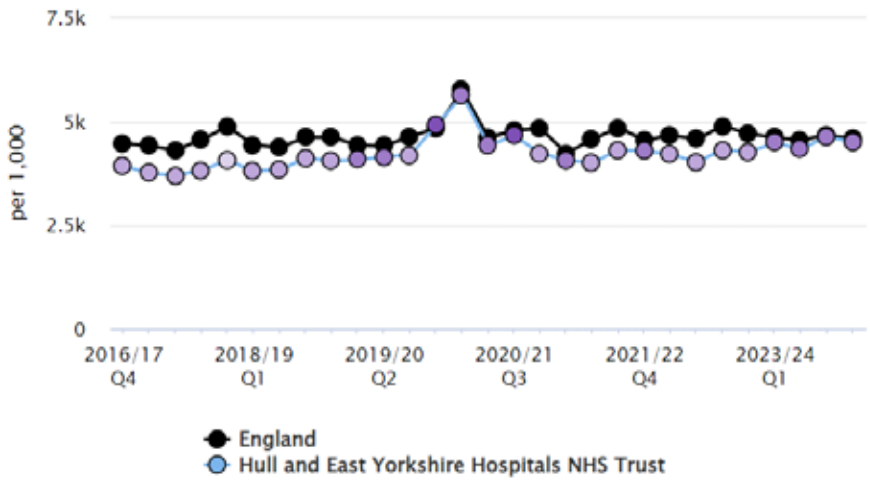


Figure to show the Trust vs England average total antibiotic DDD per 1000 admissions

WATCH/ RESERVE agents

HUTH Watch/ Reserve antibiotic use was steady throughout 2023/24, and was within the lower-range for usage within the Yorkshire & Humber region. At ICB level, HUTH was still on the lower range for prescribing Watch/ Reserve agents. Access / Watch / Reserve (AWaRe) Antibiotic Breakdown Across the region, HUTH is one of the trusts with the highest proportion of ACCESS agents (64% for 23/24) and the lowest for WATCH agents (31%). In 2023/24, the top 5 agents in HUTH were all ACCESS agents. Co-amoxiclav was the most frequently used WATCH agent in 2023/24, despite a decline in use from 2022/23. The reduction in co-amoxiclav use was more evident when 22/23 usage was compared to 21/22 usage. During this period there was more than a 40% reduction in co-amoxiclav use. Colistimethate was the most frequently used RESERVE agent in 2023/24 (largely nebulised use in outpatients)

2.3.10.4 IV Antibiotic Use

During 2023/24, efforts were made to reduce overall IV antibiotic use in HUTH. At the end of 2022/23, IVAB use was 28% of all antibiotics (56% of inpatient ePMA administrations). At the end of 2023/24, IVAB use was 27% of all antibiotics (57% of inpatient ePMA administrations). Throughout the Yorkshire & Humber region, no trust had a significant reduction in IVAB use in 2023/24 compared to 2022/23.

In March 2024, an automatic stop at 72hours was introduced on Lorenzo ePMA for IV co-trimoxazole prescriptions. Between Feb and March 2024, there was a decline in IV ePMA administrations and an increase in PO ePMA administrations trust wide. The most notable change was within medicine, where IV ePMA administrations dropped by almost 30%. Data for 2024-25 will be reviewed to see if this improvement is maintained and whether hard stops for other agents can be safely considered.

2.3.10.5 Prescribing Audits – Health Groups

In 2023/24, each health group was audited once against the standards recommended nationally. Results showed improvements in prescribing as per HUTH guidance in all health groups. This was particularly noticeable since the introduction of MicroGuide (July 2022).

	Medicine	Surgery	Clinical Support	Family & Women's	Emergency Department
No of patients audited	147	123	35	25	80
Indication on drug chart	90%	75%	63%	82%	87.5%
Duration/ in-date review on drug chart	60%	45%	52%	61%	Not assessable
Prescribing appropriate (as per guidance or with documented Rationale)	70% ↑ (Baseline 62%)	78%↑ (Baseline 71%)	66%↑ (Baseline 51%)	72%↑ (Baseline 44%)	87.5%

2.3.10.6 National Point Prevalence Survey 2023

In Oct/Nov 2023 HUTH took part in the National Point Prevalence Survey (PPS) on Healthcare associated infections (HCAIs) and Antimicrobial Use (AMU). 1091 in-patients were included (755 at HRI, 336 at CHH). Overall, 34.5% of patients were on antimicrobials (33.1% at HRI, 37.5% at CHH). Usage trends showed the use of ACCESS agents to be 55%, WATCH 35% and RESERVE 10%. This differed from the annual breakdown, but as this survey only included inpatients, differences are to be expected. Prescribing in the survey was largely as per HUTH or national guidance, with compliance lower in medicine and surgical wards than reported in local audit. The top four agents used in HUTH during the survey were all ACCESS agents (compared to national data where the top two are both WATCH). Cefuroxime and piperacillin/tazobactam were our most frequently prescribed WATCH items (at 5th and 6th place respectively). Overall, the results of the PPS highlighted that prescribing was appropriate in ~75% of prescriptions for HUTH.

2.3.10.6 Antimicrobial Stewardship Action Plan and Key Priorities for HUTH 2024/25

The antimicrobial stewardship team request the support of the executive team to ensure the ongoing improvements in the use of antimicrobials. The suggested plan includes the following key points, but its success is mostly dependent on the buy-in of clinical teams which can be promoted by Antimicrobial Stewardship being seen as a clinical priority area.

1. Reduce broad spectrum/ restricted antibiotic (WATCH/ RESERVE classification) use and maximise appropriate use of these agents.
2. Reduce the amount of IV antibiotics prescribed and administered at HUTH
    a. Promote appropriate IV antibiotic initiation
    b. Promote timely IV to PO switches (IVOS)
3. Continued promotion and awareness of HUTH Antimicrobial Prescribing Guidance accessible via MicroGuide app and Bridget.

4. Promotion of principles of good anti-microbial prescribing. Follow recommendations in national strategy 'Start Smart then Focus'. Utilise resources (including digital) to encourage and facilitate good prescribing practices.
5. Promote and improve access to the COPAT (complex outpatient antibiotic therapy) service.
6. Monitoring of prescribing practices through audit and ward support.
7. Dissemination of information on prescribing usage, audit and prescribing concerns through the appropriate governance structures.
8. Restriction policies - promotion of the agents restricted for use within the trust and support pharmacy to manage appropriate supply.
9. Trust wide campaign on key antimicrobial stewardship priorities to coincide with World Antimicrobial Awareness Week In November.
10. Education programme to be agreed for all staff including medical, nursing and pharmacy staff.
11. Pursue the role of antimicrobial champions within clinical specialities that can link in with the wider anti-microbial stewardship (AMS) agenda and Advisory Committee on Antimicrobial Therapy (ACAT) team.
12. Quality improvement project work to support AMS.
13. Improve diagnostics in sepsis – in particular, target the improvements around the blood culture pathway.

2.3.11 SEPSIS

The Trust Sepsis service consists of 1PA of Infectious Diseases consultant time as the clinical lead for the service and 2 Sepsis specialist nurses. The Trust has a Sepsis Steering Group, which is held monthly and supported by the quality improvement team. A five-year Sepsis Strategy was developed in December 2021 with the aim of reducing sepsis mortality rates with key elements including audit & quality improvement projects, launch of a new sepsis pathway, training needs analysis and evidenced based educational package, prevention inclusive of outpatient follow up clinic. There are a number of quality improvements programmes inclusive of medical and nursing teams on sepsis throughout the Trust and a sepsis audit dashboard was launched to demonstrate compliance and highlighted areas of improvement inclusive of recognising sepsis in patients in ED and during an inpatient stay. The Trust sepsis action plan is appended.

2.4 LOCAL SERVICE IMPROVEMENTS

2.4.1 Infection prevention and control intranet page

Updated resources and reviewed, in date policies are available for staff to access.

2.4.2 Multi-drug resistant organism (CPE, VRE, MRSA) screening

Rapid diagnostics are utilised to support the timely identification of multi-drug resistant organisms, reducing the risk of onward transmission. Combine with improved initial patient assessment this aims to prevent outbreaks.

2.4.3 IPC Simulation training

The IPC have utilised the experience and expertise of the simulation team to introduce novel and innovative ways of training staff in IPC. This led to high satisfaction scores from those involved in the training. This method of education is resource intensive, although highly effective and resource to expand this programme would be greatly beneficial.

2.4.4 Patient Infection assessments

New nerve centre electronic patient assessment is in development and remains a key improvement priority.

2.4.5 FFP-3 mask fit testing service

During 2023-24 the IPCT continued to work alongside the Health & Safety team to ensure Trust employees required to wear a filtering face piece (FFP3 facemask) were provided with adequate training and fit testing. The Trust were successful in achieving the highest percentage of staff fit tested from the Trust across England during 2022-23 via Ashfield Healthcare commissioned by DOH, this free of charge support ended on the 31st March 2023. By Quarter 2 2023-24 this position had deteriorated because the Trust did not have a fit testing service. A business case was approved to recruit fit testers to the IPCT and during 2023-24 the team have prioritised staff in high risk areas and continue to deliver this required service across the Trust with fit testing available on both the HRI & CHH sites.

2.4.6 Blood culture pathway

The Microbiology laboratory has made changes to the capacity and access to the blood culture machines to enable 24 hour a day loading. Work has been undertaken with the sepsis and clinical teams to increase awareness of the requirements of the recommendations for blood culture collection. This has seen a significant improvement in the proportion of patients samples attaining the required standards, although there remains room for improvement.

2.5 CONCLUSION

IPC encompasses a huge variety of patient, environment and behavioural aspects that are vital to patient safety. Much of standard patient care undertaken throughout the Trust has implications for infection prevention, and as such this needs to be a priority area for all staff.

The Board is asked to accept this report, and review the recommendations for the following year for improvement.

4 RECOMMENDATIONS

1. *Improvements in the rates of MSSA BSIs and GNBSIs will need to be a priority for 2024-25. These are linked to significant morbidity, mortality and patient bed days and a proportion are preventable. This will require significant resource and multi-disciplinary working, with leadership from the senior management teams.*

2. *The Trust is the highest placer of vascular lines in the region and with it the increased risk of suboptimal management and ensuing line related infections – rationalising the use of IV access and improving care once lines are in situ must be a priority for 2024-25.*

3. *Review of the use of other medical devices, the association with healthcare acquired infections and ensuring best practice is maintained at all times. A particular focus on urinary catheters, their placement and care is recommended.*

4. *A focus on surgical care is suggested, due to concerns around surgical site infections. Clinical teams need to take ownership of patient outcomes associated with surgical site infections, supported by the multi-disciplinary team including IPC.*

5. *Support for raising awareness of the importance of antimicrobial stewardship in reducing anti-microbial resistance and complications such as C difficile, including introduction of mandatory training for all prescribers.*

6. *Support for improvement work to reduce the total amount and proportion of IV antibiotics used, which will bring substantial benefits for patients, reduced healthcare acquired infections and staff time savings*

7. *Improvements in patient hydration to ensure the risk of dehydration and subsequent sepsis needs to be a focus of work.*

8. *Continued focus on the identification of sepsis and prompt actions in order to positively impact on morbidity and mortality is an ongoing priority 2024-25*

9. *The identification and management of resistant infections with the propensity to cause outbreaks, including the completion of the rollout of CPE screening.*

10. *Implementation of the new Nerve centre infection assessment should be a priority – this will allow for early identification of patients at risk of contagious conditions or carriage of multi-drug resistant organisms and their appropriate managements, reducing the risk of outbreaks.*

11. *Support the work of the IPCT with capital and estates colleagues to prioritise improvements in the estate to maximise the patient environment with the focus on patient safety*

12. *The findings from the CQC inspection associated with suboptimal IPC practice need to remain a driver for improvement not only in the areas inspected but Trust-wide*

13. *Embedding learning from incidents involving HCAIs and outbreaks of infectious diseases*

14. *Ongoing utilisation of the national IPC BAF during 2024-25 as a means to provide assurance*

15. *Support to ensure that the Trust moves towards compliance with the national framework for IPC education and training, including the resources required to implement this.*

16. *Working alongside Northern Lincolnshire & Goole Hospitals NHS Foundation Trust, York and Scarborough Teaching Hospitals NHS Foundation Trust, Integrated Care Boards, NHS England, UKHSA and other system partners will continue during 2024-25*

17. *Review of the IPC team structure, meetings and governance structures to support the HHP.*

Greta Johnson, Director of Infection Prevention and Control
Dr Debbie Wearmouth, Infection control doctor.

5 APPENDIX

1 INFECTION PREVENTION & CONTROL ARRANGEMENTS

Greta Johnson is the Trust **Director of Infection Prevention and Control (DIPC)** and was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan during 2023-24. Jo Ledger, Acting Chief Nursing Officer, had executive responsibility for infection prevention and control during 2023-24. During 2023-24 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist. During 2022-23, additional recruitment for Infectious Diseases Consultants and a Consultant Microbiologist was made.

Infection prevention & control meetings are held to ensure the Trust remain compliant with the Health & Social Care Act (2008): code of practice on the prevention and control of infections. During 2023-24, **Strategic Infection Reduction Committee (SIRC)** continued to meet, in two formats - a business SIRC and a developmental SIRC meeting, meeting every other month respectively providing the opportunity to discuss key areas for improvement such as antimicrobial stewardship and managing gram negative blood stream infections (GNBSIs). SIRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing healthcare associated infections/ infectious diseases and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. Attendance by the senior HG representatives has been good, and most meetings were quorate with the exception of some medical directors.

The **Operational Infection Reduction Committee** (OIRC), continued to meet monthly. During 2023-24 this committee was chaired by the Infection Control Doctor. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate. The OIRC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, the Department of Infection, Occupational Health, the Estates & Facilities Directorate, and Pharmacy. It reports to the SIRC. The OIRC has responsibility for guiding infection prevention and control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to infection prevention and control and the decontamination of medical and surgical equipment.

Other relevant committees

The Trust has specific committees responsible for decontamination, ventilation safety and for water safety. These committees have representation on the Operational Infection Reduction Committee (OIRC), and report to SIRC. Attendance by the HG and departmental representatives has been good, and most meetings are quorate. The Water Safety Committee, which is a mandatory requirement, has seen ongoing good attendance from

departments and HGs. The Water Safety Committee benefitted from the continuation of input from an Authorising Engineer for water safety. A Trust wide Water Safety Plan is in place and monitored accordingly. Water safety issues are also reviewed regularly by both the SIRC and OIRC.

The Trust's designated Board level Decontamination Lead (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development supported by the Surgical Health Group Operations Director and Medical & Nursing Directors. The Trust Decontamination Committee met quarterly during 2023-24 and items for escalation were facilitated via OIRC and SIRC.

During 2023-24, the Trust Ventilation Safety Group continued to meet quarterly following specific guidance released by the Department of Health in 2021 (Health Technical Memorandum 03-01, HTM 03-01). The management of ventilation systems of a healthcare provider should be overseen by the Ventilation Safety Group (VSG). The Ventilation Safety Group benefits from the input from an Authorising Engineer for ventilation safety. Ventilation safety issues are escalated via OIRC and SIRC. A sub-optimal performance reporting procedure was developed and is now embedded alongside monthly ventilation subgroup meetings underpinned by a Trust Ventilation Policy and monitored through the relevant committees.

The formation of a Command Structure to support the Trust during peaks of infection and operational challenges with associated meetings such as operational weekend planning meetings has further supported the IPC with either the DIPC and/or ICD in attendance, to inform and advise.

The wider infection prevention and control team

The clinical IPC team is composed of an Infection Prevention and Control Doctor, a Senior Matron, an Operational Matron and specialist Infection Prevention and Control nurses and supporting secretarial and administrative staff. During 2023-24, members of the IPCT continue to be aligned to Health Groups to ensure in reach, education and support are provided to assist clinical teams with day-to-day management of patient care and maintaining a safe clinical environment.

Continuing to deliver an effective IPC proactive and reactive service continued during 2023-24 with support from the Consultant Microbiologist/ Infection Control Doctor, Infectious Diseases Consultants, Corporate Nursing team and site team. There is currently no system analyst, data manager, or epidemiological/ SSI surveillance support for the team.

The clinical IPC team work in unison with the wider **Department of Infection clinical team** inclusive of Consultant Infectious Disease physicians, Consultant Microbiologist, Virology Consultant Clinical Scientist and Clinical Scientists in Medical Microbiology. The nursing team consists of Specialist Nurses in HIV, viral hepatitis, sepsis and Outpatient Antibiotic Therapy (OPAT), as well as a team of ward-based nurses managing the infectious disease ward at Castle Hill Hospital (CHH), these individuals currently are managed by a Matron within the Support Services Division, Clinical Support Health Group.

In addition to the core clinical IPC team, an increasing number of other clinicians were recruited to support the Trust's efforts including the Quality Team and clinicians with a

special interest in the quality of care patients receive and delivering prudent infection prevention & control practice.

During 2023/24 the IPC team were successful in producing a business case to secure funding to provide a Trust wide fit testing service for healthcare workers across the Trust. The Trust had maintained fit testing previously via a nationally commissioned and delivered free of charge service via Ashfield Healthcare which was withdrawn when the contract ended. This resulted in a risk of staff not being adequately fit tested, a legal requirement under the Health & Safety at Work Act (1974). Although funding was initially fixed term this was extended and made permanent providing the opportunity to recruit trained professionals to deliver a fit testing service at both HRI and CHH.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Education is facilitated by the Infection Prevention and Control Team (IPCT) and Link Practitioners continued to be supported by the IPCT to be proactive in implementing guidance and maintaining IPC standards in their workplace.

Access to infection prevention and control information can also be obtained from the Trust Pattie page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required. In addition, a global IPC team email address remained available for staff to access and email the team with queries, concerns and/or requests for advice or assistance.

2 DEFINITIONS OF HEALTH CARE ACQUIRED INFECTIONS

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)

- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)

- community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)

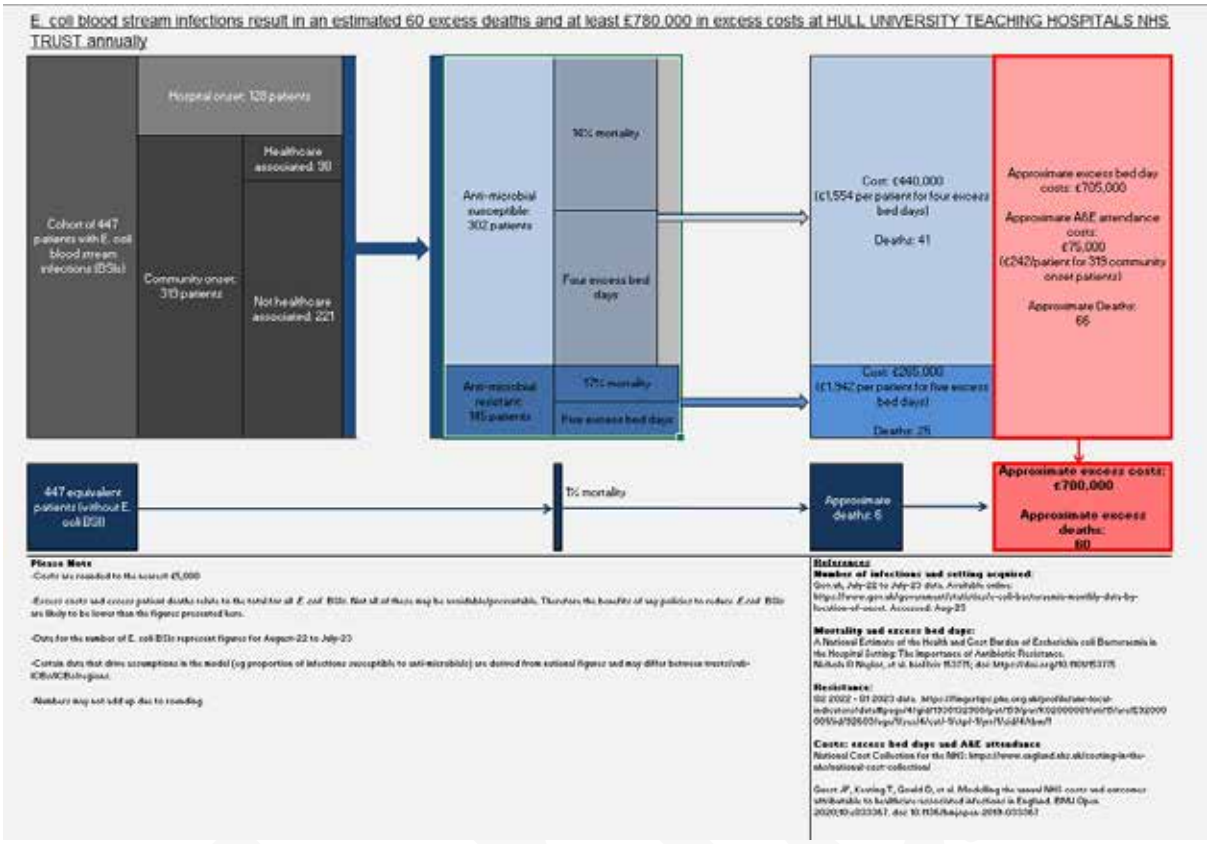
- community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA)

Acute provider objectives via NHS Standard Contract 2022/23 were published for 2022-23 on the 26th May 2023 and data was collected utilising these two categories:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission

- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

3 Organisational level impact of E coli BSI: Mortality and excess cost analysis (2022-23 data)



4 SEPSIS IMPROVEMENT ACTION PLAN

Area for Improvement	Clinical areas & action taken	Current status
Sepsis Recognition:	HUTH-wide Electronic sepsis pathway (Led by Sepsis Team)	Launched January 2023. Revision submitted June 2023 Digital work progressing. Expected re-launch due March 2024 Launch may be delayed due to new 2024 guidelines with new red/amber flags
Sepsis prevention/ reduction of mortality rates/ prevention of re-admission	HUTH-wide (Lead by The Sepsis Team) Mandated sepsis E-learning for all staff members, including non-clinical and non-patient facing	Proposal submitted, awaiting response, awaiting response to be mandated May be delayed due to new 2024 guidelines with new red/amber flags
	HUTH-wide (Led by The Sepsis Team) Post-sepsis follow-up clinics: Explanation of sepsis related to the patients case, assessment for post-sepsis syndrome (self-help books provided), encourage vaccinations, safety netting with signs & symptoms, and sign-posting for health promotion and social support.	Friends and family survey requested - unable to send via text currently Patient experience survey approved. Data collection to start March 2024
	ED (Led by Donna Gotts -Sepsis Nurse) Aim: All patients with infection, but low risk for sepsis to receive safety netting information at the point of discharge.	Safety netting leaflet requires approval.
Patient monitoring:	HUTH-wide • Escalated to Nursing Workforce Committee • Sepsis Team to provide Divisional 3-monthly reports to Governance meetings	Dashboard updated- ready to write reports
Monitoring, escalation of the deteriorating patient and sepsis recognition:	Mandated NUTS-S training for all nurses in acute/ high risk areas, annually (Led by Donna Gotts- Sepsis Nurse & Dr Eirini Kasfiki)	Proposal submitted, awaiting response
	HUTH-wide Sepsis e-learning for all HUTH staff (Led by Sepsis Team)	Proposal submitted, funding approved, awaiting response to be mandated Launch may be delayed due to new 2024 guidelines with new red/amber flags
	AAU QIP: escalation of deteriorating patients (Led by Dr Eirini Kasfiki) NUTS-S training, simulation training, posters	Improvement seen following NUTS-S training, but not sustained. Proposal for NUTS-S to be mandated annually for all nurses in acute/high risk areas- awaiting approval from Nursing Workforce Committee
	C7 (Infectious Diseases Ward): escalation of deteriorating patient (Led by Laura Davis- Sepsis Nurse)	Planning stage. Currently auditing compliance & performing staff surveys
	Cardio-thoracic surgery: escalation of deteriorating patient	Scoping phase: audit
	Oncology & Haematology Department (C29, C30, C31, C32, C33, CCAU): sepsis recognition, escalation of deteriorating patient (Lead by Laura Davis- Sepsis Nurse & Gemma Haire- Quality & Safety Manager for Support Services)	All nurses planned for NUTS-S training within 1-2 years
Investigations to determine the source of infection:	ED (Lead by Austin Smithies)	Planning phase
	HUTH-wide/Microbiology (lead by Philippa Burns & Debbie Wearmouth) Reducing the number of rejected samples due to insufficient clinical details provided in sample request. Action taken November 2023: Order form amended with prompts for relevant clinical details	Awaiting data to evaluate effect

Area for Improvement	Clinical areas & action taken	Current status
Improving IV antibiotic administration times:	ED (Lead by Dr Austin Smithies) Implementation of escalation/safety nurses & Drs, part time sepsis nurse, launch of high acuity bay	Significant improvement seen in response to actions. Unable to maintain sufficient staffing to reliably continue with safety nurses/ doctors. Funding withdrawn for sepsis nurse. Improvement not sustained. See BI dashboard for full results.
	AAU (Lead by Laura Davis- Sepsis Nurse) April- June 2023- 1st PDSA cycle: Introduction of white boards for communication between doctors and nurses December 2023- current- 2nd PDSA cycle: improved communication about the use of white boards, with intervention added to induction training	1st PDSA cycle showed significant improvement but was not sustained after the junior doctors rotation. 2nd PDSA cycle: significant improvement 3rd cycle commenced: presentation to Steering Committee, April 2023?
	Oncology & Haematology Department (CCAU, C29, C30, C31, C32, C33) (Led by Laura Davis- Sepsis Nurse & Gemma Haire- Quality & Safety manager)	Planning phase Departmental process mapping and solutions workshop complete- Feb 2024
	H6/60 General Surgery (Lead by Laura Davis- Sepsis Nurse)	Planning phase
Improving Patient Experience & Education	HJTH-wide (Led by Laura Davis) Patient Information leaflet revised. Plans to attach information leaflet electronically to IDL	Leaflet approved February 2024. IT have approved project- waiting to discuss logistics
Sepsis Recognition & compliance with guidance in Paediatrics	Paediatrics ED & wards: Requires Consultant Lead, audit, pathway and policy.	Consultant Lead: Dr Simon Richardson (ED) & ? Dr Sanjay Gupta for Paediatrics Audit and pathways submitted for approval. Dr Richardson to Lead on audit and QIP

References

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

INFECTION PREVENTION & CONTROL TEAM ANNUAL REPORT TO THE DIRECTOR OF INFECTION PREVENTION & CONTROL

2023-24

Written by

Wendy Millard

Deputy Director of Infection Prevention & Control

Contents:

Table and Figures

Executive Summary

This report is a record of activities relating to the prevention and control of healthcare associated infection (HCAI) in Northern Lincolnshire and Goole NHS Foundation Trust during the year April 2023 to March 2024.

The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance and Care Quality Committee (CQC) regulations requires that the Board of Directors have a Board-level agreement outlining the Boards' collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks. A requirement of the Act is the production of a Director of Infection Prevention & Control Annual Report.
This annual report provides an overview of the work done with respect to all aspects of IPC within the Trust and in accordance with the Infection Prevention and Control Board Assurance Framework (IPC BAF) during the financial year 2023-24.

The winter months were a substantial challenge and significant strain on the IPC team compounded by a demanding on call rota.

Despite this, business as usual continued with full completion of the audit and surveillance IPC programme with focus on continuing the work around nosocomial infections, invasive devices, and antimicrobial stewardship.

Overall, there have been several achievements in the past twelve months, which include:

Performance

- The IPC Team worked closely with Operations to navigate The Trust through the COVID-19 pandemic, and during this report specific period, managed the relaxation of the COVID restrictions and allowing more normal hospital functioning.
- Supported The Trust in achieving very good performance of alert organism case thresholds regionally and nationally.
- 100% compliance with IPC Strategy
- There were no lapses/care associated with C. difficile infection from cases reviewed.
- Gram negative blood stream infections which remain a challenge, however we have achieved good performance in E. coli bacteraemia cases compared to our peers.
- Use of medical devices such as PVC and urinary catheters remains broadly the same.
- Antimicrobial usage
- Continuation of the IPC newsletter produced.
- Completed HCAI and AMU PPS national audit.

Governance

- IPC data reviewed and challenged at the Nursing Metrics Board
- Continued use of systems using Power BI to feedback ward / dept performance against KPIs.
- Undertook the Infection prevention and control board assurance framework assessment on the latest versions which showed overall good compliance.
- Undertaken point prevalence surveillance across acute adult wards 6 monthly.
- The Infection Prevention & Control committee continued to meet.

Areas for further improvement and support include:

There remain several challenges for the Trust that needs to be considered going forward.

As part of the estate's strategy, future build projects/upgrade plans continue to take into consideration the IPC requirements including enhanced ventilation, oxygen demands and isolation capacity. This will help the Trust prepare for future infection challenges. Adequate mechanical ventilation is now seen as being essential to help mitigate the risk of airborne pathogens to help protect staff and patients and not solely rely on the use of PPE. This is critical within areas that are undertaking AGPs such as respiratory wards and critical care settings. Currently we do not have this functionality widespread within the Trust as such have relied on the purchase of HEPA filtration units. However, the opening of the new Emergency Departments (ED's) at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPOW) provides excellent ventilation, spacious waiting areas and isolation facilities.

The lack of single rooms across the trust have partly been addressed however Scunthorpe General Hospital (SGH) continues to be a challenge due to the historic closure of the Coronation wards and loss of 11 single rooms. The opening of ward 25, SGH which has 14 single rooms has helped address the imbalance. Redirooms are used to maximise isolation facilities.

There is no High Dependency Unit (HDU) at SGH which causes issues when there needs to be escalation of respiratory patients, especially if no capacity on ICU to manage patients. The HDU at Diana Princess of Wales Hospital (DPOW) is also not currently fit for purpose due to only having x1 single room, which has posed a challenge again this year with surges of COVID-19, other respiratory illness, example Influenza as well as Norovirus. The physical layout of this unit is not conducive to segregate of staff.

There continues to be a lack of Consultant Medical Microbiologists onsite 5 days a week, with DPOW having no one on site.

A Lead for FIT Testing needs to be established.

Historically the deep clean schedule has unfortunately been subjected to operational pressures and as such frequently cancelled. The setting up of a Deep Clean Compliance Group should enable significant improvement going forward.

Currently there is no enhanced cleaning system used in the Trust, the purchasing/renting of a system i.e., UV needs to be addressed.

Introduction

This report is a record of activities relating to prevention and control of healthcare associated infection (HCAI) in North Lincolnshire & Goole Hospitals NHS Foundation Trust during the year April 2023 to March 2024. Healthcare associated infection remains a top priority for the public, patients and staff and remains one of the Trust's strategic objectives 'to provide treatment, care and support which is as safe, clinically effective, and timely as possible'. Avoidable infections are not only potentially devastating for patients and healthcare staff, but they also consume valuable healthcare resources and impact on antimicrobial resistance pressure. Investment in infection prevention and control remains both necessary and cost effective.

The purpose of this report is to inform patients, public, staff, the Trust Board of Directors, Council of Governors and Integrated Care Board (ICB) of the infection prevention and control work undertaken in 2023-24 and provides assurance that the Trust remains compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and other related guidance e.g. IPC COVID-19 Board Assurance Framework (Department of Health, 2015). This report is structured using the criteria in the Health and Social Care Act 2008 – Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance which sets out the criteria against which a registered provider's compliance with requirements relating to cleanliness and infection control will be assessed by the Care Quality Commission (CQC).

Effective infection prevention & control is fundamental to the delivery of high quality, safe and effective patient care. This remains a significant priority for the Trust with an objective for engagement and ownership of infection prevention & control throughout the organisation at all levels from ward to board.

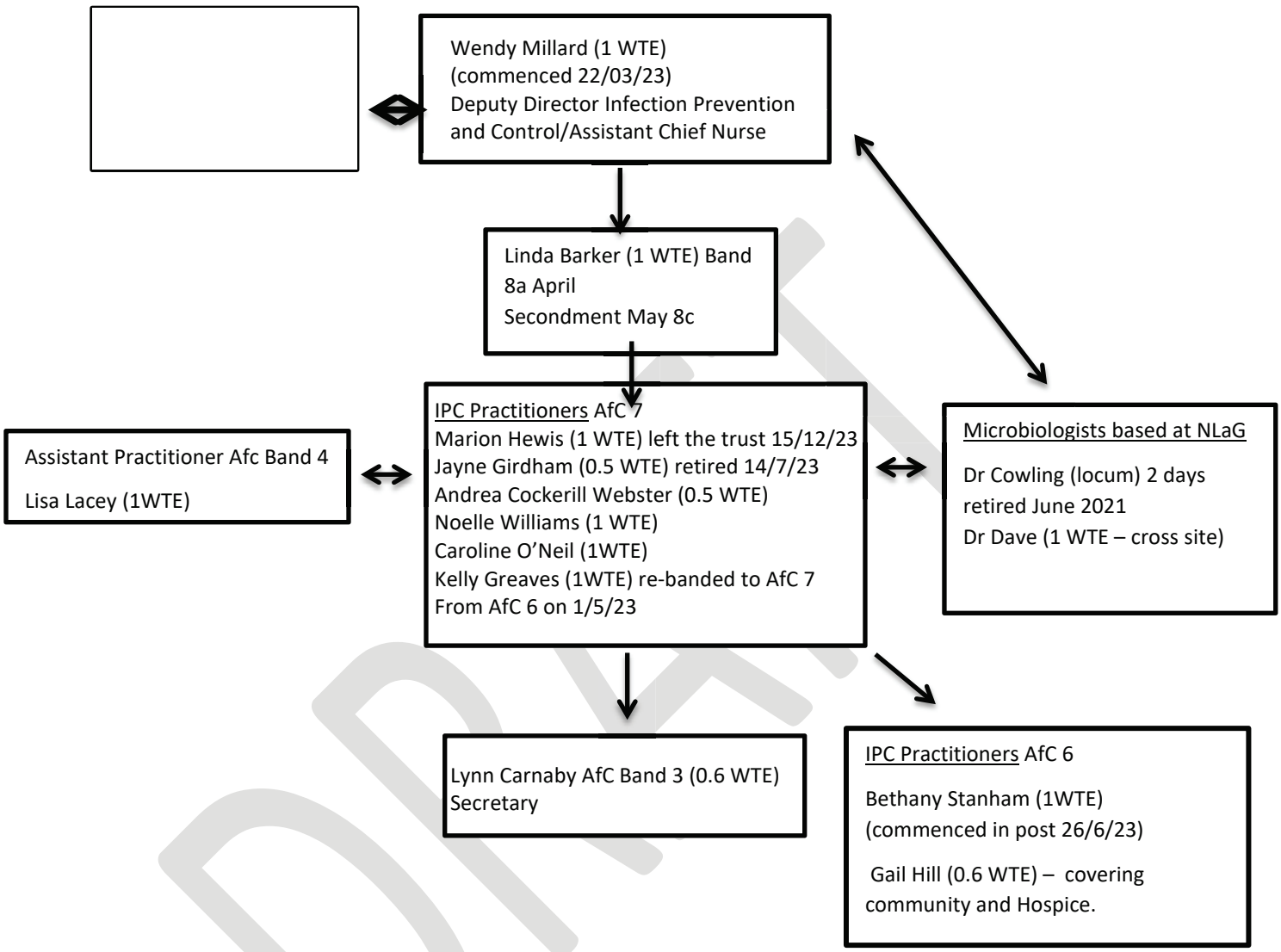
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Infection Prevention and Control Workforce arrangements

The Trust's arrangements for the prevention and control of infection are contained within the document, *Infection Prevention & Control Strategy: Overview of the Trust Approach and Arrangements for Infection Prevention & Control* [IC/SP3], which is held by the Directorate of Governance & Assurance/Trust Secretary. This document details the responsibilities of various parties within the organisation and their governance and management arrangements. While the Chief Executive has the final responsibility for all aspects of infection control, the functional responsibility lies with the Director of Infection Prevention and Control (DIPC) who was the Director of Nursing until the partnership evolving. The deputy DIPC for IPC oversees the day-to-day activities of the IPC team and delivery of the IPC Strategy and incorporating the Board Assurance Framework (BAF) and annual work plan.

The number of consultant microbiologists available within PathLinks to provide on-site presence continues to be a challenge. The use of virtual meetings has helped to mitigate some of these issues. The limited availability of onsite consultant microbiologists has severely stretched the amount of ward rounds undertaken. A weekly Trust wide antimicrobial stewardship round is undertaken by the consultant antimicrobial pharmacist and consultant medical microbiologist on the SGH site which has been well received by colleagues. However, the Antimicrobial Pharmacist post is currently vacant with a suitable person being successfully appointed and to commence post in September.

Infection Prevention & Control Team at March 2024



The infection control service is provided 7 days a week with an on- call service available to cover the weekends and Bank holiday periods. All nurses who provide on call advice service have completed a programme of study and are experienced infection prevention and control specialists. There is also 24/7 consultant medical microbiologist cover through Path Links. An opportunity arose allowing review of the team structure and succession planning the overall team structure to be reviewed, culminating in the promotion of a band 6 to band 7 and the recruitment of a full time Band 6 Infection Control Nurse. The team continues a service level agreement to provide cover to the local hospice unit in Scunthorpe.

Infection Prevention & Control Committee

The IPC committee oversees and directs all infection prevention and control activity in the Trust, is responsible for ensuring appropriate implementation of national guidance and that infection prevention and control policies are in place, regularly reviewed and compliance audited.

The annual infection prevention & control programme and IPC strategy are endorsed by the Infection Prevention & Control Committee and updates are received on a periodic basis. The committee membership includes representatives from Occupational Health (co-opted), Consultant Microbiologist, Senior Infection Prevention and Control nurses, senior divisional nurses or representatives, Consultant Antimicrobials Pharmacist, ICB representatives, Estates / facilities, nominated deputy for medical director and others co-opted as required.

Surveillance of Healthcare Associated Infection

One of the main elements of Infection Prevention and Control workstream is undertaking active surveillance. Surveillance is more than just the recording or reporting of infections. Data is collected in accordance with strict definitions and protocols to ensure consistency. Some surveillance data are only reported internally, and other data are reported externally either as part of mandatory or voluntary surveillance schemes. However, the most important element of surveillance is feedback to clinicians in a timely manner. Feedback prompts review of, and where necessary, planned improvements to clinical practice. There are a number of mandatory surveillance activities that are routinely undertaken to meet UKHSA Mandatory Surveillance team requirements, and this is growing year on year with increasing demands on the team and information team.

MRSA Bacteraemia

Nationally, there remains a zero tolerance for preventable MRSA bacteraemia cases. Thus, once again the Trust had a trajectory of zero avoidable hospital-acquired cases. There has been 3 MRSA hospital acquired cases at NLAG. 2 cases were assigned to Scunthorpe and 1 case to Diana Princess of Wales. A Post Infection Review Process deemed 1 case non-preventable and 2 of the cases preventable, with the root cause being peripheral cannula related. An action plan and learn lessons is in place.

TABLE 1 MRSA BACTERAEMIA CASES

Year	Total
2018/2019	2
2019/2020	7
2020/2021	1
2021-2022	0
2022-2023	1
2023-2024	3

Clostridioides difficile (formerly known as Clostridium difficile) Infections

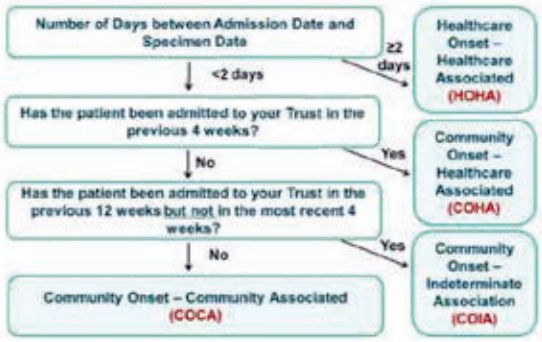
Clostridioides difficile infection (CDI) remains an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups especially those who have been exposed to antibiotic treatment. *Clostridioides difficile* is a bacterium that releases a toxin which causes colitis (inflammation of the colon), and symptoms range from mild diarrhoea to life threatening disease. Asymptomatic carriage also occurs. Infection is often associated with healthcare, particularly the use of antibiotics which can upset the bacterial balance in the bowel that normally protects against *C. difficile* infection. Infection may be acquired in the community or hospital, but symptomatic patients in hospital may be a source of infection for others.

The *C.difficile* objective guidance continued the use of lapse in care as a performance indicator. A lapse in care would be indicated by evidence that policies and procedures consistent with local guidance or best practice were not followed. There was also a change four years ago in the classification of a healthcare onset or community onset case. This reduced the number of days to identify hospital onset healthcare associated (HOHA) cases from ≥3 to ≥2 days after admission. The introduction of the Community Onset Healthcare Associated (COHA) category also will assign cases to the Trust where the patient has been an inpatient in the trust reporting the case in the previous four weeks. In 2023/24 the Trust has been allocated a trajectory of no more than 20 cases combining the HOHA and COHA.

FIGURE 1 BREAKDOWN OF C.DIFFICILE CASES BY DIVISIONS

C. difficile cases by Site, Division and Ward

Financial Year	2023/24												Total
Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	
⊟ DPOW	0	1	0	1	3	0	1	1	0	0	0	0	7	7
⊞ Medicine	0	1	0	1	2	0	1	0	0	0	0	0	5	5
⊟ Surgery & Critical Care	0	0	0	0	1	0	0	1	0	0	0	0	2	2
High Dependency Unit	0	0	0	0	0	0	0	1	0	0	0	0	1	1
Ward B2	0	0	0	0	1	0	0	0	0	0	0	0	1	1
⊟ NELCCG	0	0	0	0	0	0	0	1	0	0	0	0	1	1
⊞ Medicine	0	0	0	0	0	0	0	1	0	0	0	0	1	1
⊟ SGH	0	1	1	2	0	0	1	1	0	2	1	1	10	10
⊞ Medicine	0	1	0	2	0	0	1	0	0	2	1	1	8	8
⊞ Surgery & Critical Care	0	0	1	0	0	0	0	1	0	0	0	0	2	2
Total	0	2	1	3	3	0	2	3	0	2	1	1	18	18



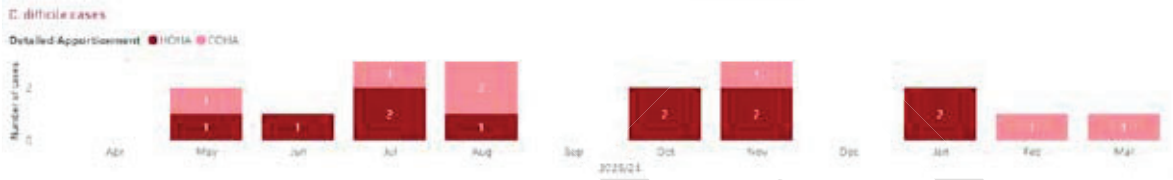
The trust had a CDI objective of no more than 20 cases and ended the year on 18 reported cases. There were no significant lapses in practice / care detected from the Post Infection Reviews undertaken with the main issues around antimicrobial prescribing, and previous CDI.

The SGH site had 10 cases, Goole & District Hospital (GDH) 0 cases and DPOW 8 cases which is a significant improvement from the previous year. There have continued to be a number of ward moves during the last 12 months for a variety of reasons which makes identification of any links and determining a local prevalence rate very difficult. The IPC team routinely submit positive stool samples for ribotyping to the reference laboratory to

help establish the presence of virulent strains of C. difficile and also monitor if there is a possible relationship between cases. It was pleasing to report there were no clusters or outbreaks of C. difficile infection. Overall, the trust is performing well compared to Yorkshire & Humber data for CDI rates in patients over 2 years of age and has been rated as the top three performing Trust in the country.

Highest/Lowest Performing Trust's *	C. difficile 12 Month Rolling Rate
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3.63
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	9.20
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	10.84
WEST SUFFOLK NHS FOUNDATION TRUST	64.73
THE ROYAL MARSDEN NHS FOUNDATION TRUST	75.48
THE CHRISTIE NHS FOUNDATION TRUST	91.22

FIGURE 2 NUMBER OF C. *DIFFICILE* CASES BY MONTH AND ALLOCATION.



Post Infection Review

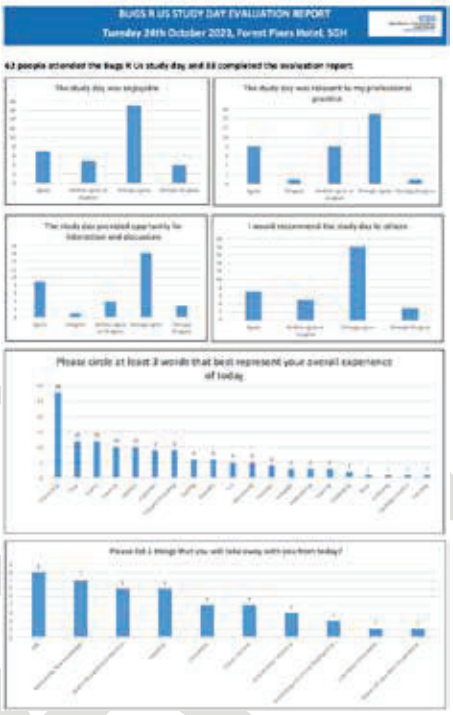
Following a case of Healthcare Onset Healthcare associated C. *difficile* infection a PIR is undertaken with relevant clinical staff to ascertain if there have been any deviations from best practice. During 2023/24 a thorough review of each case was held and they were deemed no lapses in care.

Some of the initiatives introduced to reduce the risk of nosocomial infections

Link Practitioner Meetings 2023 	The Infection Prevention & Control Team held Link Practitioner Meetings in November 2023 on all sites (name changed to Link Champion) including Community, items on the agenda included: • Alert Organisms • Patient Screening – using the IPC Tool – case studies/swabbing/requesting/testing/results • MRSA including decolonisation introducing Prontoderm • Cleaning – What is it? • Flushed away – What is it? • Reducing Reconditioning
Bugs R Us 24th October 2023 	For the first time since the pandemic The Infection Prevention & Control Team (IPC) held their Bugs "R" Us Conference on the 24th of October 2023. The event themed 'After the Pandemic – Our New World' was held at The Conference Centre, Forest Pines Hotel. Speakers included David Charlesworth from NHS England and Rebecca Greenwood from The Yorkshire and Humber Health Protection Team as well as NLAG staff and included insights into specific infections and tips on prevention, antimicrobial resistance and even a treasure Hunt.

The day was very well attended, and delegates also enjoyed meeting a number of company reps who provided a wealth of information on their stands.

Bugs R Us Evaluation Report for information:

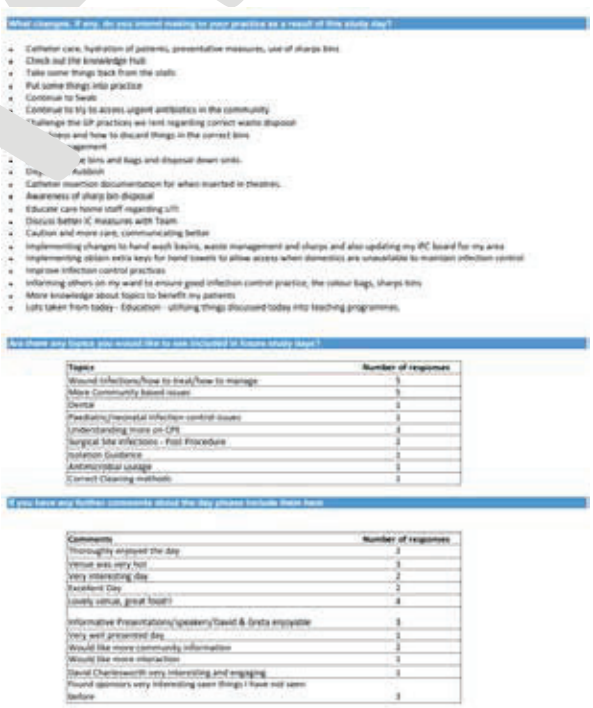

BUGS R US STUDY DAY EVALUATION REPORT

Tuesday 24th October 2023, Forest Pines Hotel, SO51

63 people attended the Bugs R Us study day, and 33 completed the evaluation report.

Please circle at least 3 words that best represent your overall experience of today

Please list 3 things that you will take away with you from today?


What changes, if any, do you intend making to your practice as a result of the study day?

- Catheter care, hydration of patients, preventative measures, use of sharps bins
- Check out the knowledge Hub
- Take some things back from the stalls
- Put some things into practice
- Continue to Swab
- Continue to try to access urgent antibiotics in the community
- Challenge the GP practices we rant regarding correct waste disposal
- ...ways and how to discard things in the correct bins
- ...agement
- ...e bins and bags and disposal down sinks.
- Dis... Audibon
- Catheter insertion documentation for when inserted in theatres.
- Awareness of sharp bin disposal
- Educate care home staff regarding u/ti
- Discuss better IC measures with Team
- Caution and more care, communicating better
- Implementing changes to hand wash basins, waste management and sharps and also updating my IPC board for my area
- Implementing obtain extra keys for hand towels to allow access when domestics are unavailable to maintain infection control
- Improve infection control practices
- Informing others on my ward to ensure good infection control practice, the colour bags, sharps bins
- More knowledge about topics to benefit my patients
- Lots taken from today - Education - utilising things discussed today into teaching programmes.

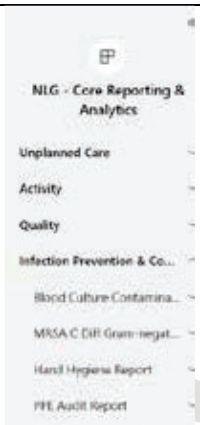
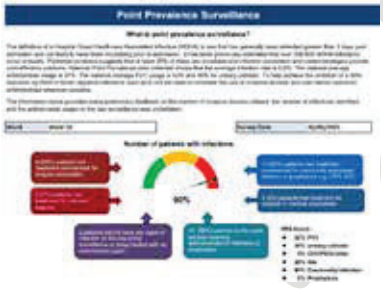
Are there any topics you would like to see included in future study days?

Topic	Number of responses
Wound Infections/how to treat/how to manage	5
More Community based issues	5
Dental	1
Paediatric/neonatal infection control issues	1
Understanding more on CPE	1
Surgical Site Infections - Post Procedure	1
Isolation Guidance	1
Antimicrobial useage	1
Correct Cleaning methods	1

If you have any further comments about the day please include them here

Comments	Number of responses
Thoroughly enjoyed the day	3
Venue was very hot	1
Very interesting day	2
Excellent Day	2
Lovely venue, great food!!	4
Informative Presentations/speakers/David & Greta enjoyable	1
Very well presented day	1
Would like more community information	1
Would like more interaction	1
David Charlesworth very interesting and engaging	1
Found sponsors very interesting seen things I have not seen before	1

Hand Hygiene Roadshow May 2023   	The Infection Prevention & Control Team visited all ward areas on all three sites and including Community Areas, for World Hand Hygiene Day on the 5th May 2023, with quizzes, and competitions.   The Infection Prevention and Control team also invited staff to get creative and enter our Hand Hygiene Poster Competition for World Hand Hygiene Day. 
Ward Board – July 2023 	The Infection Prevention & Control Team review the ward boards for staff information on a 6 monthly basis, the topics covered for the July 2023 ward board was: • Cannula Care • Catheter Care • Enteral Feeding

Winter Ward Boards – December 2023 	The Infection Prevention & Control Team review the ward boards for staff information on a 6 monthly basis, the topics covered for the December 2023 ward board was: • Influenza • Covid-19 • CPE/VRE
	The implementation of bespoke audits to help ensure best practice was in place during the pandemic – including PPE and IPC Board assurance audits with dashboards for staff. Infection Prevention and Control Power BI App. The reports have been updated and include data includes incidence per 1000 bed days. NLG-Core Reporting and Analytics
	Point prevalence surveillance continues to be undertaken twice a year to monitor invasive device usage and antimicrobial adherence to Start Smart and Focus. The results are emailed to ward managers and Matrons once completed to close of any issues identified. The use of urinary catheters has increased slightly and will form part of an improvement project going forward.

Staphylococcus aureus bacteraemia

Staphylococcus aureus is a bacterium commonly found colonising the skin and mucous membranes of the nose and throat. Although approximately a quarter of the population carry this organism harmlessly, it can cause a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome. In hospitals, it can cause surgical wound infections and bloodstream infections. When *Staphylococcus aureus* is found in the bloodstream it is referred to as a *Staphylococcus aureus* bacteraemia. The

reporting of Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia's became mandatory from January 2011. Prior to that only voluntarily collected data was available.

The number of trust apportioned MSSA bacteraemia's detected during the current year is shown in Figure 6. The definition of Trust-Acquired vs Community-Acquired is based on the positive blood culture sample being collected on or after the 3rd day of admission. All actions taken to minimise MRSA bacteraemia's will have the

effect of minimising MSSA bacteraemia's. The number of cases detected deemed healthcare acquired compared to the previous year have generally remained static. The majority of MSSA bacteraemia cases are detected within 2 days of admission and in many cases the source is not always obvious despite a review by the IPC team. There are many causes for MSSA infections and there are generally no obvious trends at present. Most cases have been detected within medical wards, however with the frequent reconfiguration of wards and bed pressures the specialty of the patient cannot be taken for granted.

Gram negative blood stream infections (GNBSIs)

UKSHA and NHS England required NHS Trusts to continue to report bloodstream infections relating to E coli, Klebsiella species and Pseudomonas aeruginosa (P. aeruginosa) throughout the operational period of 1st April to 31st March 2024.

On the 26th of May 2023 NHS England published NHS Standard Contract 2023/24 – Minimising Clostridioides Difficile and Gram-negative bloodstream infections. Trusts were required under the standard contract to minimise rates of both C.difficile and Gram-negative bloodstream infections so that the hospital onset Healthcare Acquired (HOHA) and the Community onset Healthcare acquired (COHA) cases are no higher than the threshold levels set by NHS England. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 50% reduction by 2024-2025 inclusive of the GNBSIs described.

Locally the number of E. coli bacteraemia cases remains a significant burden for patients. The number of E. coli blood stream infections detected after day 2 of admission has improved from 65 to 59 against a threshold of 46. The number of cases detected is very dependent on the presenting patient condition and timeliness of the blood culture. There was no seasonal variation identified within the operational year. Previously more cases have been recorded during the spring and summer period and have been linked with urogenital issues exacerbated by dehydration. As seen most blood stream infections detected are within 2 days of admission, many of the required interventions will require a health economy approach if a long-lasting reduction is to be made. Due to the age profile of most cases a significant number will have numerous co-morbidities and risk factors e.g., dementia, increasing their risk of infection. Therefore, measures such as hydration, removal of urinary catheters, appropriate diagnosis and treatment of urinary tract infections and improved surgical management are some of the key priorities to tackle this burden. These are key priorities for 2024-25. This will not only improve patient outcomes significantly with reduced morbidity and mortality from sepsis but also the

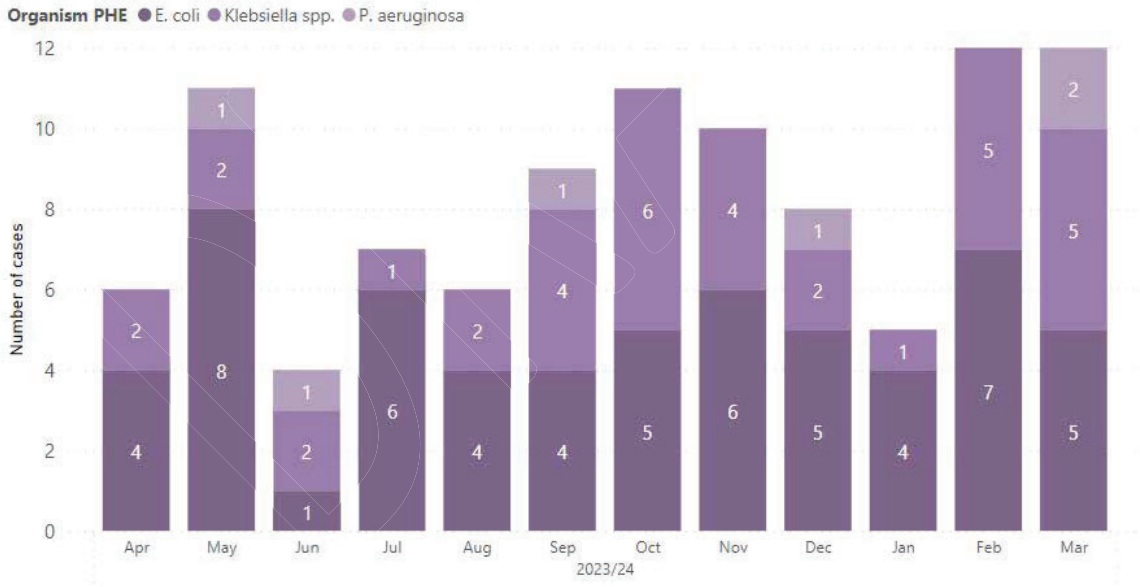
substantive cost savings in terms of emergency admissions, excess bed days and the requirement of antimicrobial treatments.

TABLE 2 TRUST APPORTIONED GRAM-NEGATIVE CASES

E. coli bacteraemia cases by Site, Division and Ward

Financial Year	2023/24													Total
Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	
⊟ DPOW	1	6	1	4	0	2	2	2	4	2	3	1	28	28
⊞ Family Services	0	0	0	0	0	0	0	0	1	0	0	0	1	1
⊞ Medicine	1	5	1	4	0	2	1	2	3	1	2	1	23	23
⊞ Surgery & Critical Care	0	1	0	0	0	0	1	0	0	1	1	0	4	4
⊟ GDH	1	1	0	1	1	1	1	0	1	0	0	0	7	7
⊞ Medicine	1	1	0	0	1	1	1	0	1	0	0	0	6	6
⊞ Surgery & Critical Care	0	0	0	1	0	0	0	0	0	0	0	0	1	1
⊟ SGH	2	1	0	1	3	1	2	4	0	2	4	4	24	24
⊞ Family Services	0	1	0	0	0	0	0	0	0	0	0	0	1	1
⊞ Medicine	1	0	0	1	1	0	2	4	0	1	1	2	13	13
⊞ Surgery & Critical Care	1	0	0	0	2	1	0	0	0	1	3	2	10	10
Total	4	8	1	6	4	4	5	6	5	4	7	5	59	59

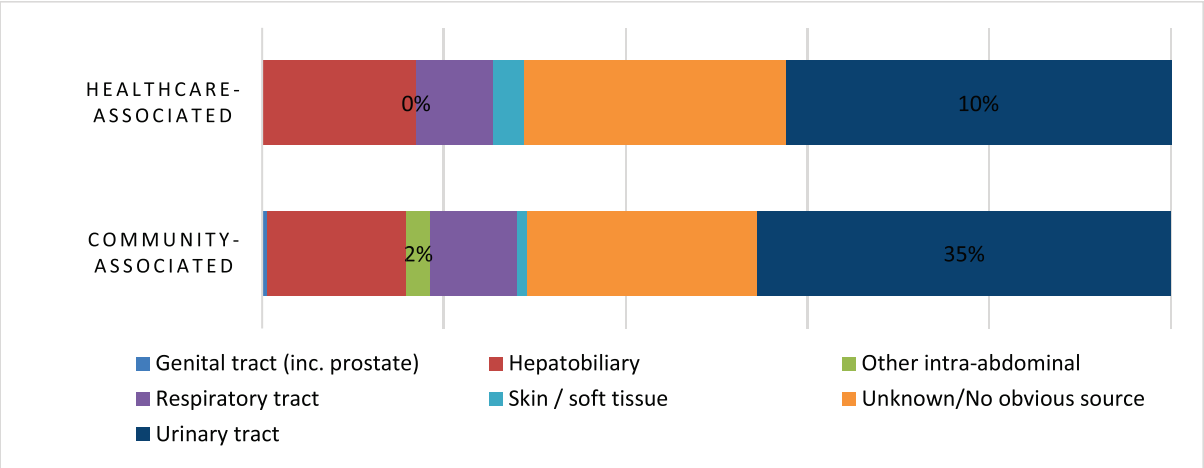
FIGURE 3 TRUST APPORTIONED GRAM-NEGATIVE CASES



Examination of the main source of E.coli infection locally in the stack chart would suggest the urinary system and hepatobiliary are the main predisposing risk factors and this is where targeted interventions are to be directed e.g. avoid / removal of urinary catheters, streamlined surgical pathways. The national picture is not too dismilar to our local position.

As a trust our rate of E.coli bacteraemia is better than comparible trusts however we always strive for improvement in reducing the number of cases.

FIGURE 4 COMMON CAUSES OF E. COLI BACTERAEMIA IN CASES DETECTED IN NLAG



In addition to E. coli the Trust reports the number of Klebsiella and Pseudomonas aeruginosa blood stream infections.

Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. P. aeruginosa is an opportunistic pathogen and it rarely affects healthy individuals. It can cause a wide range of infections, particularly in those with a weakened immune system. These infections are sometimes associated with contact with contaminated water. In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and catheters. P. aeruginosa is resistant to many commonly used antibiotics.

The trust detected 6 Healthcare Onset against a threshold of 7 of Pseudomonas aeruginosa, which was a reduction of 9 from the previous year. The infections were associated with hospital, community and or ventilator associated pneumonia, and skin and soft tissue infections. There were no reported outbreaks of Pseudomonas aeruginosa blood stream infections throughout the operational reporting period.

Klebsiella species belong to the family Enterobacteriaceae. Klebsiella species are a type of gram-negative rod shaped bacteria that are found everywhere in the environment and also in the human intestinal tract (where they do not cause disease). Within the genus Klebsiella, 2 common species are associated with most human infections: Klebsiella pneumoniae and Klebsiella oxytoca. Both species are commonly associated with a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

In healthcare settings, Klebsiella infections are acquired endogenously (from the patient's own gut flora) or exogenously from the healthcare environment. Patient to patient spread can occur via contaminated hands of healthcare workers or less commonly by contamination of the environment. There were 36 Healthcare Onset of Klebsiella, which is an increase of 13 to the previous year.

Surgical Site Infection Surveillance

The Department of Health introduced mandatory surveillance of certain categories of surgery in 2004. It is a requirement that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period (3 months) in the financial year. The categories are:

- hip replacements
- knee replacements
- repair of neck of femur
- reduction of long bone fracture

The Infection Prevention and Control team in conjunction with our orthopaedic colleagues undertake continuous surveillance of primary total hips (THR) and primary total knee (TKR) at DPOW and GDH hospital sites.

TABLE 3 ORTHOPAEDIC HIP AND KNEE REPLACEMENT INFECTION RATES - APRIL 2023 - MARCH 2024

	All Hospitals	Grimsby			Goole		
	National Rate	No. Operations	No. Infections	% Infection	No. Operations	No. Infections	% Infection
Hip Replacement	0.5%	231	0	0.0%	167	0	0.0%
Knee Replacement	0.4%	263	1	0.38%	220	1	0.45%

Overall, the infection rates remain within normal parameters. However it has now been identified that there have been some gaps in the surveillance which is currently under review to improve and enable the Trust to provide increased accuracy to the data recorded. The one SSI detected found no lapses in care or practice and the organism detected was Enterococcus Faecalis and MSSA. Elective orthopaedic procedures take place on both the Goole and Diana Princess of Wales site. Theatre IPC audits are also completed to support any environmental issues identified.

Influenza / Viral respiratory disorders

Influenza is a viral infection with an incubation period of 2 – 3 days usually but varying between 1 and 7 days. It usually presents as a non-specific febrile illness with headache, muscle pain and a dry cough but may even be asymptomatic. The two main Viruses that affect humans are Influenza A and Influenza B.

One of the best ways to protect vulnerable patients and front-line staff from influenza virus is the influenza vaccine. The overall uptake of influenza virus was lower than the previous year which may have been a consequence of low circulating levels of influenza numbers.

The Trust did experience Flu transmission in ward areas. This was Influenza A cases. The cases were predominantly from patients acquiring infection in the community. The rise with Influenza A was comparable with other acute Trusts regionally and nationally.

Cases of COVID-19 during 2023-24 were due to different COVID-19 variants which resulted in peaks and troughs of infections. At times of high prevalence and incidence within the community we continued to see subsequent increases in hospital admissions and resulting outbreaks of infection.

During 2023-24, the Infection Prevention & Control team responded to updates in guidance providing a pragmatic approach to the management of patients and staff across the Trust. When rates of infection increased additional measures were introduced such as clinical staff wearing respiratory protection, additional enhanced cleaning and cohort areas being created to manage patients safely.

TABLE 4 INFLUENZA VACCINATION UPTAKE BY FRONTLINE WORKERS

StaffGroup	Flu Vaccine Received	Grand Total	Percentage of Staff who have received their Flu Vaccine
Medical and Dental	160	842	19.00%
Nursing and Midwifery Registered	669	2062	32.44%
Add Prof Scientific and Technic	54	117	46.15%
Allied Health Professionals	166	473	35.10%
Additional Clinical Services	470	2080	22.60%
Administrative and Clerical	166	409	40.59%
Estates and Ancillary	185	605	30.58%
Students	2	8	25.00%
Grand Total	**1872**	**6596**	**28.38%**

Carbapenemase-producing Enterobacteriaceae

The management of patients with an antibiotic resistant organism is an increasing priority nationally. The emergence of Carbapenemase-producing Enterobacteriaceae (CPEs) is predicted to pose significant challenges nationally soon with antimicrobial prescribing. Carbapenem antibiotics are a powerful group of B-lactam antibiotic used in hospitals. Until recently they have been able to be used to treat infections when other antibiotics have failed. Emerging resistance patterns have rendered in some cases Carbapenems ineffective. Public Health England have issued toolkits for use in either acute or community settings to enable the early detection, management, and control of CPE. A Trust policy has been updated with the latest national framework and is in place to support and guide staff to provide safe and effective management of patients colonised or infected with resistant bacteria and minimise the risks of transmission in patients.

The trust fortunately does not see many cases of CRE or CRO cases, however this picture is likely to change as the framework now dictates an increased criteria for screening on admission.

Vancomycin- Resistant Enterococci (VRE)

Enterocci are bacteria that colonise harmlessly in the bowel. Enteroccoci can be resistant to Vancomycin – an antibiotic used to treat infections. When these bacteria are resistant to Vancomycin they are referred to as Vancomycin-resistant Enterococci (VRE). Screening of susceptible high risk patients is now embedded across the organisation.

Point Prevalence Surveillance

As part of the ongoing review process the IPC team undertake a modified version of the national Point Prevalence Surveillance twice a year where possible. The main advantage of utilising this approach is that it enables the team to gain an immediate insight into the practices on the ward re invasive devices, antimicrobial prescribing, and management of patients with infections. All patients within the ward are reviewed and staff are then provided with a verbal resume, and this is followed up with a written report usually the same day. Divisions are provided with a dashboard that is available on the HUB site to help support any changes in practice.

The Trust is currently performing well and is below the national average on all alert organisms. It was noted that the number of antimicrobials prescribed remains around **60%** compared to the recommended standard of around 30% Again, this may be a result of the pandemic where most patients admitted with signs of a chest infection were generally prescribed an antimicrobial, which many required intravenous administration.

Provide and maintain a clean and appropriate environment for managed premises that facilitates the prevention and control of infections.

Facilities Service update (written by Karl Cliff)

Cleaning - The National Standards of Healthcare Cleanliness which was introduced in 2021 remains fully embedded at NLaG and encompasses all cleaning tasks regardless of who is responsible for them. We achieve full compliance with the 2021 Cleaning Standards and provide assurance through a dedicated monitoring team who record their audits using the latest digital technology. This enables us to streamline workflows to operate more efficiently, providing audit scores immediately following an audit. Auditors can access the system from a provided Android mobile device, letting them react to changes across our estate. For example, if an area or room changes use, we can amend this immediately and adjust cleaning and auditing frequencies to reflect the new use. All our auditors work collaboratively with senior nursing colleagues who in turn conduct their own assurance audits such as the 15 Step Challenge. This allows all the Trust auditing teams to identify any issues early and react swiftly and accordingly. Looking forward, any changes to embedded cleaning practices considered as part of collaboration within any new group structure should be based on existing performance data specific to cleaning models.

Deep cleaning – We currently operate a yearly deep clean schedule with areas categorised in priority and cleaned at the appropriate frequency. This programme remains challenging due to restricted access to wards and associated bed pressures. We frequently find areas falling out of compliance owing to the fact it is problematic to decant patients whilst a deep clean takes place. We also conduct reactive cleans under the guidance of IPC where infections such as VRE have been identified. We are able to support these reactive cleans with our dedicated Deep Clean team supported by specially trained HSA Staff and Team Leaders and of course the support from IPC teams across all of our three sites.

Capital Investment - Our Capital Investment Programme 2023/24 ensures that cleaning remains a priority as the Hospital and its environment evolves. Specifically, we have seen the mobilisation of two brand new SDEC Centres at both Scunthorpe and Grimsby. For this we invested in the latest cleaning equipment that provides a flexible battery powered floor cleaning solution that minimises trip and slip hazards and allows for a rapid cleaning turnaround to maximise the areas efficiency and patient flow. We have also secured funding for a £120K belted dishwasher for the Scunthorpe main kitchen which will see plates and dishes cleaned efficiently whilst helping to achieve our sustainability goals as the new dishwasher is powered by electricity and negates the reliance on steam produced onsite which is inefficient. The new dishwasher generates its own steam and is due to be installed at the end of August 2024.

Linen - As part of HTM 01-04 we manage and segregate linen and ensure its categorised accordingly. This service is facilitated onsite by our own linen and portering teams but the laundering of linen is provided offsite by Synergy LMS who deliver to us six days per week. This service has not been without its challenges over the last year, namely shortages of linen provided, but our teams ensure a core level of stock is kept at each site allowing continuity of service. Supporting these challenges, the team have worked with Synergy LMS to implement stock control, quality assurance and rejected items across two main sites.

Summary - One of the most significant challenges we face is the aging infrastructure and the ability to clean this effectively, however our teams work to ensure any maintenance jobs are reported. Estates, Facilities and Development have started the process to align the Directorate with group and partnership working. Despite any pressures the Facilities teams remain positive and react to any challenge they face with dedication and professionalism.

IPC Environmental Audits

The IPC team undertake a yearly environmental audit of clinical areas and if required repeat the process depending on findings. Many of the IPC areas of concern have now been incorporated within the Ward Assurance Tool (WAT) and Matron audits. Therefore, the IPC audit acts as an independent validation and is triangulated with the WAT.

The average scores per section are highlighted in table 6 below. The main areas for future improvement are generally associated with general environmental fixture and fittings such as floor and wall condition. Any items that are potential patient safety concerns are dealt with by estates and facilities in a timely manner. Areas that score below 85% are reaudited usually within a month period to allow any practice issues to be addressed. Below is an example of the feedback form emailed to clinical staff following the audit.

FIGURE 5 IPC ENVIRONMENTAL AUDIT TOOL FEEDBACK FORM

Infection Prevention and Control Environmental Audit

NHS Northern Lincolnshire and Goole

Site:	**DPOW**
Location:	**Amethyst & D1 Hazel**
Date:	**20/06/2023**
Observer / Auditor:	**Marion Hewis**

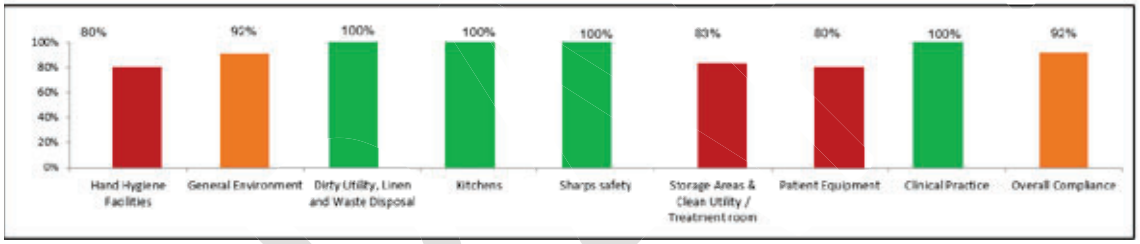
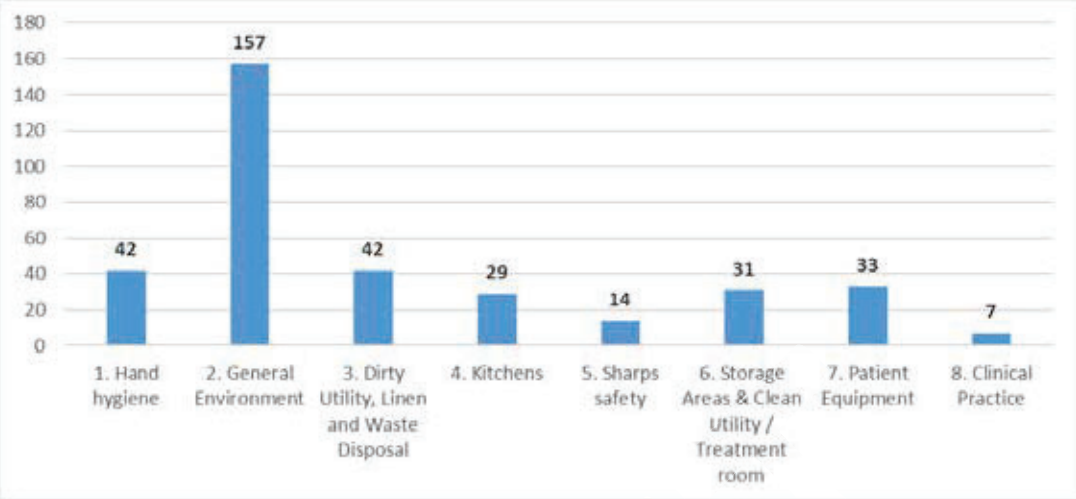


TABLE 5 ENVIRONMENTAL AUDIT SCORES

Compliance by Ward and Division

	1 Hand Hygiene	2 General Environment	3 Dirty Utility, Linen & Waste Disposal	4 Kitchens	5 Sharps Safety	6 Storage Areas & Clean Utility/ Treatment Rm	7 Patient Equipment	8 Clinical Practice	Overall
2023/24	91%	80%	86%	80%	89%	83%	84%	95%	86%
Community	86%	73%	82%	58%	86%	79%	86%	93%	81%
DPOW	92%	88%	91%	88%	83%	91%	85%	93%	89%
Medicine	88%	92%	92%	85%	78%	89%	90%	89%	88%
Surgery & Critical Care	90%	88%	90%	90%	78%	94%	89%	94%	89%
Family Services	98%	81%	89%	93%	96%	91%	74%	100%	90%
GDH	100%	82%	83%	100%	96%	83%	89%	100%	91%
Medicine	100%	70%	79%	100%	100%	83%	80%	100%	89%
Surgery & Critical Care	100%	88%	77%	100%	92%	83%	89%	100%	90%
Family Services	100%	83%	100%	100%	100%	67%	100%	100%	94%
Chief Operating	100%	82%	100%	100%	100%	100%	100%	100%	98%
SGH	94%	81%	86%	86%	95%	82%	80%	98%	87%
Medicine	94%	81%	87%	88%	95%	82%	80%	97%	87%
Surgery & Critical Care	89%	83%	84%	83%	100%	71%	83%	100%	86%
Family Services	100%	81%	86%	83%	89%	92%	78%	100%	89%

FIGURE 6 NUMBER OF IPC ENVIRONMENTAL AUDIT ISSUES BY TYPE



Decontamination

A member of the Infection Prevention and Control team attends the Trust Decontamination group. This group oversees decontamination issues including the function of the Synergy run HSDU and the adherence to National guidance as per Health Technical Memorandum 01-01. The committee is responsible for ensuring that reprocessing systems are revalidated as required and dealing with problems by exception. It serves as a conduit between equipment reprocessing departments and reports into IPCC.

Water Safety Group

During the operational period 2023-24, as per national guidance on water safety Health Technical Memorandum 04-01 (HTM 04-01), water safety was monitored by the Water Safety Group (WSG), reporting to IPCC, as and when required. The Trust has a Water Safety Plan (WSP) which provides a risk-management approach to the water safety management and establishes good practices in local water usage, distribution and supply.

The Estates team continue a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients. Any positive water samples culturing Legionella and/ or Pseudomonas are reported by UKHSA to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.

There has been a systematic approach to risk minimisation and multiple preventative actions have been taken as recommended by the Authorising Engineer (AE) and corrective risk reduction actions as indicated by independent risk assessors with respect to water safety over several years.

Flushing of infrequently used outlets, a requirement of HTM 04-01 is now firmly established on all hospital sites, with improved compliance now seen. The Estates department utilise a software database to record flushing.

The Deputy DIPC is a core member of this group to help ensure relevant guidance is adopted to help reduce the risk of waterborne infections such as Pseudomonas and Legionella.

Ensure appropriate antibiotic use to optimise patient outcomes and resistance

Antimicrobial Stewardship

Antimicrobial Stewardship

Antimicrobials stewardship is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (NICE guideline NG15, 2015). It is therefore an important part of Medicines Optimisation.

Within the Trust the antimicrobial stewardship agenda is predominately led by the Consultant Pharmacist, Antimicrobials, who works closely with Pharmacy staff, the Infection Prevention and Control Team and with clinicians. This includes working with the ePMA (electronic prescribing medication and administration) implementation team to incorporate appropriate antimicrobial stewardship into the prescribing and administration system.

The close working relationship with the Infection Prevention and Control (IPC) Team is essential with the UK's five-year national action plan - Tackling antimicrobial resistance 2019-2024 - (HM Government, January 2019) stating that the UK will "Ensure board level leadership with a combined IPC and antimicrobial stewardship role for all regulated health and social care providers".

The Trust's Antimicrobials Stewardship Strategy incorporates all elements of the national 'Tackling Antimicrobial Resistance 2019 – 2024: The UK's five-year national action plan'. The strategy aims to:

- Ensure the optimal use of antimicrobials in the Trust
- Minimise the risk of causing Healthcare Onset, Healthcare Acquired infections (HOHAs), antimicrobial related adverse effects and the development of antimicrobial resistance, whilst maximising their clinical and cost effectiveness.
- This report outlines the antimicrobial activities and progress with the action plan made in 2023/24 and activities related to antimicrobial stewardship

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary. Education and training is facilitated both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses. The aim is to reduce unnecessary or inappropriate durations of prescriptions for antimicrobials and optimise treatment for patients through an effective stewardship programme. The pharmacist staffing levels continue to be challenging. The Trust has been exploring all options to improve capacity including a recruitment drive. The antimicrobial pharmacist post is currently vacant, with a successful candidate currently working through the recruitment process.

Activities undertaken:

Guidelines

- Path links paediatric antimicrobial guidelines reviewed and now available on Microguide.
- Adult antimicrobial guidelines published on Microguide.

Education and Training

The following E & T activities have been delivered:

- Induction training for junior doctors
- Induction training for pharmacy staff
- Point of care training
- Immunisation training
- Penicillin allergy training

Audit and surveillance of antimicrobial use

There have been challenges with collating data each quarter due to staffing and capacity issues. The Trust have found a way round this so that the data is collected every quarter and fedback to the audit and quality team each quarter to be included as part of the Trust quality priority data. Two of these standards were included in the quality priorities namely the percentage of patients prescribed an antibiotic and the number of patients that have a review date documented. The following targets were agreed for the 2022/23:

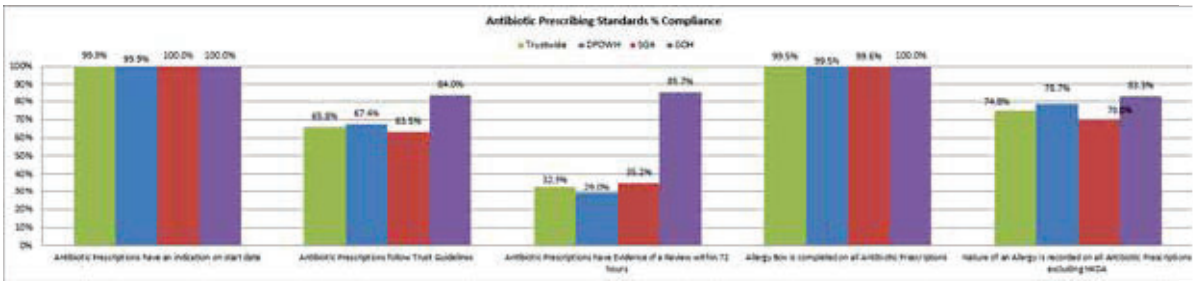
- Reduction in patients prescribed an antibiotic – target reduction to 50% this finished at end of Quarter 4 at 60.19%
- Antibiotic prescriptions have evidence of a review within 72 hours – target 70% this finished at 32.9% at end of Quarter 4 2023-24

Data shows the desired targets and thresholds were not achieved and specific actions will be implemented to improve this for the next financial year. This will feature in the Group Partnership annual work plan once the antimicrobial pharmacist commences post.
The Trust also participated in the Point Prevalence Survey on Healthcare Associated Infections, Antimicrobial Use and Antimicrobial Stewardship in England. This survey was the sixth national point prevalent survey (PPS) on healthcare -associated infections (HCAI) and the third national PPS on antimicrobial use (AMU). Local recommendations were made within the report from UKSHA and will feature in the new work plan.

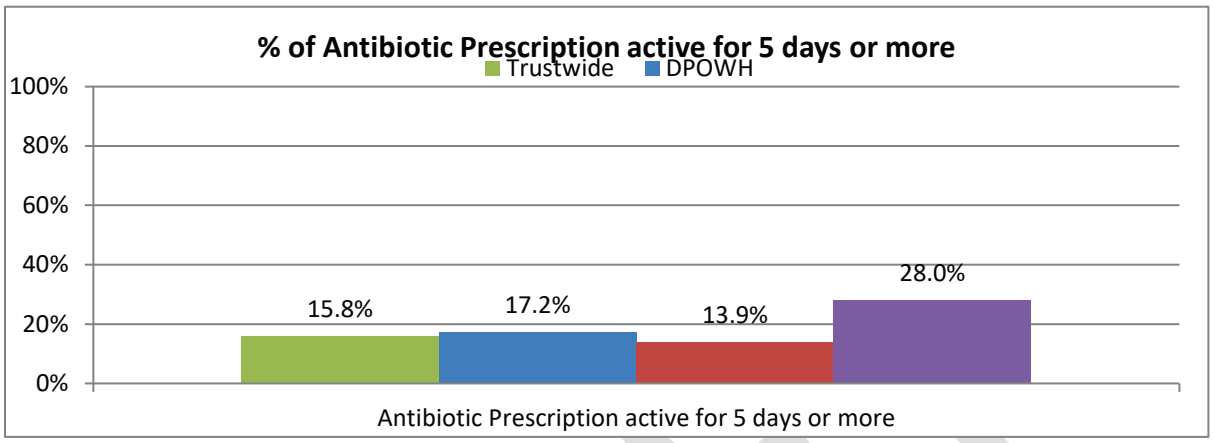
	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4
% of Patients prescribed an Antibiotic Trustwide	64.82%	58.35%	67.76%	60.19%
% of Patients prescribed an Antibiotic DPOW	64.31%	56.27%	63.27%	57.76%
% of Patients prescribed an Antibiotic SGH	64.33%	58.13%	71.25%	59.30%
% of Patients prescribed an Antibiotic GDH	15.79%	26.92%	15.63%	25.00%

Standard Thresholds
Over 90%
Between 70% and 90%
Under 70%

	Trustwide			DPOWH			SGH			GDH		
Audit Prescribing Standards	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions compliant	% Compliance
Antibiotic Prescriptions have an indication on start date	1529	1528	99.9%	772	771	99.9%	732	732	100.0%	25	25	100.0%
Antibiotic Prescriptions follow Trust Guidelines	1529	1006	65.8%	772	520	67.4%	732	465	63.5%	25	21	84.0%
Antibiotic Prescriptions have Evidence of a Review within 72 hours	809	266	32.9%	420	122	29.0%	375	132	35.2%	14	12	85.7%
Allergy Box is completed on all Antibiotic Prescriptions	1529	1522	99.5%	772	768	99.5%	732	729	99.6%	25	25	100.0%
Nature of an Allergy is recorded on all Antibiotic Prescriptions excluding NKDA	325	243	74.8%	169	133	78.7%	150	105	70.0%	6	5	83.3%



Audit Prescribing Standards	Trustwide			DPOWH			SGH			GDH		
	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance	No. Of Prescriptions Audited	No. of Prescriptions active 5 days or more	% Compliance
Antibiotic Prescription active for 5 days or more	1529	242	15.8%	772	133	17.2%	732	102	13.9%	25	7	28.0%

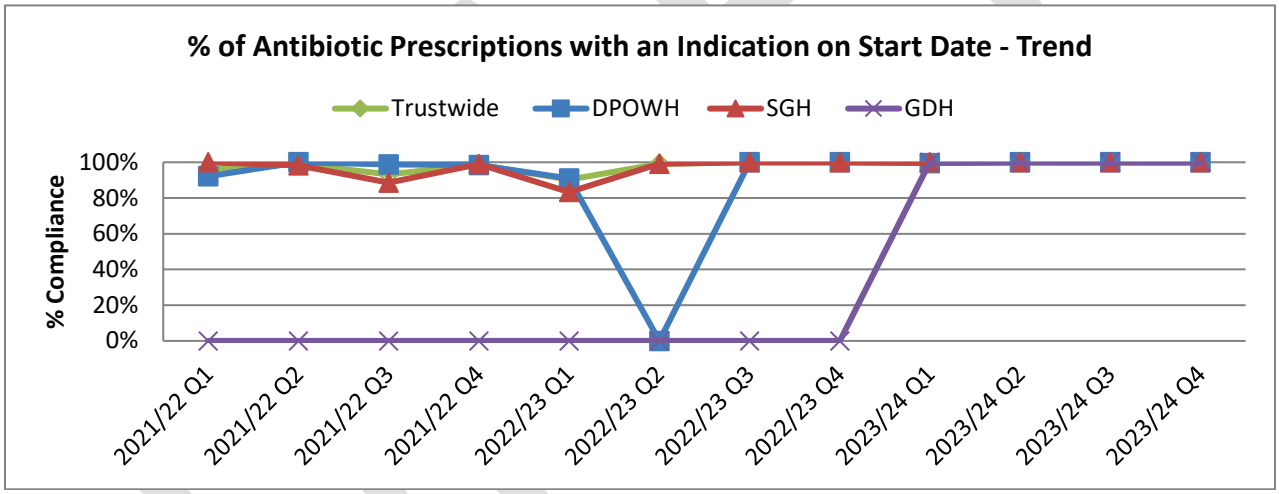


72 Hour Review Decision	Trustwide	DPOWH	SGH
Antibiotic **stopped**	**1.1%**	**2.5%**	**0.0%**
No change with no review/stop date given	**36.8%**	**27.0%**	**44.7%**
No change with review / stop date given	**20.3%**	**18.9%**	**19.7%**
De- escalated antibiotic treatment with no review / stop date	**1.9%**	**4.1%**	**0.0%**
De- escalated antibiotic treatment with review / stop date	**2.3%**	**2.5%**	**2.3%**
Escalated antibiotic treatment with no review / stop date	**4.9%**	**5.7%**	**4.5%**
Escalated antibiotic treatment with review / stop date	**0.4%**	**0.0%**	**0.8%**
Route changed from IV to PO with no review / stop date given	**4.1%**	**2.5%**	**6.1%**
Route changed from iv to oral with review / stop date given	**26.7%**	**35.2%**	**20.5%**
Route changed from po to iv with no review / stop date given	**0%**	**0%**	**0%**
Route changed from po to iv with review / stop date given	**0.8%**	**0.0%**	**1.5%**

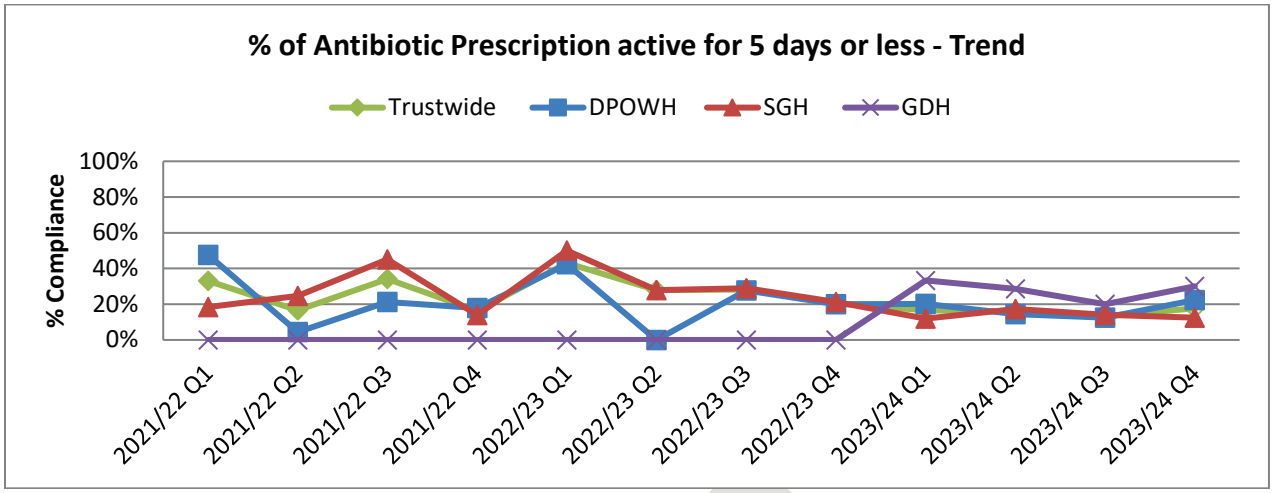
Prescribing Standard Trends

% of Antibiotic Prescriptions with an indication on start date

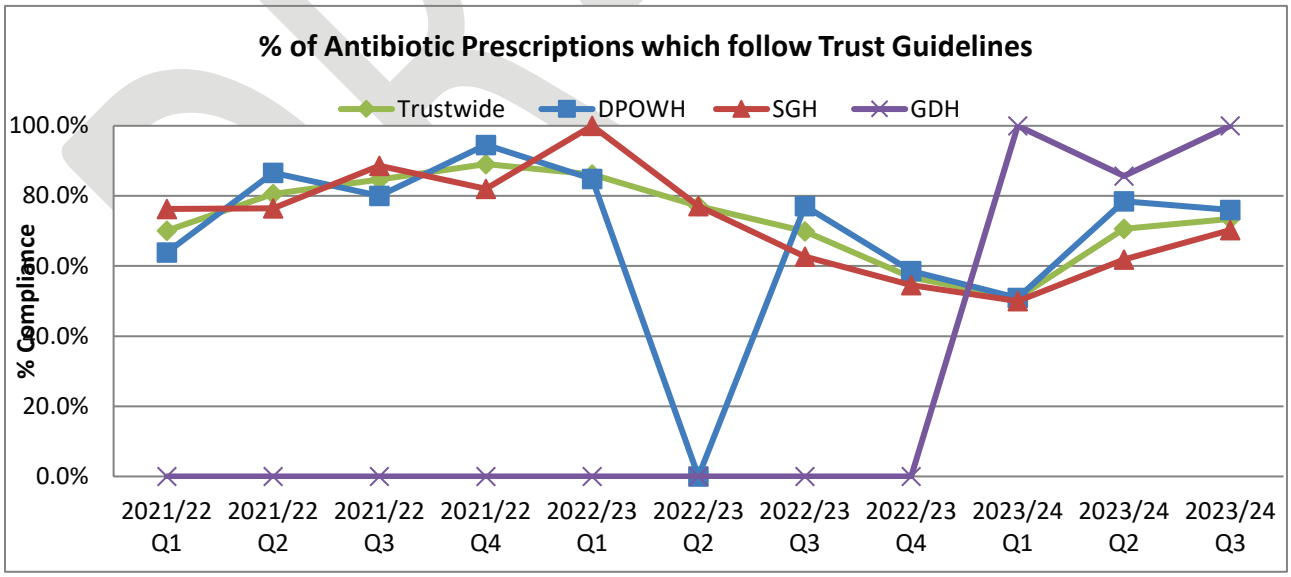
Year & Quarter	Trustwide	DPOWH	SGH
2022/23 Q1	90.3%	90.9%	83.3%
2022/23 Q2	99.2%	Not Available	99.2%
2022/23 Q3	100.0%	100.0%	100.0%
2022/23 Q4	100.0%	100.0%	100.0%
2023/24 Q1	99.7%	99.5%	100.0%
2023/24 Q2	100.0%	100.0%	100.0%
2023/24 Q3	100.0%	100.0%	100.0%
2023/24 Q4	100.0%	100.0%	100.0%



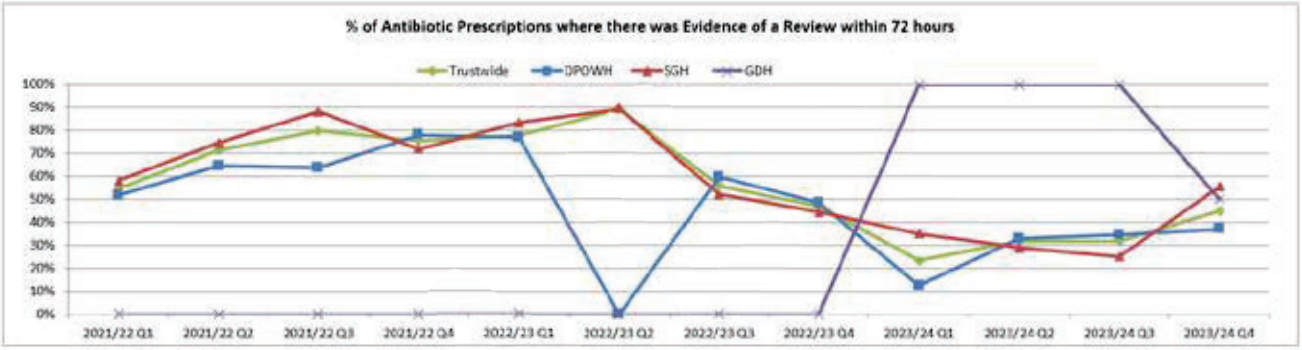
% of Antibiotic Prescription active for 5 days or more			
Year & Quarter	**Trustwide**	**DPOWH**	**SGH**
2022/23 Q1	43.1%	42.4%	50.0%
2022/23 Q2	28.0%	Not Available	28.0%
2022/23 Q3	28.3%	27.7%	28.9%
2022/23 Q4	20.6%	20.1%	21.3%
2023/24 Q1	16.5%	20.2%	11.9%
2023/24 Q2	16.1%	14.5%	17.3%
2023/24 Q3	13.4%	12.4%	14.2%
2023/24 Q4	17.7%	22.3%	12.5%



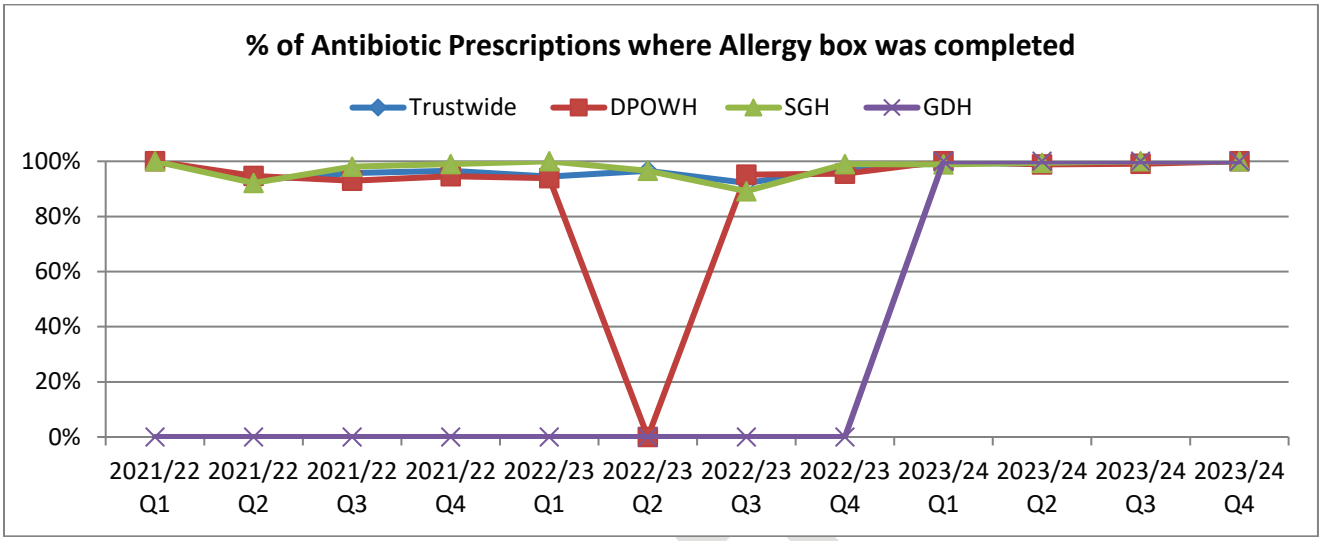
% of Antibiotic Prescriptions which follow Trust Guidelines			
Year & Quarter	**Trustwide**	**DPOWH**	**SGH**
2022/23 Q1	86.1%	84.8%	100.0%
2022/23 Q2	77.1%	Not Available	77.1%
2022/23 Q3	69.9%	77.1%	62.7%
2022/23 Q4	56.8%	58.6%	54.6%
2023/24 Q1	50.9%	51.0%	50.0%
2023/24 Q2	70.6%	78.5%	61.9%
2023/24 Q3	73.5%	76.0%	70.3%
2023/24 Q4	67.9%	65.1%	70.5%



% of Antibiotic Prescriptions where there was Evidence of a Review within 72 hours			
Year & Quarter	**Trustwide**	**DPOWH**	**SGH**
2022/23 Q1	77.8%	77.1%	83.3%
2022/23 Q2	89.3%	Not Available	89.3%
2022/23 Q3	56.0%	59.6%	52.1%
2022/23 Q4	47.0%	48.7%	44.7%
2023/24 Q1	23.4%	12.5%	35.2%
2023/24 Q2	32.0%	33.0%	29.0%
2023/24 Q3	31.6%	34.6%	25.2%
2023/24 Q4	44.9%	37.2%	55.6%



% of Antibiotic Prescriptions where the Allergy box was completed			
Year & Quarter	**Trustwide**	**DPOWH**	**SGH**
2022/23 Q1	94.4%	93.9%	100.0%
2022/23 Q2	96.6%	Not Available	96.6%
2022/23 Q3	92.2%	95.2%	89.2%
2022/23 Q4	97.1%	95.5%	99.0%
2023/24 Q1	99.5%	100.0%	98.9%
2023/24 Q2	99.1%	98.8%	99.4%
2023/24 Q3	99.5%	99.1%	100.0%
2023/24 Q4	100.0%	100.0%	100.0%



% of Antibiotic Prescriptions where the Nature of the Allergy was specified if an Allergy was recorded			
Year & Quarter	**Trustwide**	**DPOWH**	**SGH**
2022/23 Q1	5.9%	3.2%	33.3%
2022/23 Q2	38.5%	Not Available	38.5%
2022/23 Q3	57.5%	65.0%	50.0%
2022/23 Q4	58.3%	73.2%	40.4%
2023/24 Q1	80.5%	90.7%	67.6%
2023/24 Q2	89.2%	82.1%	94.6%
2023/24 Q3	72.8%	87.2%	54.8%
2023/24 Q4	61.5%	58.8%	64.9%

Other activities:

- NICE compliance
- HCAI and AMU PPS National audit
- Raised the profile of antimicrobial stewardship
- Stewardship rounds
- Continuing antimicrobial surveys – providing data on the prescribing of antimicrobials within the organisation
- Successful role out of the OPAT (Out patient antimicrobial therapy) this has been successful.and has full support of the Trust Microbiologist

Provide suitable accurate information on infections to any person concerned with providing further support or nursing / medical care in a timely fashion.

Patient Information

The trust has an IPC www website with information for the general public. There are a variety of guides for common healthcare associated infections.

The intranet HUB has a multitude of information leaflets for patients that can be quickly printed off by staff as required as well as quick reference guidance on 'how to' manage patients with infections.

Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment or care to reduce the risk of passing on the infection to other people.

The IPC team in conjunction with WebV have developed a database that is linked to the pathology system. This allows all 'alert organism' positive results to be easily identified and then allows the team to take appropriate action. The system has taken a number of years to develop and refine but is very effective and useful.

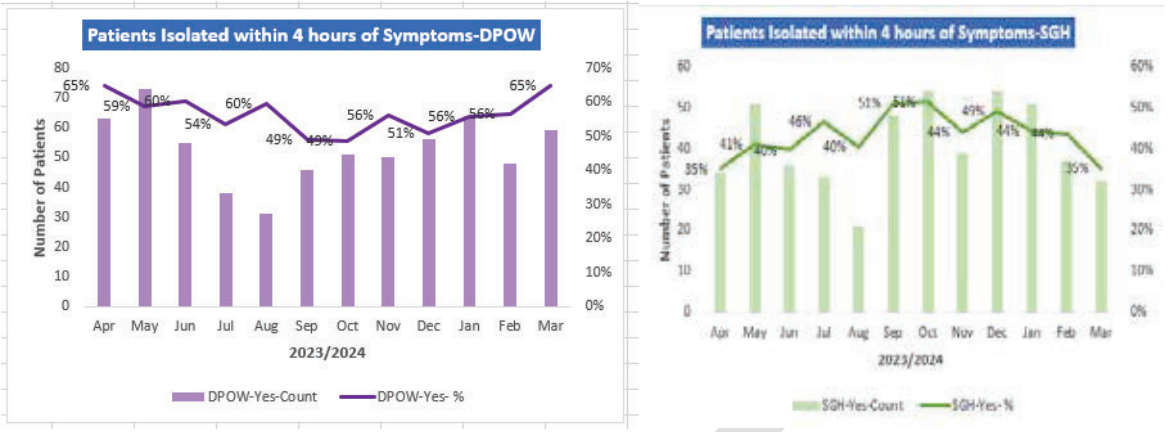
MRSA colonisation

The bulk of MRSA isolates come from routine wound swabs and from swabs taken specifically to look for the presence of the organism (screening swabs). Most patients, from whom the organism is isolated, are not infected but colonised, i.e., harmlessly carrying the organism. Patients requiring major implant surgery are routinely swabbed for MRSA and now commenced on topical decolonisation agents to help reduce the risk of Methicillin sensitive Staphylococcus aureus which can cause significant post operative issues.

Patients with Unexplained Diarrhoea

As part of the C.*difficile* reduction strategy the IPC team monitor patients who have had a faecal sample submitted to the laboratory for suspected infection. One of the main key performance indicators is patients presenting with type 5-7 stools should be isolated within 4 hours of symptoms. Once again with surges of COVID-19 and other respiratory viruses i.e., Influenza, RSV safe isolation of patients was challenging the adoption of the redirooms certainly allowed us to minimise the overall impact. By the deployment of the redirooms for patients with suspected or known contact/droplet infections which allowed single rooms to be used as priority for patients with unexplained diarrhoea and/or vomiting

FIGURE 7 PATIENTS WITH DIARRHOEA AND TIME TO ISOLATION



The IPC team also review whether the stool sample submitted is deemed appropriate based on clinical information. Staff are given feedback if samples are deemed inappropriate to help improve practice and reduce pressure on single rooms. There is ongoing education and stool sampling and correct management of patients with diarrhoea is part of the IPC yearly roadshows and highlighted on the IPC Ward Boards.

Norovirus

Norovirus used to be a predominant winter pathogen. It is extremely easily transmitted between people even with excellent IPC practice. UK Health Security Agency (UKHSA) surveillance data in February 2023 showed that laboratory reports of Norovirus were 77% higher than the 5-season average for the same period prior to the COVID -19 pandemic. Prevalence in the community was high during the winter of this report period which was reflected in Care Home outbreaks and number of inpatients/outbreaks in our hospitals.

Winter Picture 2023 -2024

As can be seen the number of COVID cases escalated again during the winter. Omicron variants such as BA 2L15 proved highly infectious which caused disruption not only with outbreaks but staff illness. However, since the vaccine programme has been introduced protection against severe illness has been maintained and we have seen fewer deaths and critical care admissions. The lack of effective ventilation to help dilute airborne particles which is important in a busy confined environment also cannot be overstated as an important mode of transmission.

Improving air quality assists the prevention of outbreaks, opening windows to improve ventilation along with the use of HEPA filtration units is now common practice on the wards.

As part of the COVID strategy the use of the Redirooms were deployed to enhance the isolation capacity and continue to be utilised.

The use of fluid repellent surgical masks and FFP3 masks was encouraged for clinical staff managing COVID, affluenza positive patients within their infectivity period and within admission units where the status of the patient was unknown. The supply and availability of FFP3 masks is now much improved and most staff can find a disposable mask to fit their needs. The fit testing was supported by an external provider and clinical practice facilitator team and worked well helping to maintain the 2-year cycle of fit testing requirements.

Outbreaks

Outbreaks occur when there are two or more linked infections which may or may not be preventable. Usually, these events are, by definition, unpredictable. Historically this has mainly been associated with viruses such as

Norovirus or Influenza. However, with the emergence of SARS CoV-2 we have mainly been dealing with numerous outbreaks associate with this virus. The winter period brought outbreaks of all 3 viruses with numerous patients with dual viruses resulting in challenging management decisions. The Trust experienced outbreaks of both Influenza A and lower numbers of Influenza B and also Norovirus over the winter period. These were managed appropriately by the IPC team with support from Operational management teams and facilities to ensure areas were cleaned effectively prior to reopening.

FIGURE 8 NLAG OUTBREAK DATA

Ward Closed	Site	Date Closed	Date Opened	Number of patients affected	Number of staff affected	Outbreak
Ward C2	DPOW	26/09/2023	29/09/2023	7	8	COVID-19
Amethyst & D1 Hazel	DPOW	30/09/2023	03/10/2023	7	0	COVID-19
Short Stay Unit	DPOW	19/12/2023	21/12/2023	2	1	Norovirus
Ward C2	DPOW	31/01/2024	05/02/2024	3	0	Influenza A + B
Stroke Unit	DPOW	18/03/2024	28/03/2024	12	8	D & V
Ward 16	SGH	31/01/2024	06/02/2024	8	4	Influenza A + B

Measures implemented to assist with the management of Respiratory Viruses i.e., COVID-19, Influenza, RSV.

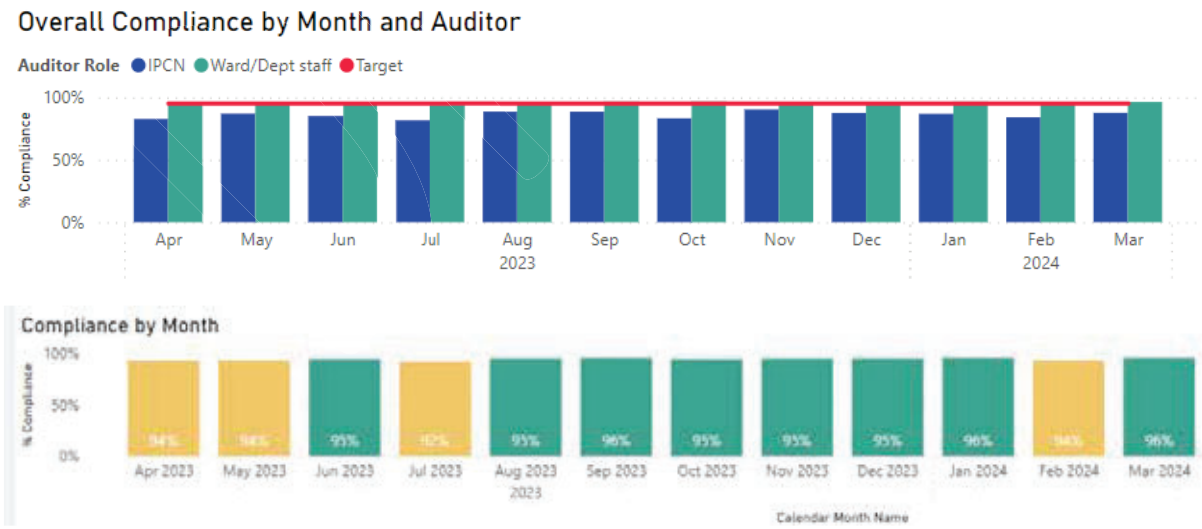
	The Trust purchased furthermore Air filtration units following on from the Pandemic. These help to reduce the number of airborne contaminants by filtering the air and passing it through a HEPA filter. Depending on the room size is equivalent to 6-12 Air changes per hour.

6. Ensure that all care workers are aware of their responsibilities in preventing and control of infection.

Hand Hygiene

Hand Hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team continue to promote hand hygiene compliance incorporating the WHO five moments tool. Hand hygiene compliance including bare below the elbows is an expectation for all clinicians. Ward staff continue to record opportunistic hand hygiene observations on a monthly basis, and these are supplemented by IPCN observations to provide some quality assurance. Areas that are found deficient are provided with a feedback plan and remedial actions worked through with the ward manager and if required the Matron.

A WebV hand hygiene App was launched in February 2019 allowing staff to use the smart phones on wards / depts. to record compliance. Results are displayed in an interactive dashboard so that all areas can view their compliance with each of the WHO five moments, overall hand hygiene compliance remains good, as highlighted in the graph below.



Isolation Facilities

The infrastructure of the Trust continues to pose a challenge in the number of isolation facilities available. During the pandemic Redirooms were purchased and are still used to maximise isolation facilities. As part of the estate's strategy, future building projects/refurbishments continue to take into consideration IPC requirements including enhanced ventilation. This helps the Trust prepare for the IPC infection challenges including future waves of COVID – 19. Adequate mechanical ventilation is now seen as being essential to help mitigate the risk of airborne pathogens to help protect patients and staff. We do not have this functionality widespread within the Trust, as such we rely on the use of HEPA filtration units. The opening of the new Emergency Departments (ED's) at DPOW and SGH then followed by the opening of the new Integrated Acute Assessment Units providing further isolation areas and has significantly improved the provision of excellent ventilation and isolation facilities.

7. Secure adequate access to laboratory support as appropriate.

Microbiology Laboratory (report by Nick Duckworth Laboratory manager)

Report from Microbiology Directorate.

Microbiology has remained considerably busy 2023-24 with increased activity especially associated with respiratory culture and PCR, TB, legionella & pneumococcal urinary antigen and *C.difficile* testing. Currently we are 4% over-active against last year. Support has been given in dealing with CPE and VRE outbreaks within NLAG.

The Directorate continue to see considerable requests for extended respiratory PCR during the period of increased Bordetella pertussis incidence locally and nationally. The Directorate was also involved in measles preparedness and incident meetings but fortunately not many requests materialised.

Meningitis/encephalitis PCR was implemented at the end of May 2024 which has already had a valuable positive impact clinically, and, in light of the aciclovir shortage, supporting prevention of unnecessary treatment and antimicrobial stewardship in general.

Teicoplanin assays were brought in-house at Lincoln Blood Sciences following a request from Microbiology, and this has greatly improved availability of results, allowing more appropriate use especially OPAT, which benefits the patient, reduces the need for hospital stays and supports antimicrobial stewardship.

The Directorate is working with NLAG (and ULHT) to improve the sepsis pathway by trying to improve capacity, time for receipt from collection and the volume of blood collected, adjusting the new blood culture tender specification to include an analyser at Grimsby if cost will allow. Additionally, we look forward to working together to address the blood culture contamination rate. It is hoped that we can finally resolve MALDI with the same tender.

2023-24 KPI TaT performance for metrics relevant to ICPN were *C.difficile* testing 97.7% (target 97%) and MRSA 99.6% (target 97%).

Infection Prevention and Control Policies

There are an extensive number of policies, guidelines and how to documents that are maintained by the IPC team in a timely manner. Recent policies updated can be seen below.

TABLE 6 POLICIES UPDATED WITHIN LAST YEAR

Reference	TITLE OF DOCUMENT	REVIEWED
IC/OP-POL25	Infection Control Decontamination Policy	30/05/2023
IC/OP/POL-43	Glycopeptide Resistant Enterococci (GRE) Policy	03/08/2023
IC/OP/POL-055	Guidance for the Control & Prevention of Carbapenemase-Producing Enterobacterales (CPE)	31/07/2023
IC/OP/POL-32	Guidelines for the Management of a Patient with Meningitis/Meningococcal Disease	25/08/2023
IC/PG/17	Infection Control Guidelines for the standard of Routine Cleaning required for Vacated Bed Spaces	28/04/2023
IC/OP/POL-10	Infestation Policy – Lice & Fleas	30/05/2023
IC/OP/POL-08	Infection Control Policy – Medical Devices	28/04/2023
IC/OP/POL-56	Middle East Respiratory Syndrome Coronavirus (MERS-COV) Policy	29/09/2023
IC/OP/POL-49	Infection Control Outbreak Policy	28/04/2023
IC/OP/POL-11	Scabies Policy	30/05/2023
IC/OP/POL-47	Infection Control Policy regarding Viral Haemorrhagic Fevers & Other Hazard Group 4 agents	28/04/2023
IC/OP/POL-36	Infection Control Policy : Transmissible Spongiform Encephalopathy Agents (TSE)	29/04/2023
IC/OP/POL-27	Policy for the Prevention & Control of Tuberculosis	25/08/2023
IC/OP/POL-02	Policy for the Safe Use and Disposal of Sharps	28/04/2023

6. Have a system in place to manage the occupational health needs of staff in relation to infection.

The Occupational Health team have undergone changes within the last year with the senior nurse leaving the service. The team have played a crucial role in the delivery of the influenza vaccines and the also helped to implement a successful support service during the pandemic. The lead nurse has an open invite to the Infection Prevention & Control Committee.

Training and Education

The IPC team continue to make education of staff one of its key priorities. There are a wide variety of educational portfolio materials available for clinical and non-clinical staff to help maintain their mandatory training requirements. Due to the ongoing pandemic and social distancing guidance most of the education has continued to be remote learning.

The materials include: -

- Workbooks for clinical and non-clinical staff updated into flip books
- Care Camp
- Induction
- Clinical updates
- New Doctors / HYMS training
- Burs R Us Study Day – held annually for clinical staff

Over 9000 members of staff have undertaken some form of IPC training which is a significant increase from last year.

TABLE 7 TRAINING UNDERTAKEN

Count of Competency Match	Column Labels			
Row Labels	**No**	**Yes**	**Grand Total**	**%compliance**
208|LOCAL|Antimicrobial Stewardship|	160	2399	2559	94%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	33	902	935	96%
NHS|CSTF|Infection Prevention and Control - Level 1 - No Specified Renewal|	18	1418	1436	99%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	836	3852	4688	82%
Grand Total	**1047**	**8571**	**9618**	89%

Community & Therapies Services Infection Prevention and Control Annual Report 2023-2024 (written by Gail Hill Community Infection Prevention Nurse)

Overview

The 2022-2023 Community and Therapies annual report was filled with information on Covid 19. Graphs on Covid figures and regional reports. In some instances, Northern Lincolnshire and Goole NHS Trust (NLaG) went above National Guidance based on regional figures.

In 2023/2024 Covid 19 has significantly changed; National Guidance on Covid 19 has stepped down, Lateral Flow Testing (LFT) no longer required for some, Government funding for LFT 's for the public rescinded. Regionally NLaG stopped the compulsory wearing of face masks and advised staff to assess 'the need to wear a mask' which is standard Infection Preventions precautions (based on assessment/holistic nursing of a patient/situation)

Advising staff on Covid continues but not to the extent on the previous year, other organisms have come to the forefront. For example, some of the community staff were involved in a Streptococcus A cluster emm77.0 type.

IPC Environmental Audits have continued to take place, which are broken down into quarters in more detail.

Community staff have faced numerous challenges in the community, as staff shortages, and staff covid clusters/outbreaks have occurred. Although Covid 19 is something 'we have to live with', it has not gone away and even a minor outbreak can have a detrimental impact on services. Team leaders have excelled in handling outbreaks and maintained a safe and effective service to patients; the Community IPC Team/Nurse has supported.

Community staffing within the IPC Team decreased to one 0.6 wte Band 6 Community staff nurse.

Lindsey lodge remains part of the Community IPC Team, 7.5 hours per month is spent on the premises.

Goole Hospital is not part of the Community IPC Team and not included in the community annual report.

The community IPC team and Northern Lincolnshire and Goole NHS Trust (NLaG) acute team work closely together to share up to date knowledge and education to ensure patient safety is not compromised.

GP practices are informed of organism results that come through the IPC Module, these results are entered onto SystmOne in North Lincolnshire and if a new case 'Symphony' is notified by email to 'flag' the patient and alert staff of the organism present. If the organism is resulted for North East Lincs (NEL) only an email is required to inform the NEL Infection Prevention & Control Team and they follow up the result.

IPC Nurse contributes to reading community policies and documents that go for ratification.

Surveillance organisms

Table below shows Alert Organism figures for the period April 2023- March 2024. The arrows indicate if increase or decrease from the targets/previous year. There are no target figures set for MSSA at present (arrow shows increase from previous year)

Comparison of North Lincolnshire performance against CAI surveillance organisms for 3 years

Organism	2021/2022	**2022/23**	**Target for 2023-2024**	**2023/2024**	**2023/2024**
	Performance	Performance	Target	Actual Performance against targets	Performance against previous year
MRSA	2 ↑	2↓	**0**	**2 (2↑)**	**2 2↑**
C.difficile	6 ↓	0 →	**18**	**17 (-1↓)**	**17 4 ↓**
E.coli	48 ↓	4↑	**109**	**131 (22↑)**	**131 3↑**
MSSA	10 ↑	15↓	**No target set**	**42 (16↑)**	**42 15↑**
P. Aeruginosa	12 ↑	10↓	**12**	**13 (1↑)**	**13 4↑**
Klebsiella spp.	9 ↑	6↓	**29**	**38 (9↑)**	**38 5↑**

Audits and findings

Hand Hygiene (HH) Audits

Staff are asked to complete 10 hand hygiene observations per month and input the data/findings onto Web V: which then is exported to Power Bi. Power Bi then produces a dashboard to populate HH compliance and provide assurance that: -

- Hand hygiene is being undertaken.
- Correct technique
- Bare Below the Elbows (BBE)

However, it is acknowledged that staff in the community cannot complete the HH audits due to lone working or working in twos. It is asked that managers make sure their areas are removed from Power Bi as it will be recorded as non- compliant with their HH submissions.

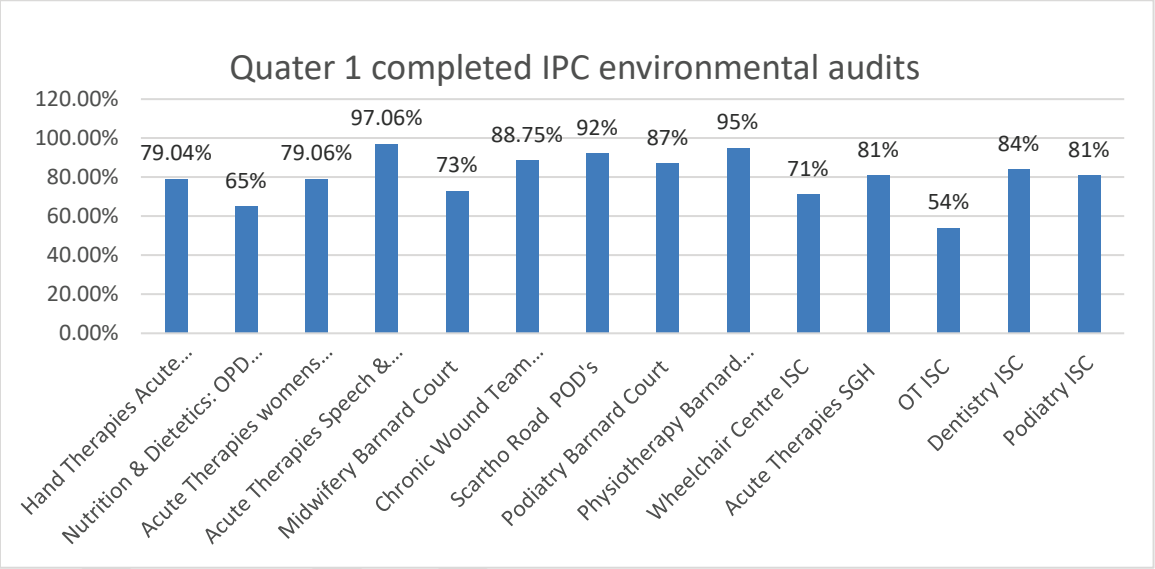
Infection Prevention & Control (IPC) Environmental Audits

The community IPC Team undertook 38 IPC Environmental Audits throughout 2023-2024 which is broken down into quarters, and one review of Global House.

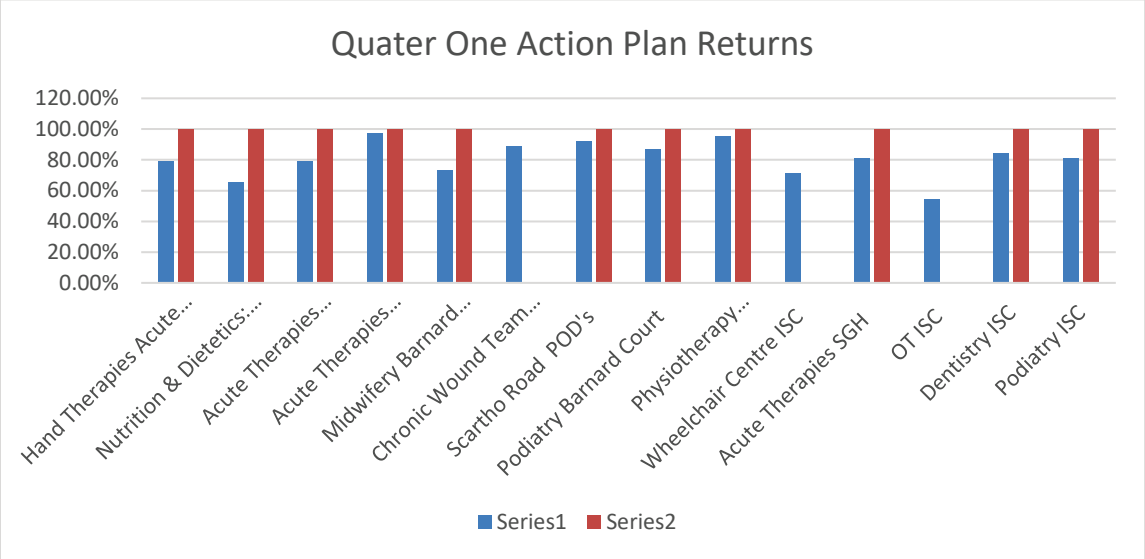
RAG Rating Key (as per Audit tool)
Green 92 - 100%
Amber 82 - 91.9%
Red 0 - 81.9%

Quarter 1 April 2023 – June 2023

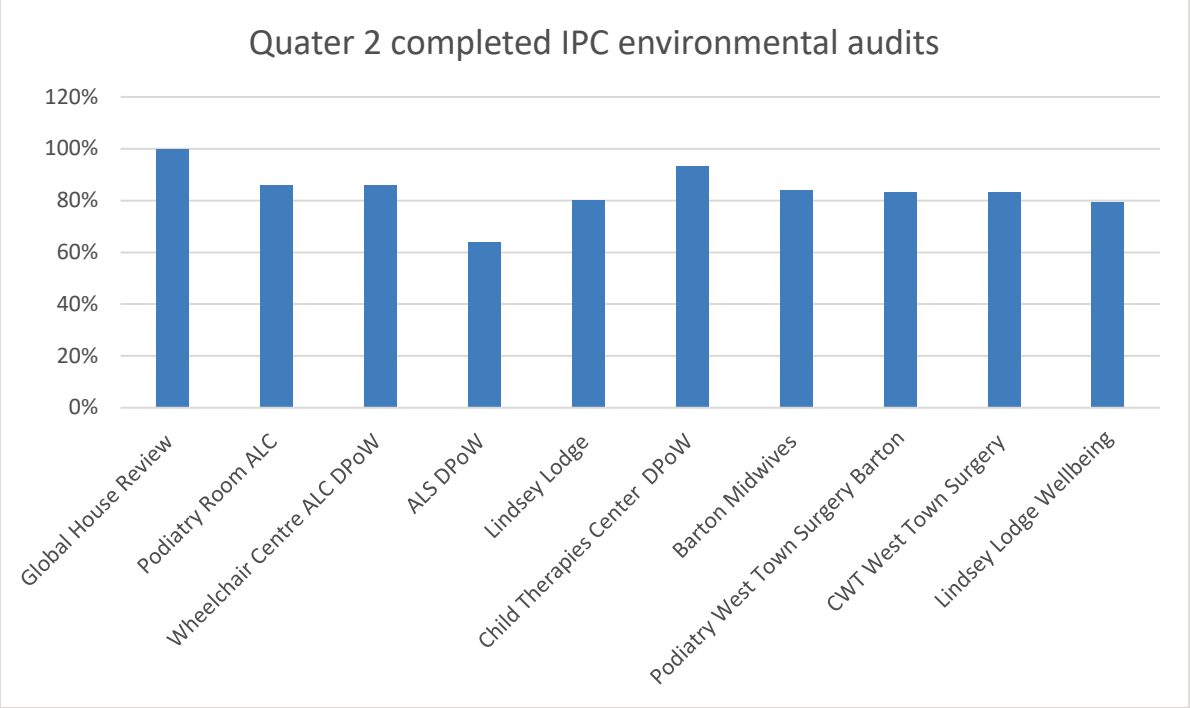
14 IPC Environmental Audits were undertaken. The graph below shows areas audited in the annual report period.



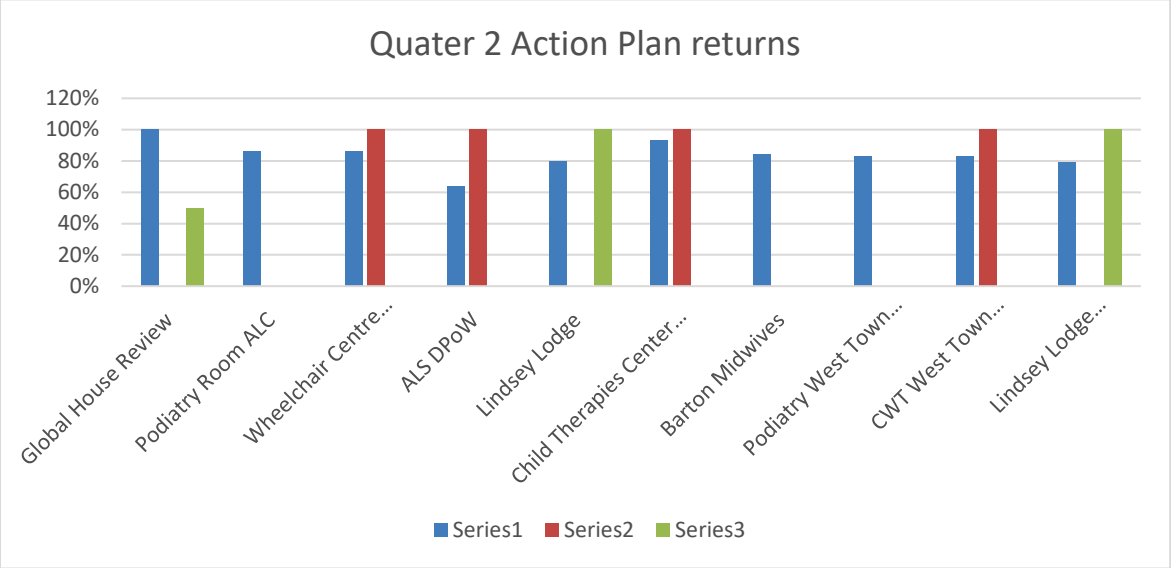
The second graph shows Quarter 1 'Action Plan' returns; the areas with a series 2 indicator shows returns. (Series 1 shows completed audits)



Quarter 2 July 2023- September 2023

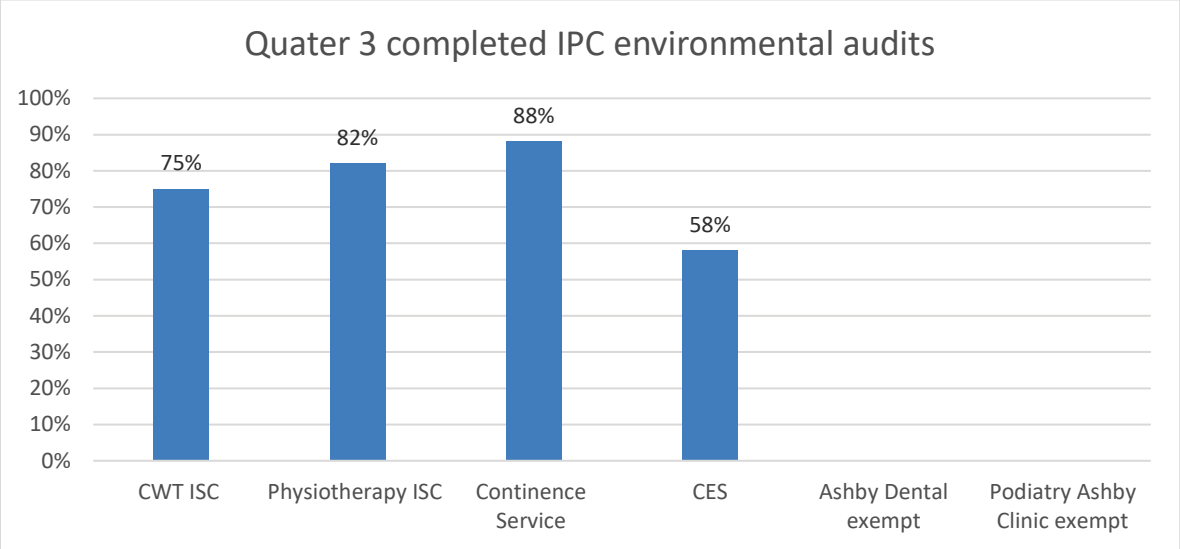


The graph below shows Quarter 2 'Action Plan' returns (series2) Series 3 (green) is Lindsey Lodge which is covered by the community IPC team, but not part of Northern Lincolnshire and Goole NHS Trust (NLaG) per say. Also, Global House review.

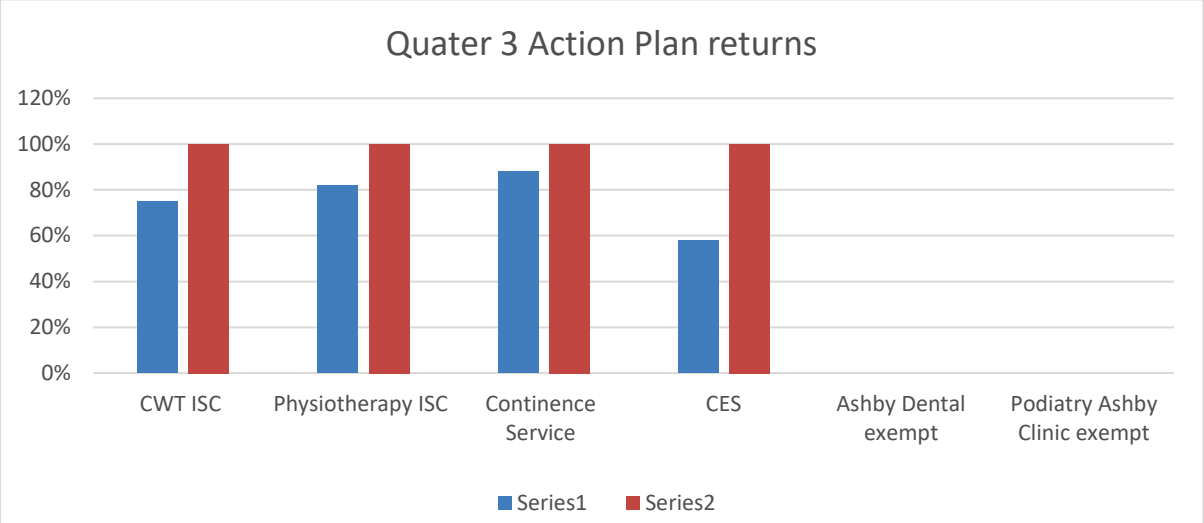


Quarter 3 October 2023 -December 2023

4 IPC Environmental Audits were undertaken (2 audits planned). Ashby dental and podiatry were unable to use the premises. High counts of legionella were found in the water testing by an outside company. The situation was assessed by experienced NLaG staff and a decision to relocated and suspend Dental and Podiatry services was made as a matter of safety to patients and staff.

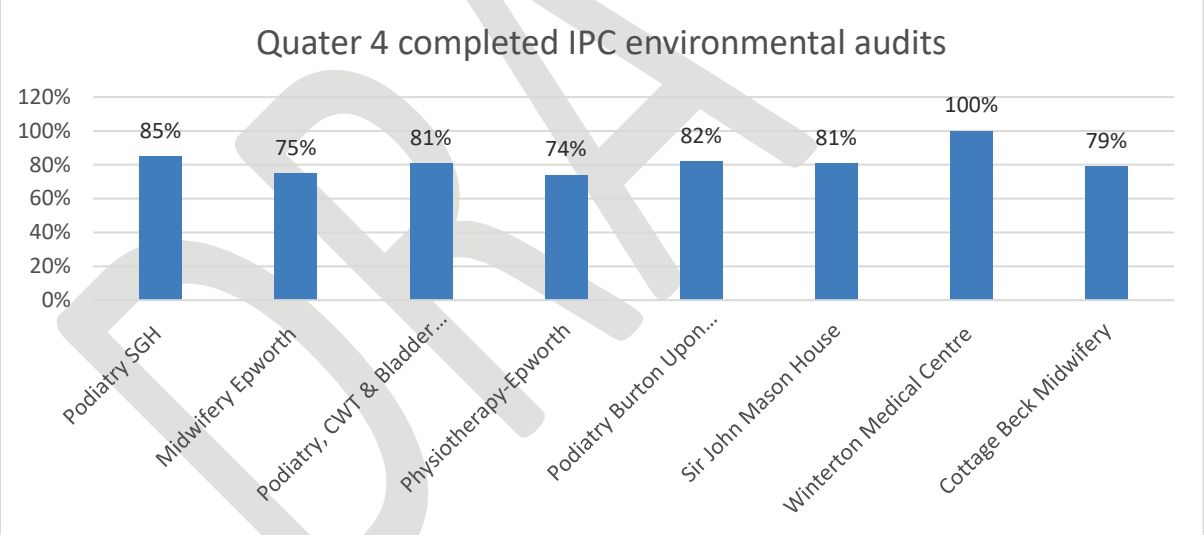


The graph below shows Quarter 3 'Action Plan' returns (series2)

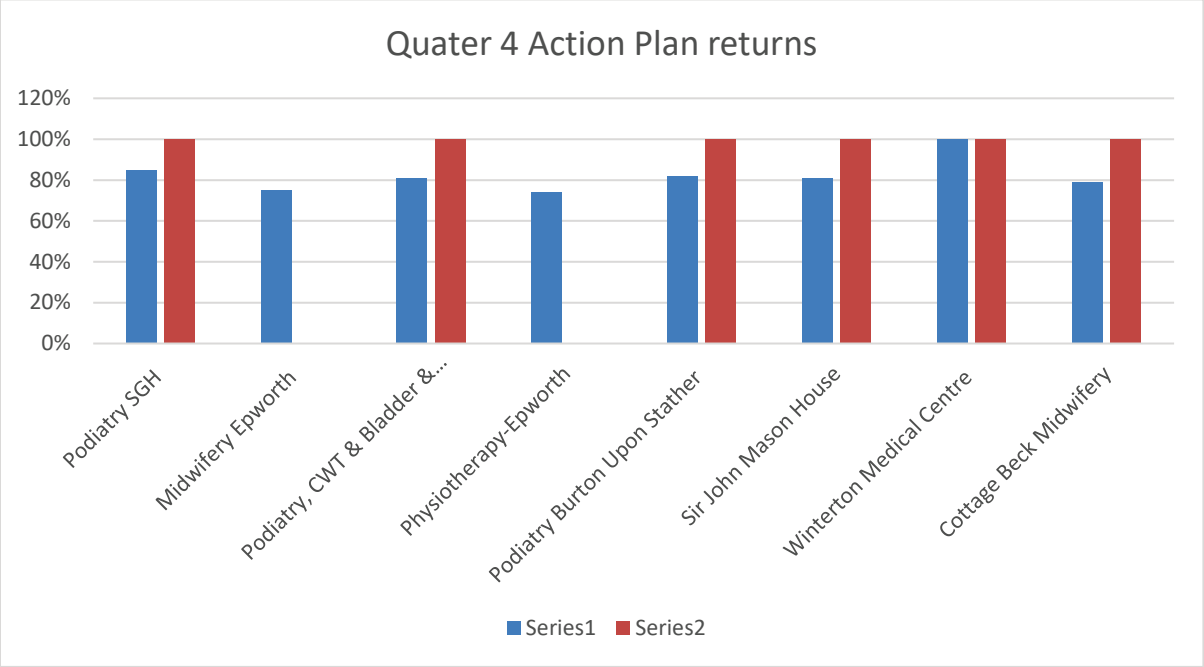


Quarter 4 January 2023 -March 2024

8 IPC Environmental Audits were undertaken.



Series 2 indicates Action Plan returns.



Themes from the IPC Environmental Audits

Some of the findings from the IPC environmental audits are listed below, which are reoccurring themes.

- Environmental issues with walls damaged, flooring stained and the skirting coming away from the wall, ceiling tiles stained and require repair.
- Dust – high and low dust found on visits. (Bases of couches dusty)
- Boxes/items stored on the floor.
- Missed opportunities of Hand washing
- Staff not compliant with Bare below the elbows.
- Inappropriate items on the sink, soap not in brackets on the wall and some soap out of date.
- Areas needed decluttering (and general tiding) making cleaning areas more accessible.
- Blinds not made of impervious material.
- Inappropriate items kept under the sink, mugs, food items.
- Disposable curtains out of date/no date.
- Temporary closure mechanism not utilised on Sharps contains/bins.
- Rust on some patient equipment. i.e., trolleys.
- Rusty and broken on pedal bins.
- No Blood spillage poster in the area.
- Ceiling tiles damaged.

- Orange waste stream being utilised in areas which do not need to be. This is costly and not necessary. Areas have been challenged on visits to ask the rationale for this.

It is hoped that 2024-2025 will have a new community audit which will better suit the community areas and services. Plans to review the community audit have been difficult due to workload/prioritization.

15 Steps Audits

The Community IPC Nurse has took part in the 15 Steps audits and provided IPC support. Areas attended include Chronic Wound Team at Barnard Court, Dental at Ironstone, discharge office in Scunthorpe General Hospital, Intermediate Care Team at Beacon House.

Audit Action Plans

Areas that were audited were asked to submit their Action Plan for improvement within a 6-week period.

The responsibility was issued to one person to ensure actions from the audits were rectified/escalated. Environmental issues should be reported at the time of finding issues and a record kept as proof. Issues then need to be escalated if not in a reasonable time frame.

Those who returned Action plans promptly 'a big thank you' for your diligence in doing so.

Special mention needs to go to the facilities service manager at SGH for in-detail action plans and prompt rectification of an issue(s).

Outstanding Action Plans that were not returned shows in the graphs of the community report.

Areas of Concern/Improvement

Central Equipment store

The Central Equipment store (CES) has been identified as not fit for purpose, as the decontamination area is not enclosed; this is an historical issue believed to be on the Risk register.

Barnard Court Facilities

This is a Rotherham Doncaster and South Humber (RDaSH) building. The patient and staff toilets at Barnard Court, Brigg have been escalated as they require attention by RDaSH property services. The premises have had some improvement, but the toilet(s) remains the same in a poor state.

Chronic Wound Team (CWT)

The CWT share the same room as the Midwives at Barnard Court, which is not recommended by IPC; it is mitigated by essential cleaning of the room after each service use. The outside waste was not in a secure area

The Acute Therapies SGH

The main gym in Acute Therapies had to be temporarily closed due to RAAC found in the gym. Works to rectify the issue started.

Central Equipment store

The Central Equipment store (CES) building remains not fit for purpose, as the decontamination area is not enclosed; this is an historical issue believed to be on the Risk register. Although this is an area of concern, improvements have been made.

Barnard Court Facilities

This is a Rotherham Doncaster and South Humber (RDaSH) building. The patient and staff toilets at Barnard Court, Brigg require attention. It has been escalated through NLaG to RDaSH property services. The premises have had improvements/decorated, but the toilets are still outstanding.

The Chronic Wound Team share the same room as the Midwives at Barnard Court which is not recommended by IPC; it is mitigated by essential cleaning of the room after each service use.

Maternity at Cottage Beck

The building has had some environmental improvements, decorating in the rooms and cleaning improved on the last audit. No issues with vermin (rats) reported, which was a problem on the previous annual report.

The Acute Therapies SGH

The main Gym had to be closed due to RAAC found in the gym and works to rectify the problem started. Staff worked hard to maintain the service and ensure patients had an assessment and treatment. Some treatment was outsourced to the POD's in Scunthorpe. The service is well lead and IPC issues rectified/reported to facilities immediately.

Information

Lindsey Lodge Support

IPC support to Lindsey Lodge Hospice continues as per service level agreement between the two Organisations. Presentations, audits have been delivered and continuous

Activity and Engagement/Education

Face to face training began to take place at Beacon House, following 'Living with Covid' and getting back to normality.

'Bugs R Us' was a great success with speakers, stalls, quizzes and lunch provided. Many community staff attended the day. The majority of feed-back from those who attended was positive and enjoyed the IPC conference.

Link Practitioner Study Day (name changed to link Champion)

A two hour 'face to face' link 'champion' day took place in November 2023 at Beacon House which discussed the role of the IPC link champion. It also had a presentation on 'Prontoderm' the MRSA body wash now used

to decolonize/suppress MRSA patients and had a session on Streptococcus A (Strep A). An invitation to all staff to attend the session (and not only link champions) was extended due to the information on Strep A.

Glow Box HH Training

Glow box (HH) training commenced at Beacon House and Lindsey lodge during the time frame of the annual report.

Annual Hand Hygiene practical assessment should have been undertaken for all Community & Therapy staff and inputted onto the Oracle Learning Management system (OLM).

FIT Testing

Throughout the period from April 2023- March 2024 the IPC Team continue to ask for community staff to be FIT tested. It is so important that this is adhered too, and a permanent reminder is included in the Community and Therapies governance highlight report. It recommends that staff be FIT tested on two types of masks due to supply issues. The onus put on staff to know which masks they 'passed' on (make and model number) as this was essential information. If any changes to facial structure, for example losing weight, dental extractions altering facial shape or facial accidents they would need to re FIT tested.

Glossary

MRSA	Meticillin resistant Staphylococcus aureus is a bacterium that is resistant to commonly used antibiotics such as flucloxacillin.
C.difficile	Is the organism most frequently identified as the cause of antibiotic-associated diarrhoea
Bacteraemia	The presence of bacteria in the blood
Colonisation	The presence of a bacteria on or in the body without causing infection
ESBL	Extended-Spectrum Beta-Lactamases are enzymes produced by bacteria, making them resistant to broad-spectrum antibiotics.
PIR	Post Infection Review is a systematic review of an event to determine if any deviation from best practice and lessons to be learnt.
Antimicrobials	Antibiotics
Dashboard	Is a way of presenting data in a visual format.
Carbapenemase-producing Enterobacterales	Resistance to carbapenem antibiotics
NLAG	Northern Lincolnshire & Goole NHS Foundation Trust
TB	Tuberculosis
DHSE	Department of Health & Social Care

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)200

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10th October
Director Lead	Helen Wright / Gill Ponder, Non-Executive Directors / Chairs of Performance, Education and Finance Committees-In-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common meeting held on Wednesday 24th July and Wednesday 28th August 2024.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	**The minutes attached are for information.**
Prior Approval Process	Performance, Estates and Finance Committees-in-Common on 28th August and 25th September 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:

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 24th July 2024
at 09:00 to 12:30 hours in the Boardroom, Diana Princess of Wales, Grimsby

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) – Chair
Lee Bond	Group Chief Financial Officer
Simon Parkes	Non-Executive Director (NLaG)
Dr Kate Wood	Group Chief Medical Officer
Jane Hawkard	Non-Executive Director (HUTH)
Paul Bytheway	Interim Group Chief Delivery Officer

In Attendance:

Adam Creeggan	Group Director of Performance
Jennifer Granger	Head of Compliance & Assurance (NLaG)
Leah Coneyworth	Head of Quality Compliance and Patient Experience (HUTH)
David Sharif	Group Director of Assurance
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (Minutes)
Stuart Hall	Non-Executive Director (Vice-Chair)
Julie Bielby	Associate Non-Executive Director (NLaG)
Simon Tighe	Group Deputy Director of Estates, Compliance and Information Services

Observers

Ian Reekie	Lead Governor (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. Apologies for absence were noted for, Helen Wright, Non-Executive Director (HUTH), Ivan McConnell, Group Chief Strategy & Partnerships Officer (HUTH).

1.2 **Declarations of Interest**

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

1.3 **To approve the minutes of the meeting held on 26 June 2024**

The minutes of the meeting held on the 26 June 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

4.3 Groups IPR

- Paul Bytheway and Julie Bielby had not yet met to discuss the hospital discharge scheme options and agreed to meet prior to August's meeting.

3.1 Board Assurance Framework

- Agreed to close the action relating to the Business Continuity Plan as the ARG CiC were to receive an update on the EPRR assessment at its next meeting.

3.2 – Risk Register

- David Sharif to bring an updated risk register to August's meeting.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

Gill Ponder reported that no items had been referred for consideration at present to the PEF CiC.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF) HUTH & NLaG including High Level Risks**

David Sharif took the report as read and explained the front sheet for the BAF gave a more detailed oversight of the high level risks. The score for the risks relating to Performance, Estates and Finance had remained the same since June's meeting. The finance risk was 25, and there were 2 risks for estates which were scored a 20.

Lee Bond queried the Estates risk score, and whether this was accurate. David Sharif informed that there was a Board session to be arranged to refresh the strategic risks, with conversations to follow to support a refreshed BAF and risk register.

Jane Hawkard queried why the finance risk was sitting at 25, and believed it could potentially be a 20 score as 25 suggested it was catastrophic. Dr Kate Wood informed the Committees that quality risks sitting at 16 would be discussed in the Quality and Safety CiC as they were equally as important. Paul Bytheway felt the finance risk should remain as 25 as the Group should be signalling this as a significant risk. Simon Parkes added that the risk required further attention, and the Group should be focusing on what is being done to address it. The Committee agreed to leave the score at 25 in view of a letter received from the NHSE FD and submission of the month 4 financial returns.

Gill Ponder challenged the target for performance. David Sharif explained the score of 16 was the target for the year, and the gap in control was due to the quality of reports to the Board Assurance Committees. This target score would be monitored regularly to make sure it was on track.

Gill Ponder raised on behalf of Helen Wright that she would like to know more about the mitigations of the risks rather than the scores. David Sharif explained that the appendix was being developed to show this.

Jennifer Granger and Leah Coneyworth joined the meeting at 9.37am

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports & recommendations to note.

3.3 **Review of Relevant External Report(s), Recommendation(s) & Assurances(s)**

There were no external reports, recommendations or assurances to note.

3.3.1 CQC Actions Report – Group

NLAG Update:

Jennifer Granger gave a brief overview of the report. There were 5 open actions relating to Performance, Estates and Finance; 2 of the open actions were green and 2 were amber and 1 had moved to red from amber (End Of Life 02) (EOL) due to concerns around the reliability of manually extracting raw data. The Care Group were seeking advice for a timescale for completion.

Gill Ponder raised a question around how they have found themselves in a position to have lost data. Jennifer Granger advised the QI team were previously supporting with the manual extraction of data, and an EOL Governance meeting had been arranged to help triangulate the information. Jennifer Granger added that a new initiative called ‘Comfort Obs’ is set to be

implemented to review what will be measured. Paul Bytheway stated that it was important that the QI team carried on with the manual extraction of data until a new system was in place.

Action: Paul to have a conversation with Ivan/Amanda to resolve EOL data extraction issues.

Gill Ponder raised a question on behalf of Helen Wright around the financial strategy and if there was a timescale. Lee Bond explained that he can start to look at this now due to having an organisational strategy, but the clinical strategy was still required. Lee to pick this up with Ivan McConnell. Lee queried what the Committees-In-Common wanted to see in the strategy and Gill Ponder believed it would be beneficial to see the management of finances and the changes within the organisation. Jane Hawkard asked that the strategy include the accountability mechanisms to be used to manage finance, a realistic timescale for managing the underlying financial deficit, the strategy for increasing productivity, increasing income, cost reduction and value for money, financial reporting in terms of project evaluation, an investment strategy. It was acknowledged that some parts of financial strategies are generic but as a new group it was important to have a financial framework in which the care groups should work.

HUTH Update:

Leah Coneyworth gave a brief overview of the report. There were 3 open actions relating to Performance, Estates and Finance; 2 of those related to the ground floor reconfiguration and flow, and 1 around Maternity triage and the staffing challenges. A business case was in place to support this action. She added that there had been an improvement in the time it takes to triage which had reduced from 90 minutes to 10 minutes.

Leah Coneyworth provided further assurance that HUTH and NLaG were undertaking an assurance piece to review all actions plans with the care groups and looking at any barriers, as well as any closed actions to ensure improvements had been sustained.

Jennifer Granger and Leah Coneyworth left the meeting at 9.55am.

4. The Committees agreed to escalate to the Board the in-depth discussion around risks and that further information had been requested on the EOL CQC Action. The CiC agreed reasonable assurance for this section of the agenda.

4.1 **COMMITTEE SPECIFIC BUSINESS ITEMS**

<u>Joint Business Items</u>

Financial Report – Month 3 / Financial Recovery Board Minutes

Lee Bond updated the CiC and advised that the in month Group deficit was £12.4 million, which was £2.6 million adverse to plan. This takes the year to date deficit to £25.1m, which is £2.6m adverse to the YTD plan.

The ICB had a plan of £50 million deficit by the end of the year, and currently they were expecting to deliver circa £47 million at month 3. The 42 ICBs had been arranged into tiers 1, 2, 3 or 4. Lee Bond advised that he had spoken with colleagues in South Yorkshire and they weren't sure what the intervention looked like for the Group ICB which was in tier 4. Our understanding at present is that our ICB is in tier 3+ and would therefore come under further scrutiny in the coming months.

Lee Bond informed the CiC that he would be looking at Month 4 numbers from 29th July 2024 after a request from the ICB Finance team and this could help to demonstrate that the run rates were getting better.

The month 3 underlying position hadn't seen any real improvements. There was continued pressure on financs on the North bank, but it was noted that the South Bank had reduced their agency spend considerably. A piece of work was in motion to identify ways to improve the group position. The Executive team were meeting with care groups regarding their expenditures and comparing spend over the first 3 months of the year with 2023 data.

The cash position appeared to be manageable for the year, but is heavily dependent on the CIP delivery. At month 3 the cash balance was at £45.4m.

Lee Bond voiced that the financial impact of improving productivity had been discussed at the Care Group meetings. Examples such as increasing follow-ups and theatre productivity were believed to improve productivity and benefit the group financially. He added that there was a lot of work to do around how much work could be done, and how much income could be generated through the reduction of waiting lists. The Executive team had received a paper which had around 40 different initiatives from across the care groups.

Lee Bond concluded that he would be adding an appendix to the Financial Report that will show the detailed CIP plans are for the rest of the year and was hoping to be closer to plan in month 4.

Julie Bielby questioned if the current spend was only for essential items? Lee Bond had tasked the procurement teams to monitor spending.

Jane Hawkard queried why the estimated 22.3m improvement in CIP delivery to the year end was outlined in total as a risk. Lee Bond explained that in the past the Group had done a best and worst case in run rates, and the £22.3 million was mainly based on productivity. Bank& agency and medical staffing was the area with the biggest cost. Jane Hawkard requested that a detailed plan would be useful to see at this Committee. Lee Bond expressed he supplied a report to Cabinet every fortnight and would bring this to the next Committee to provide further assurance.

Action: Lee Bond to bring a detailed Cost Improvement Plan (CIP) to the August meeting.

Paul Bytheway indicated that he had a conversation with Neil Rogers around productivity and concluded there were two pieces of work to help get the financial position back on track, including the elective recovery money which would help with waiting lists.

Simon Parkes emphasised that it would be useful to see the detailed CIP list at August's meeting but felt he hadn't heard anything that gave him confidence that the group is able to deliver the annual plan. There was nothing that suggested this would be possible without causing a significant impact on services to patients.

Gill Ponder queried whether the financial plan had been reset. Lee Bond confirmed it had and it was agreed that it would be beneficial to compare the new plan to the original one to see if we spent more than we had planned to spend. At month 3 the forecast outturn for year end estimates a £18.7m deficit to plan. This forecast include an improvement of £22.3m in CIP delivery over the remaining 9 months of the year and the release of £11m of annual leave accruals. This situation adds weight to the risk score for finance of 25 and this issue needs to be escalated to the Trust Boards.
Gill Ponder referred to non-paid consumables on the report and questioned why this hadn't been reviewed already. Lee Bond stated that Surgery appeared to be at high spending rate and was unsure on the activity that drove that. This issue needs to be reviewed further.

Gill Ponder quoted the divisional month performance from the report and wondered if more could be done around accountability to the biggest outliers such as anaesthetics. Lee Bond stated he had met with the anaesthetics Care group on the 23rd July, and was comparing their spend from 2023 to 2024. There was not much of a difference so Lee felt this was a historical spend that had been growing. Furthermore, theatres had appointed 6 trainee CESR Doctors in the last year and once qualified they would fill the existing vacancies. However the Care Group did not have the authority to decide this and would be held to account.

Grant Thornton was set to be commissioned and would review 3 key areas across the ICB and Providers. The review will determine whether there is enough grip and control and what more could be done in this area to improve finances. They would also review the CIP and pace of expenditure and the mitigations in place.

Gill Ponder raised some positives stating that the Financial Improvement Board was now well established, the Care Groups were meeting with Jonathan Lofthouse and the Executives individually to discuss specific challenges. The Group was maintaining its headcount position with weekly reviews, and long waiters were reducing, but there was still a lot more to be done around grip and control.

The Committees-In-Common agreed that they had limited assurance.

4.2 **National Cost Submission**

Lee Bond gave a brief overview on the National Cost Submission and advised that the Lorenzo implementation had made it harder to r analyse Costs and units of activity. He added this report was for information to give assurance to the CiC that the team was on track with providing information.

Lee Bond explained that they were in a position to submit, but they did have limitations across the Group. There had been a cost steering group on the North bank and Lee confirmed that he wanted to create a Group wide cost steering group.

The 22/23 reference costs had been recently published, and Lee Bond gave an overview of these. In 21/22 HUTH sat at 97%, 22/23 rate was 95% and in 21/22 NLaG was at 102% and 22/23 was showing at 93% but Lee felt this was inaccurate and was more likely to be around 105% based on the 21/22 data.

Lee Bond reported that Acute and Emergency Medicine across the Group had deteriorated. Family and Women's at HUTH had shown improvement.

Stuart Hall queried how we compared against peer groups. Lee Bond explained that the 95% was a national index.

Lee Bond informed the CiC that the team were pulling together a group, and taking learnings from the last year to look at the weaknesses and areas of improvement.

The Committees-In-Common agreed that they had limited assurance, but noted that there were plans in place to meet the national submission requirements.

4.3 **Group Integrated Performance Report (Including areas of improvement with the 75% late theatre starts)**

Paul Bytheway took the report as read. He informed the Committees-In-Common that the Referral To Treatment (RTT) 78 week long waits for June were at zero, and the 65 week waits had seen a reduction and were on trajectory to be at zero by September.

Dental within the community remained a risk, as well as Paediatric ADHD assessments. Paul Bytheway announced that he was attending a meeting that day to help work through the issues.

Paul Bytheway reported that there were 170 late starts in June. Neil Rogers is carrying out work to understand the timings, and is breaking them down into time categories such as 0-15 minutes late. Further detail will be provided in August's IPR.

Paul Bytheway informed the CiC that he had met with Adam Creegan on the 22nd July to review the waiting lists. Adam Creegan voiced that this was not due to a Lorenzo problem, but a process based issue and the 12 week wait text reminder issue was also significant in causing the growth seen at NLaG.

Cancer had entered into tier 1 at NLaG. Paul Bytheway advised that there were a number of improvement plans in place to push forward cancer delivery and challenge the backlog with help from funding available from the Cancer alliance team.

Stuart Hall suggested that it would be beneficial to see more detail on the Patient Initiated Follow Ups (PIFU) and the reduction in follow-ups. Paul Bytheway explained this was sitting with the Outpatient transformation programme and they were engaged with the Chiefs of Services who were looking into the level of activity being taken off their waiting lists following the implementation.

Gill Ponder queried why the daycase admissions at NLaG were showing below plan at 516, and HUTH were at 197 above. Adam Creegan explained that investigations were underway to look into it, and there had been a significant shift in month 2 at NLaG. It was believed to be due to the intended management recording of daycase admissions, and this was being investigated.

Action: Adam Creegan and Paul Bytheway to bring back to the next meeting the investigations around the day case admissions at NLaG.

Adam Creegan revealed that NLaG had a better ratio of new patient follow ups. He also added that script changes where due to be implemented within the next 2 weeks to help stop patients from automatically going onto a No Criteria to Reside (NCTR) pathway.

Gill Ponder raised concerns around the cancer performance. Paul Bytheway stated that he was checking the process that helps to oversee all the key implementation plans. He explained that the Planned Care Board meeting oversees the Cancer delivery and has a clear focus on what the individual tumour sites look like. Paul Bytheway added that the Faster Diagnosis Standards (FDS) was over 80% and he was looking at the potential to outsource non-cancer work.

Simon Tighe joined the meeting at 11.23

Lee Bond queried whether there was a particular tumour site to target to help with cancer targets. Paul Bytheway explained there were 5 non-compliant cancer sites, and there was no clear tumour site that could be targeted. The Cancer Alliance funding was helping to make changes to the pathways.

Jane Hawkard expressed it would be useful to see what improvements had been made in these cancer sites performance given that the CIC received actions plans late in 2023 from Julia Mizon which included actions and assisiance from the Cancer Alliance.

Action: Paul Bytheway agreed to review the cancer site report previously bought to the group and to bring back and update for the Cancer Deep Dive.

4.3.1 **Care Groups Transitional Arrangements**

Paul Bytheway gave a brief update on the current status of the Care Groups. The Care Groups are officially in place at the senior levels, and the structure below was almost finished. The overall formal review was being managed by Jonathan Lofthouse and he would be giving an update to the Board in October.

4.4 **Deep Dive – Urgent Care**

Paul Bytheway/Adam Creegan gave an update regarding Urgent Care. The three metrics that the Group were focusing on this year were:

- time to see a clinician
- reducing the time non-admitted patients spend in ED (flow through the department)
- Improving the assessment, decision making and flow through ED of frail patients over 65 years of age.

Adam Creegan stated that he had a conversation regarding the Integrated Care Board (ICB) and Tiering. The ICB was in tier 2 for Urgent and Emergency Care (UEC) Performance. Currently at a regional ICB level the Group had not been compliant against the acute footprint target, due in part to City Health Care Partnership (CHCP) elements not delivering to expectation.

Adam Creegan informed the CiC on the tasks set to help improve Urgent Care such as workforce alignment to patient footfall in the dept. to help allow clinicians to see patients earlier into their pathway. Increasing assessment spaces and ambulance handovers were also tasks set to help show improvements. Adam Creegan expressed that due to previous failed improvement initiatives it had created a sense of burnout within the teams, but work was underway within the UEC delivery group to help make a genuine change as well as cultural changes.

Jane Hawkard raised issues around flow out of the Emergency Department particularly regarding admissions into hospital wards. The data showed a large reduction on the delayed discharge list. Paul Bytheway confirmed that a lot more beds had been opened due to long admissions, and the teams where trying to focus on the non-admitted and time to see a clinician, as this allows pathways to be started sooner. Medicine and Same Day Emergency Care (SDEC) on both sites had a good plan to allow flow through the department.

Lee Bond informed everyone that Johnathan Lofthouse had advised that the regional team were looking at the Group and waiting for the next rotational change in Junior Doctors. There were plans to reconfigure how the Junior Doctors work across the department to improve overall performance. Their shifts would align more to high times of demand.

Gill Ponder queried how long it would take to see improvements from the metrics of the 3 focus areas. Paul Bytheway explained that he had asked for a refreshed UEC action plan to help track against the operation plan.

The Committee agreed they had reasonable assurance on the diagnostics and ED based on the improvements seen and the plans in place. However the assurance for Cancer and Planned care was limited.

4.5 **Estates and Facilities – General Update including building investments**

Simon Tighe gave a brief overview of the report, and informed the CiC of the current risks.

On the North Bank, there was 1 high risk, which was linked to the IT server room that had been closed due to completion of work. There had been 3 high risks on the Estates risk register but one had been closed.

On the South Bank they had dropped to 9 risks from 11 in the last quarter. 1 had been closed which was the fire compliance at Scunthorpe. The team had risk assessed the Goole fire alarms and they did not warrant an immediate replacement so this had moved to a moderate risk. Another risk moved to moderate was the testing of legionella linked to removing baths from SGH.

The Estates Returns Information Centre (ERIC) had been submitted which feeds into the model health system data. This is set to be published and would feed back into the system by January 2025 across the Group.

Simon Tighe updated that his team are trying to establish a holistic approach to help target high utility costings due to the increase in price of electricity, and he was confident they could deal with the increase.

Stuart Hall left the meeting at 11.56am

The group had obtained further accommodation in Scunthorpe city centre and the draft contract was agreed. This would grant 46 extra beds to provide housing for Junior Doctors and Nurses.

Simon Tighe informed the committee that EFD senior team were working with ICB procurement colleagues using the Crown Commercial Services Framework to provide an outsourced Facilities Management contract in place to manage the Community Diagnostic Centres in Scunthorpe and Grimsby.

Simon Parkes queried why the Group was focusing on accommodation when we needed to save money. Re car parking. Lee Bond explained they were looking into the charging rates and trying to equalise those across the group . The accommodation on the main sites were not well utilised due to quality issues and further accommodation for overseas nurses and Junior Doctors was a key part of the recruitment strategy.

Gill Ponder referenced page 7 which was the total facilities management contract and queried if this would be brought to this meeting before going to the Board. Lee Bond explained that the contract was not ready yet, and it may be slightly delayed further. Jane Hawkard felt it would be beneficial for an update on t progress to be reported at August's meeting.

Action: Simon Tighe to provide an update in Augusts report regarding the progress on the total facilities management contract.

4.5.1

Premises Assurance Model

Simon Tighe took the report as read and gave a background on the model.

At HUTH the biggest issue was premises that are occupied predominately around outpatient settings where the Group was not the primary lease owner or landlord, and hence there was a lack of control over those areas. The Group currently has staff in areas with no leases with no assurances that the landlords were providing a safe and fit building, as the landlords had not been able to provide the data that was being asked of them. Simon advised that risks were minimised in these areas as they were outpatient settings.

Simon Tighe advised that the policies for the transport areas in the North were up for review.

It was highlighted that there was a new criteria around maintenance which was not covered in the NLaG report. The SH21 risk was around reducing harm with anti-ligature in practice. Simon Tighe advised that this would be a large piece of work, and currently the Group did not have a maintenance contract that covered anti-ligature facilities.

Jane Hawkard questioned if there would be a time when the Estates and Facilities team would be assured, and was there any particular areas they were concerned about. Simon Tighe advised that there were no immediate concerns.

Gill Ponder requested on behalf of Helen Wright a forecast for retail catering at HUTH given the significant loss experienced in prior year. Lee Bond explained the prices had been increased to bring the service to breakeven and the team were doing a fundamental review of The offer. This would be going to Cabinet in 6 weeks time.

Action: Simon Tighe/Lee Bond to bring a HUTH catering price plan and forecast to September's meeting.

The Committees-In-Common gave approval for the Premises Assurance Model to go to the Board and agreed reasonable assurance.

4.6

Contract Approvals – Routine Radiology

Lee Bond briefed the CiC that the report was not a request for approval and was merely for information and to advise of the current progress. Gill Ponder confirmed that the Committee was supportive of the initiative.

Lee Bond left the meeting at 12.19pm

4.7

Emerging Issues

There were no emerging issues raised.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

The Committees-In-Common had nothing to raise in relation to the work plan.

5.2 / 5.3 Consolidated North Bank Site Report & South Bank Site Report

The Committees-In-Common had nothing to raise from the consolidated North Bank and South Bank Site Reports.

5.4 Planned Care Board Meeting Minutes

There were no minutes for this Agenda Item as June's Planned Care Board Meeting was cancelled.

5.5 Unplanned Care Board Meeting Minutes

The Committees-In-Common had nothing to raise from the Un-planned Care Board Minutes.

6. ANY OTHER URGENT BUSINESS

6.1 There was a discussion around the risk rating on finance. Many committee members were unhappy with the score of 25 as it suggests that mitigations are not in place or working at this early time in the year, and there may be a need to reconsider a reduction to 20. Julie Bielby stated that the CiC had requested a bridging plan of how to address the declining performance within the Group, and felt she would be more comfortable reviewing the risk once they had seen what the bridging plan looked like.

The Committee recommended to review the Finance risk rating score once the bridging plan had been produced.

David Sharif informed that the Terms of Reference will be approved by the Board in 2 weeks for all the Committees-In-Common.

ACTION: Lee Bond to bring back a bridging plan to the next meeting

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

There were no matters for referral to any of the other Board Committees.

7.2 Matters for Escalation to the Trust Boards

Items for escalation to the Board were captured in the summaries after each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

Wednesday, 28th August 2024 at 09:00 hours at Diana Princess of Wales Hospital, Grimsby.

Gill Ponder thanks everyone for their attendance and the meeting closed at 12.30pm.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	Y		Y	Y					
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y	N					
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y	Y					
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N	Y					
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y	Y					
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y								
Paul Bytheway	Interim Group Chief Delivery Officer						Y	Y					
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y	Y					
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D	D					
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N	N					
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y	Y					
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N		N	N					
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y	N					
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N	N					
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y	Y					

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 28th August at 09:00 to 12:30 in the Boardroom at Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Helen Wright	Non-Executive Director (HUTH) - Chair
Gill Ponder	Non-Executive Director (NLaG)
Lee Bond	Group Chief Financial Officer
Simon Parkes	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Paul Bytheway	Interim Group Chief Delivery Officer

In Attendance:

Ivan McConnell	Group Chief Strategy & Partnerships Officer
Adam Creeggan	Group Director of Performance
David Sharif	Group Director of Assurance
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Julie Beilby	Associate Non-Executive Director (NLaG)
Peter Sedman	Deputy Chief Medical Officer
Brian Shipley	Deputy Director of Finance
Debbie Hudson	Personal Assistant (Minutes)
Jennifer Granger	Head of Compliance & Assurance (NLaG)
Leah Coneyworth	Head of Quality Compliance and Patient Experience (HUTH)
Simon Tighe	Group Deputy Director of Estates, Compliance and Information Services
Edd James	Director of Procurement
Rachael Ellis	Scan 4 Safety Lead

Observers

Ian Reekie	Lead Governor (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

Helen Wright welcomed those present to the meeting. The following apologies for absence were noted:

Dr Kate Wood, Group Chief Medical Officer
Alex Best, Deputy Director – Major Developments

Lauren Rowbottom, Personal Assistant

1.2 **Declarations of Interest**
No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meetings held on 24 July 2024**
The minutes of the meetings held on the 24 July 2024 were accepted as a true and accurate record subject to the following amendment(s):

- Further review of high spending in surgery to be brought back in September
- Correct Julie Beilby's surname.

1.4 **Matters Arising**
Helen Wright invited committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.5 **Committees-in-Common Action Tracker**
The following updates to the Action Tracker were noted:

4.3.1 Groups Deep Dive into length of stay and beds

Simon Parkes joined the meeting at 9.08 am

Action: Helen Wright, Gill Ponder and David Sharif to meet to discuss deep dives further. It was agreed in the meeting that the Integrated Performance Report would be used to provide deep dive data, with more focus on the area under review and sufficient time allowed for debate.

Action Number	Action	Comments
4.3	**Groups IPR**	Paul Bytheway and Julie Beilby had met and agreed there is a problem which the team would work through.
4.3.1	**Groups Deep Dive into length of stay and beds**	Helen Wright stated that LOS had been carried forward to September's meeting in line with the workplan. It was initially added to August agenda as carried forward from a previous meeting. A discussion took place regarding the need to rework the workplan for future meetings regarding deep dives as the amount of work to produce and present deep dives and the additional pressure on teams was challenging alongside business as usual.
3.2	**Groups Risk Register**	David Shariff confirmed that this agenda item could be closed as the High Level Risks are now included in the BAF Report. However, further detail around risk mitigation will be brought back in October.

4.1	**Group Financial Report**	Helen Wright confirmed this action could be closed.
4.2	**Group IPR Report**	Helen Wright confirmed this action could be closed.
4.3	**Group Estates and Facilities**	Lee Bond confirmed that this action was included within the agenda item and could be closed.
5.1	**Group Workplan**	Lee Bond confirmed that this action was included within the agenda item and could be closed.
3.3.1	**NLaG CQC Actions Report**	Paul Bytheway confirmed he had spoken with Amanda Stanford who had agreed to keep the current process.
4.3	**Group IPR**	Paul Bytheway confirmed that this action was included within the agenda item and could be closed.
4.5	**Estates and Facilities**	Helen Wright confirmed the Total FM contract had been approved at Trust Board and could be closed.
4.3	**Group IPR**	Paul Bytheway asked for clarity that the cancer deep dive is due back in October not September, as stated on the action tracker. The action tracker to be updated to reflect the October date
6.1	**Bridging Plan**	Helen Wright confirmed that this item was to become a standing agenda item and could be closed on the Action Tracker.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Helen Wright reported that the following matters had been referred by the Capital and Major Projects (C&MP) Committees-in-Common for consideration by the committees:

The data quality issue which would be covered on the agenda.

Fire compliance and a better understanding of the risk scores, based on Scunthorpe General Hospital having the fire alarm system replaced and the residual risk status at Goole District Hospital , which will be picked up within the agenda item.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF) – HUTH and NLaG including Risk Register Report

David Sharif took the report as read and explained the report incorporated the BAF and high-level risks pertaining to the committees in common. He confirmed that the high-level risks element was now complete and it captured all the risks captured through ULYSEES and Datix. The BAF has three strategic risks relating to PEF, with the finance risk rating the highest scoring risk across the Group. The full set of risks show a high-level number of risks on each PEF risk category and the number of risks which were overdue for review. Care groups (CG)s are currently reviewing, refreshing and revising their risks and a number of the risk ratings have been amended. Further development is required and the strategic risk refresh begins on 13 September 2024 with the Executives.

Helen Wright advised that a detailed conversation around risk occurred at the Capital and Major Projects CIC meeting and more information regarding the mitigations was required. The strategic risk review will be presented at Trust Board after Cabinet review.

Gill Ponder asked if the current format of the BAF would be used going forward and if the top section of the report, regarding assurance committee and executive group requires review, as the Committees should not be shown as both the assurance committee and the executive group. David Sharif replied that there may be further changes to the sections in response to recommendations from Internal Audit as greater clarity is required around the actions and the anticipated impact of the actions. Gaps in control and assurance need resolving for current areas of issue.

Action: David Sharif to ensure the BAF report is updated to reflect the correct content regarding the executive group and assurance group.

Gill Ponder asked when the Estates and Facilities integrated performance report (IPR) mentioned on the BAF would be presented. A discussion took place around the need for an Estates IPR and it was concluded that the current reporting structure is sufficient. As such the BAF summary would be updated.

Gill Ponder queried risk number 2655 and asked how the steam boiler contract expiry would be managed. Helen Wright queried risk number 2951 and asked how the failing electrical equipment will be managed. Mitigations for these items will be reviewed and shared in line with the request for further detail noted above.

Ian Reekie joined the meeting at 9.29 am

The CIC discussed the Finance Risk and its rating of 25 as well as the target, which Julie Beilby stated was aspirational. Lee Bond suggested that as the risk included the in-year risk and the underlying risk, it could be separated, with the short term risk being added to the High Level Risk Register.

Action: David Sharif to arrange for the risk register to be updated to only show the short-term financial risk and the long-term financial risk to remain on the BAF.

3.2 **Review of Relevant External & Internal Audit Reports & Recommendations as referred from the Audit, Risk and Governance (ARG) CiC**
There were no external or internal audit reports & recommendations to note.

3.3 **Review of Relevant External Reports, Recommendations & Assurances as appropriate**
There were no external or internal audit reports & recommendations to note.

The agenda was taken out of order at this point.

4.2 **22-23 National Cost Collection Publication**

Lee Bond gave a verbal update on the National Cost Collection publication 2022-23 which had been published and then subsequently unpublished. An update would be provided when the revised publication was available.

Lee Bond confirmed that the Corporate Benchmarking process had recently been undertaken with some discussions taking place with the national team regarding data quality. An update would be shared once the information is published.

Jennifer Granger joined the meeting at 9.33 am

Leah Coneyworth joined the meeting at 9.35 am

The agenda returned to order at this point.

3.3.1 **CQC Actions Report – Group**

NLAG Update:

Jennifer Granger reported that following the Care Group Review meetings with the Group Chief Nurse, a number of outstanding actions would require intervention and assurance levels would be changed as a result. There were currently five open actions; two were green, one was amber and two were red. One action linked to cancer waiting times had moved from amber to red and this would be discussed at the Planned Care Board.

Paul Bytheway expressed the importance of having consistent messaging around Cancer performance, as there had been some improvements and future reports should be aligned with the Planned Care Board.

Gill Ponder requested clarity around the Clinical and Financial Strategy development and Ivan McConnell advised that the Clinical Strategy would be produced by December 2024. The Finance Strategy would follow after this.

Action: Jennifer Granger to ensure the table within the NLaG CQC report is updated to correctly reflect the timescales for production of the clinical strategy and the financial strategy.

A discussion took place regarding Lee Bond's imminent departure from the Group, the impact this may have on the timing of the financial strategy and the level of detail required within the strategy as the financial strategy will underpin all the services as a whole.

Lee Bond asked if the financial information requested by Jane Hawkard at last month's meeting was still required. Helen Wright agreed a high-level report which includes annual report data for year one and captures equipment replacement and opportunities / challenges for the next five years would be useful.

Action: Brian Shipley to include a high level finance strategy update within the finance report section at future meetings, to update on current position, the challenges anticipated in the next five years and when a more detailed financial strategy will be available.

Simon Parkes asked if there was a plan to deliver the change to the 62-day target by March 2025 and Paul Bytheway clarified that the operating plan stated that the 62-day target would be at 70% performance by March 2025. Paul Bytheway stated that future PEF reports would be discussed at Planned and Unplanned Care Board to provide a direct audit trail and to ensure consistency.

Action: Paul Bytheway to discuss with Amanda Stanford the requirement for reports to have appropriate executive signoff.

Helen Wright suggested that gradual improvement should be noted with corresponding timescales showing the action that has improved performance.

HUTH Update:
Leah Coneyworth took the report as read and shared that there are three actions linked to the PEF CIC. Two of them related to overall organisation performance and the final action related to maternity performance in triage. The service was maintaining performance over 80% and women were being seen within 10 minutes, however this relied heavily on staff being moved from different areas.

Helen Wright asked if there was progress on the business case submitted for maternity. Lee Bond clarified that several investment requests had been received from the Group Chief Nurse however the service was currently being run by goodwill, overtime and agency usage, which was causing an overspend. The model needed to be substantiated for it to be established and a budget assigned.

Paul Bytheway asked if action TW4 is for him to complete and Leah Coneyworth confirmed that it was.

Action: Leah Coneyworth to forward TW4 detail and confirmation of the Ops lead for the CQC actions report to Paul Bytheway.

Gill Ponder mentioned that the expected timescales for achievement were over a year out of date. Leah Coneyworth explained that a decision had been made not to keep moving the dates out, keeping the original date for transparency. Helen Wright asked if a column stating the revised estimate date of completion could be included.

Action: CQC report to be updated to add estimated date of completion alongside original targeted completion date.

Jennifer Granger and Leah Coneyworth left the meeting at 9.59 am

The CiC agreed reasonable assurance for this section of the agenda and that additional information was required for risk and risk mitigations.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Financial Report – Month 4 / Including Cost Improvement Initiatives**

Brian Shipley updated the CiC and advised that the in-month Group deficit was £3.2 million, which was £2.7 million better than plan and the year-to-date position was on plan at £28.6m. The plan required significant improvement over the second half of the year. The latest year end forecast deficit for the Group is £18.2 million, but the

Group were currently forecasting achievement of plan as part of the overall ICB reporting. In addition to the £18.2m gap there are risks around income streams and the value of cost improvement plan (CIP) savings that have been embedded. Ibeit with a number of significant risks to that position.

Cost improvement plans (CIP) were slightly ahead of plan at month four, but would become significantly harder to achieve in the second half of the year. £67.6 million was being forecast in CIP delivery which was £17 million adrift of plan. The underlying position for the group was estimated to be £93.4 million deficit.

System performance was on plan at the end of the month four with a deficit of £49 million.

The reported cash balance looked healthy at NLAG but tighter at Hull,this was due to slippage on the capital programme for Community Diagnostic Centres (CDC), . It was confirmed that cash could not be moved between the two Trusts. Deficit support funding is anticipated in September and, if received, a requirement for cash support was not anticipated for this year, although that position was dependent on delivery of the planned savings from CIPs.

Elective Recovery Funding (ERF) for HUTH is doing well, but is slightly behind plan for NLaG.

Temporary staffing reductions are in line with the 3.2% of total pay expenditure target and significant reductions at NLaG had contributed to CIP performance.

Lee Bond advised of a couple of smaller risks around the CDCs which were discussed at C&MP He shared the slippage of non-recurrent funding position and stressed the need for generating more productivity. Nurse staffing on the North Bank was almost fully recruited to and this would impact the ability to take further costs out.

Gill Ponder asked what is being done to close the unidentified gap of £18.2 million.

Helen Wright mentioned the lack of sustainability of performance as salary accrual release has driven improved performance and was non-recurring. Lee Bond agreed and highlighted the October pay increase as an example of further pressure on the position.

Helen Wright asked if when talking about investment and facilities and capital expenditure that elements that have improved productivity or had a financial return could be shared with their impact on the plan. Lee Bond shared that around £70 million had been spent on the south bank ED and AMU and £20-25 million on the north bank AMU with limited delivery of financial returns.

Jane Hawkard asked if the £24.3 million is really non-recurrent income and has anything come from the KPMG waste management discussion within the Capital Improvement Planning action notes.

Ivan McConnell shared that Grant Thornton have been undertaking work with the ICB looking at 10 productivity work streams. He shared that Jonathan Lofthouse and himself had begun discussions with PA Consulting regarding financial recovery.

Brian Shipley confirmed guidance had been applied as the funding is not guaranteed. As such ,the £24.3 million funding streams are non-recurrent income. Lee Bond
4.1.1 shared that other non-recurrent income sources are cancer and maternity funding.

Jane Hawkard asked what the £8.1 million additional stretching to support was and Brian Shipley responded this was to cover assumed funding that is received in quarter four.

Forecast Financial Position (ICB Bridge Submission)
Lee Bond explained that the finance teams were reviewing the number of months left in the year and determining the financial requirements including adjustments for winter. Care Group run rates and Industrial action would impact on the requirements. Severe materially impacting financial changes were not included in the adjustments and Grant Thornton would complete their second stage of consultancy around mid-September. Additional ERF was required and reducing the bed base was being considered but this was not without risks.

Ivan McConnell shared that there was the possibility of working with an external partner with regards to; no criteria to reside, theatres, endoscopy and outpatients as fundamental changes were required.

Paul Bytheway stated that there were at least 70,000 follow ups which would take time to reduce before they could be changed into new.

4.1.2 The CIC were concerned about the current forecasting and this would be escalated to the Boards in Common.

The CIC discussed the Band 2/3 back pay grievance which was causing industrial action on the South Bank.

Finance Improvement Board Action Notes
Lee Bond discussed in agenda item 4.1.1.

Helen Wright summarised there were key risks in the forecast position; £18 million gap, £17 million CIP classed as high risk and £8 million of unconfired quarter four support. Limited assurance was given due to the current and forecast underlying position alongside the overall risk rating. The key risks highlighted would be escalated. It was agreed the financial risk on the risk register would remain at 25.

Brian Shipley and Peter Sedman left the meeting at 10.50 am

4.3 **Group Integrated Performance Report (IPR)**
Paul Bytheway took the report as read and shared that he will be meeting all the Ops Directors along with Adam Creeggan towards the end of September for discussions to reset what was expected and how and when it will be achieved. There had been some improvements with urgent care, although NLaG was more static; first clinician assessment had reduced from 180 minutes to 129 minutes at HUTH, over 65-minutes had reduced from 530 minutes to 443 at HUTH and there had been some improvement with 4-hour performance at HUTH. The rotas on the north bank had been reorganised to ensure workforce was demand led. The trial to move patients to specialist assessment areas has been put on hold for a couple of weeks due to a small increase in patients with GP letters due, to the GP action. Patients presenting with a GP letter would now go directly to the assessment area. At SGH and DPoW there had

been more morning bed waits than expected in the summer, so focus was on the SAFER care bundle to discharge patients safely and timely to improve occupancy. Going forward into the winter, the plan would be to ensure patients were flowed safely into the correct area.

Gill Ponder asked why the UTC target was not being met and Paul Bytheway advised that the figures were being skewed due to the UTCs at Bransholme and Beverley. The HUTH figures were as expected.

Gill Ponder queried ambulance handovers at NLaG and asked what could NLaG learn from HUTH, where improvement was being seen. Paul Bytheway responded that there had been an increase in the number of ambulances on the south bank but an increase between 30 and 60 minutes handover time had created some of the congestion.

The CIC discussed the ED investment against performance and the impact on flow due to overcrowding and ward closures.

Adam Creeggan stated that the performance figures were impacted by the system partnership with CHCP and static delivery at NLAG.

The CIC discussed culture within the ED and the willingness from other departments to assist with flow. The launch of the Strategic Framework would help staff work towards a common goal.

Simon Tighe joined the meeting at 11.15 am

Paul Bytheway stated referral to treatment (RTT) 65 weeks is beginning to show risks regarding deep inferior epigastric perforator (DIEP) flaps in complex breast reconstruction after surgery. The issue was a national problem and mitigation plans were in place.

Paul Bytheway updated the CIC regarding theatre late starts where 85% were in the 1 – 10 minutes late category. Theatre utilisation had increased to 80% but this was being clarified.

Gill Ponder asked if the Lorenzo administration issues had been resolved and Paul Bytheway advised that they had. Additional minors' cases had been added to under-utilised theatre lists and had caused some resistance in some specialities. Ivan McConnell shared that £1.5 million of extra activity had been undertaken, around 106%.

Paul Bytheway shared that the Group remained in Tier 1 for Cancer performance. The whole cancer agenda and pathway would be reviewed with Neil Rogers, Team North Managing Director and Julia Mizon, Cancer Network Care Groups Ops Director. 62-day performance has improved and faster diagnostic standard (FDS) was improving but continues to have challenges within the tumour sites. Workforce issues within gynaecology and urology were compounding long waits with national challenges and histology workforce issues impacting SHYPS and Pathlinks.

4.4 **Deep Dive – Organisational Data Controls**

Adam Creeggan presented the report which highlighted the issues with data recording, cleansing, validation and reporting. The paper focussed on NLaG due to a higher number of systemic issues which include conflicting status recording for a patient,

differences in capped utilisation of theatres internally and on Model Hospital due to inherent data quality issues. There was also an issue with the business rules written for RTT due to the lack of national guidance. An example was a 25% increase in the number of patients being recorded as inpatients instead of day cases.

Once the data quality issues are cleansed and the two-way text reminder system for patients of 12 weeks is reintroduced, the pre-Lorenzo baseline of 42,000 will be met by September/October. However, there are an additional 3,500 patients to be added to the waiting list from the electronic referral system because they were not added pre-acceptance of the referral. This was incorrect and would be reported to NHSE.

Adam Creeggan clarified that a significant remedial piece of work on better data controls within the organisation will be undertaken and the governance strategy will be presented at Group Cabinet on 3 September. Enhanced oversight of the patient services functions at NLaG will continue and there may be additional engagement with NHSE.

Jane Hawkard asked about the conversion rate for the 3,500 patients to be added to the PTL. Adam Creeggan confirmed there are examples of patients waiting up to 26 weeks.

The CIC discussed the inappropriate business rules and Adam Creeggan advised that the issues were probably due to lack of training rather than wilful manipulation.

Julie Beilby asked about the accuracy of integration between data management when electronic patient records were introduced. Adam Creeggan agreed the organisation requires cumulative controls to ensure accuracy.

Gill Ponder stated that internal auditors had looked at the DQ in the past and the audit report gave limited assurance but the audit had been focused on urgent and emergency care data.

Jane Hawkard asked how the 3,500 patients' integration into the PTL is being managed. Adam Creeggan gave assurance that there is no evidence that treatment has been delayed for any patient and patients will be slotted on to the waiting list according to their date of referral.

Helen Wright summarised there is reasonable assurance that progress is being made with the integrated performance report, although there is more work to be done.

Helen Wright summarised that the current organisational data controls represents a negligible assurance status. This require escalation and flagging to NHSE that historic reporting has been incorrect. This would be discussed further at Group Cabinet.

4.5 **Estates and Facilities – General Update**

Simon Tighe presented the report and advised that the energy savings were a total of £4,392,299 and the LED saving of £195,600 had been received the previous year. Energy costs in the last three years had been £32.8 million versus a consumption of £39.8 million had the energy efficiency initiatives not taken place. Grant funded money had generated the £7 million savings. The SGH boiler scheme has received grant funding of £21 million and £5 million was being contributed due to the backlog maintenance value of the boilers and infrastructure at SGH.

The 46 bedded accommodation building at SGH had opened and is being used by clinical colleagues.

Gill Ponder asked if the CO2 tonnes are cumulatively saved or annually saved amounts.

Action: Simon Tighe to confirm if the Co2 tonnes saved are cumulative or annual.

Julie Beilby asked if the budget pressure of £97,000 for Community Diagnostic Centre (CDC) facilities management contract will be value engineered down. Simon Tighe stated that they are going to try their best to do so.

4.8 The agenda was taken out of order at this point.

Annual Fire Report
Simon Tighe presented the report which covered both HUTH and NLAG. Authorising Engineers had been appointed for both organisations due to the new NHS requirement following the Grenfell fire. External companies have been used to complete fire risk assessments due to recruitment issues.

Simon reported that the new double knock system had impacted positively on unwanted fire signal calls and support is ongoing with the teams to ensure fire compliance with new builds.

Simon confirmed that risk 2038 was now closed as the fire alarm test was completed. A new moderate risk had been opened for Goole but the system was currently working. The Cladding at the Day Surgery Unit at CHH remains a low fire risk.

Gill Ponder asked if there was a plan to improve the long-standing issues with bed storage on corridors, which may pose a risk of an improvement notice from the fire service. Simon Tighe confirmed it was an ongoing issue since 2017. Lee Bond stated the ideal plan was to reduce LOS and close some wards to create storage, but this was not possible at present.

The CIC discussed Executive responsibility for fire and it was confirmed that this was Lee Bond as Group CFO and would transfer to Mark Brearley once he started with the Group.

Action: Simon Tighe to present the north and south bank action plans at a future meeting.

Edd James joined the meeting at 12.10 pm
Rachel Ellis joined the meeting at 12.10 pm
Simon Tighe left the meeting at 12.10 pm

4.7 **Procurement Report Including Scan 4 Safety**
Edd James took the 2023-24 end of year report as read and highlighted the lessons learned that were being taken forward. The Group was working with colleagues at York and Scarborough and their HR and IT teams to look at how joining the back-office functions were addressed. Achievements were noted for the current financial year which included delivering savings, but there were issues with resource and vacancies. A new Procurement Act and procurement rules for procurement over £20

million would be implemented in October 2024 and all policies and procedures would be updated to reflect the changes. Edd James advised that Lloyds Pharmacy were exiting the market by the end of the year and a new supplier was being sought.

Peter Sedman joined the meeting at 12.19 pm

Rachael Ellis took the report as read and highlighted the scale of the Scan 4 Safety programme, with over 22,000 patient scans occurring in the last 12 months, £11.6 million of activity recorded and over £25 million of purchase orders raised compliantly through the system. Slide 3 was referenced with an update that orthopaedic theatres at CHH are fully implemented with body side specific procedures which provide a real time message if the product is incompatible, to assist in reducing human error.

The CIC discussed procurement response escalation processes and Paul Bytheway advised that the route should be through him if the Care Group Triumvirates could not help.

Edd James shared a process is required to audit decisions of refusal to swap products to alternative suppliers by clinical teams. Paul Bytheway responded this would be an internal process within procurement to be proposed to the Board.

Action: Edd James and Paul Bytheway to meet to discuss procurement audit process and reporting.

Gill Ponder asked if there was a plan to address the number of expired contracts at NLAG and Edd advised that there was a plan and it would be presented to the Audit, Risk and Governance Assurance CIC in October 2024.

Helen Wright asked if the savings highlighted within the report were included in the end of year financial improvement plan. Lee Bond confirmed a member of the finance team worked closely with Edd James to ensure the savings were included.

Paul Bytheway left the meeting at 12.29 pm

Lee Bond advised that procurement business partners had been recruited to the CGs but there continued to be an issue with stock valuations and end of year stock counts, which had been raised by the external auditors and work was ongoing with internal auditors on validating the stock systems. The internal auditors would be involved to ensure the Scan 4 Safety project works from a financial perspective.

Edd James left the meeting at 12.32 pm
Rachel Ellis left the meeting at 12.32 pm

The agenda returned to order at this point.

4.6 **Contract Approvals - Bank and Agency Demand Solutions (Including Direct Engagement)**

Helen Wright expressed concern that the contract appeared to differ to the overarching procurement approach of more inclusivity over a wider area. Lee Bond confirmed York and Scarborough Trusts were also involved in the procurement of vendor neutral that opened the market.

Helen Wright summarised there was a reasonable level of assurance from Estates and Facilities and the Committees recommended approval of the Annual Fire Report to the Boards in Common.

Helen Wright summarised that the Procurement report had provided good progress and would be positively escalated

4.9 **Emerging Issues**
There were no emerging issues raised.

5. ITEMS FOR INFORMATION

5.1 **Work Plan for PEF CiC**
The Committees-In-Common had nothing to raise in relation to the work plan.

5.2 **Consolidated North Bank Site Report**
The Committees-In-Common had nothing to raise from the consolidated North Bank Site Report.

5.3 **Consolidated South Bank Site Report**
The Committees-In-Common had nothing to raise from the consolidated South Bank Site Report.

Gill Ponder highlighted the difficulties in reading the north bank and south bank reports as the comments are on a different page to the actions.

Action: Lauren Rowbottom to feedback the difficulties with formatting of north bank & south bank site reports to their authors.

Planned Care Board Meeting Minutes

5.4 The Committees-In-Common had nothing to raise from the Planned Care Board Minutes.

Unplanned Care Board Meeting Minutes

5.5 The Committees-In-Common had nothing to raise from the Unplanned Care Board Minutes.

Estates and Facilities – Total Facilities Management Contract

5.6 The Committees-In-Common had nothing to raise from the Estates and Facilities – Total Facilities Management contract which had been approved by the Board.

6. ANY OTHER URGENT BUSINESS
The following items were raised:

Helen Wright asked for observations on papers and their quality. A discussion took place on whether the risks included in the BAF paper had been reviewed, as there did not appear to be any changes. The CIC felt that some papers are too long and could benefit from being shorter, with an executive summary supplemented by appendices containing detailed information, so the detail was available to Committee members that wanted to refer to it when raising questions. It was felt the CQC report and the Fire report were good examples, however the Fire report detailed content needed to be read as some important elements had not been highlighted on the front sheet or the executive summary.

Helen Wright expressed the thanks and appreciation from the Committees -In-Common to Lee Bond, as it was his final meeting as he was leaving the Trust on 6 September 2024.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards including any changes to the proposed BAF

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next PEF CiC meeting:

Wednesday, 25th September 2024 at 09.00 hours at Diana Princess of Wales Hospital, Grimsby.

Helen Wright thanked everyone for their attendance and closed the meeting at 12.38 pm with any apology for the slight overrun.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	Y		Y	Y	Y				
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y	N	Y				
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y	Y	Y				
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N	Y	Y				
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y	Y	Y				
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y								
Paul Bytheway	Interim Group Chief Delivery Officer						Y	Y	Y				
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y	Y	D				
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D	D	D				
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N	N	N				
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y	Y	Y				
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N		N	N	N				
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y	N	Y				
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N	N					
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y	Y	Y				

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)201

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10th October 2024
Director Lead	**Mark Brearley – Group Chief Financial Officer**
Contact Officer / Author	**Simon Tighe – Group Deputy Director of Estates, Compliance and Information Services**
Title of Report	Annual fire reports for Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS FT.
Executive Summary	HUTH and NLaG produce their own annual fire report in order to satisfy the statutory obligations. However, to assist those working across the Group this report contains one executive summary which considers both reports to identify key points/issues and to adopt a more consistent approach to fire safety management. The annual fire reports required PEF and then Trust Board approval.
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
Prior Approval Process	**HUTH and NLaG EFD Governance meetings June 2024** **Performance, Estates and Finance CiC – August 2024**
Financial Implication(s) (if applicable)	**Within current Estates, Facilities & Development Resources.**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Committees-in-Common Front Sheet

Agenda Item No:4.9

Name of the Meeting	**Performance, Estates & Finance Committees-in-Common**
Date of the Meeting	**28th August 2024**
Director Lead	**Lee Bond – Group Chief Financial Officer**
Contact Officer/Author	**Simon Tighe – Group Deputy Director – Estates, Compliance and Information Services**
Title of the Report	**The annual fire reports for Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS FT**
Executive Summary	HUTH and NLaG produce their own annual fire report in order to satisfy the statutory obligations. However, to assist those working across the Group this report contains one executive summary which considers both reports to identify key points/issues and to adopt a more consistent approach to fire safety management. The annual fire reports required PEF and then Trust Board approval.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	HUTH and NLaG EFD Governance meetings June 2024
Financial implication(s) (if applicable)	Within current Estates, Facilities & Development Resources.
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:

NHS
Humber Health
Partnership

Group Directorate of Estates, Facilities and Development

Annual Fire Reports

1st April 2023 to 31st March 2024

Combined Executive Summary

Executive Summary

This executive summary is formulated from the two statutory reports relating to Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Each partner organisation produces its own annual fire report in order to satisfy its statutory obligations.

However, to assist those working across the Group this executive summary considers both reports to identify key points/issues and to adopt a more consistent approach to fire safety management across the Group.

Currently, the format of the reports differ in the layout but going forward subsequent reports will be in a compatible format.

Key Points

The use of an Authorised Engineer (AE) Fire has been implemented at both organisations. However, these are currently from two different organisations and currently the use of a single AE(Fire) is being reviewed. Recommendations are identified for one of the organisations or both, and labelled as such in this combined executive summary.

1. Fire risk assessments and passive fire surveys are required to be maintained in accordance with the requirements set out in the Health Technical Memorandum (HTM) 05 series (known as the Firecode) but due to resource issues at both organisations there is a risk that the programme for 24/25 may not be completed. Whilst mitigation measures are being implemented it has been difficult to recruit any additional resources with appropriate knowledge, qualifications, and training. Fire training requirements across all fire safety responsibilities need to be reviewed as new HTM guidance has been issued.
2. There has been significant investment in the fire alarm systems within NLaG as the systems at DPOW and SGH have been replaced. At HUTH ongoing work has been undertaken however, the fire alarm management software used (known as Hercules) is causing restrictions in performance and also the ability to edit and display appropriate alarm activation addresses. This system needs to be reviewed and upgraded or replaced to ensure compliance is maintained.
3. Trained fire warden numbers are down at both organisations and more so at NLaG which suffered a significant drop as a result of Covid (from which it has never recovered). Fire training requirements in relation to fire safety management have been revised and re-issued across the NHS and so this new guidance outlining the roles and training required needs to be fully

reviewed. A consistent training package for each of these roles needs to be completed and a new campaign launched across the Group.

4. A review of the cause & effect (C&E) for the Tower Block at HUTH has identified some anomalies where more than one zone goes into alarm instead of the zone where the activation has occurred. This anomaly is restricted to the Ground to Third Floor only and has not been identified anywhere else, however, it does need to be corrected.
5. Resources for fire safety management at both organisations to ensure the passive surveys, support for capital projects, maintaining assessments etc. is limiting the ability to maintain the programme of work and so should be reviewed across the group. There have been a number of retirements particularly at HUTH which has affected the work programme currently so a review utilising more collaborative working across the group and make more effective use of current resources and identify any additional that may be required.

The above recommendations are made to ensure that adequate assurance can continue to be given and more detail is contained the respective reports for each partner organisation.

Hull University Teaching Hospitals NHS Trust

Directorate of Estates, Facilities and Development

Annual Assurance Report:

Fire Safety Management

June 2024

Contents

1.0 Introduction

The purpose of this document is to provide the Finance, Estates and Performance Committee an update to assurance regarding the Fire Management at HUTH.

Trust fire safety compliance is driven by the Regulatory Reform (Fire Safety) Order 2005 (FSO). The responsibility for ensuring necessary precautions to protect people and property in the event of fire rests with the Trust Board. The Department of Health Firecode (HTM 05) suite of documents provides guidance on statutory compliance and other fire safety measures that apply to healthcare premises.

HUTH's Risk Based Inspection Programme (RBIP) focuses resources to best effect across the Trust. This places the largest weighting on higher risk patient care areas (12 monthly inspections), plant and laboratory type areas are medium risks (18 months) with mainly lower risk administration areas at 24 monthly inspections. The programme is flexible and changes can be made for areas or buildings, dependent on relevant risk factors.

The full extent of the impact on fire safety arising from Grenfell Tower fire in June 2017 in London is now more apparent and includes changes to high-rise accommodation legislation (The Building Safety Act 2022). As a result, the Trust has registered Alderson House at HRI with the Health and Safety Executive (the Building Safety Regulator [enforcing authority] for this legislation).

Humberside Fire and Rescue Service (HFRS) last issued a statutory FSO Enforcement Order on the Trust in late 2017 pertaining to the storage of beds on the link bridge from the Women's and Children's Hospital to the main Tower Block HRI. The Notice was lifted in March 2018, however this still remains an ongoing issue as the bed storage issue has not been rectified.

The Estates, Facilities and Capital Development management teams continue to maintain existing fire safety standards and work towards improvements (including the cladding, structural integrity and fire-stopping of Trust building stock) wherever this is possible and/or practicable.

Corporate risk register entries and action plans are made for any such matters which remain outstanding.

2.0 Executive summary

Risk based Fire risk assessments (FRA) are carried out on Trust premises under the FSO. A web based software system (BORIS) is used for the majority of FRAs. All Trust main wards and departments are now on BORIS. Trust main building generic and mobile scanner unit FRAs currently remain on non-database documents. Trust FRAs are subject to periodic external audits by HFRS as part of their statutory compliance RBIP.

Increases in the number of candidates for fire warden courses continue to improve the overall Fire warden coverage. Previous anecdotal evidence showed that night shift cover remained low at times. This longstanding matter was confirmed by Fire Team spot checks between 23rd & 24th November 2023.

The Trust's fire policies and procedures were audited by an external Authorising Engineer (Fire) from Healthfire Ltd. in early 2024.

The draft report is currently under review by both parties. Confirmation of the findings and agreed ways forward are expected in the first quarter of 2024/25.

The Trust's fire alarm call filtering system commenced on 20th July 2020 in agreement with HFRS. A six minutes investigation period is implemented between 0800-1800 hours Monday to Friday on HRI and CHH sites, with suitable safeguards implemented as necessary.

At 86.2% the mandatory Fire Safety Training Statistics for 2023/24 met the Trust target of 85%. Additional fire warden courses and a wider awareness have increased the figures. A breakdown of the most recent figures is found in Section 4.6 below.

Trust global records show a total of 170 fire incidents and fire alarm activations. There were 143 in total across 2022-23. This indicates an increase of some 18.8%.

Due regard should be given to any potential variations in the recent revision of the database (from calendar year to financial year).

Additionally, a number of issues have been identified in the report but are summarised below.

- The Hercules Alarm Management Software is showing performance problems and restrictions in providing accurate address labels so should be reviewed in relation to upgrading or replacement
- The Cause & Effect for the Ground to Third Floor in the HRI Tower Block needs to be reviewed as too many zones are having alarm signals activated.
- Current team resources are impacting on the programme of passive fire surveys required to be carried out. Some interim measures are being implemented to mitigate but currently the programme is at risk.

Fire Expenditure 2023/24

Table 1

Fire Budget Expenditure 2023 - 2024	
Fire Extinguishers	£4k
Fire Dampers	£38k
Detector Heads	£7.5k
BORIS System	£5.5k
Fire Stopping	£48k
Fire Audit works	£40k
Life Cycle Detector Heads	£106k
Total	**£249k**

3.0 Compliance with regulations and guidance

The table below shows compliance against regulations and guidance. In some cases the Trust's systems and processes will be compliant but the RAG rating may be downgraded where there are frequent or major failings operationally.

Table 2

Requirement/ Recommendation	**Progress**	**RAG**
<u>Regulatory Reform (Fire Safety) Order 2005</u>		
Fire risk assessment of premises *Statutory Requirement*	Only partially compliant due to Fire Safety Advisers retirements and another transferring to the NLaG Trust.	
<u>HTM 05 – 01 managing healthcare fire safety (second edition)</u>		
Clearly defined fire safety policy. *Mandatory*	Compliant. Policy CP034 on Trust Intranet.	
Director nominated re: Fire Safety *Mandatory*	Non-compliant – no nominated Director of Estates & Facilities. Needs to be confirmed in writing and tabled at the Fire Safety Committee.	
Nomination of Fire Safety Manager *Mandatory*	Non-compliant – currently there is no nominated senior manager of Estates & Facilities or deputy is currently appointed. Needs to be confirmed in writing and tabled at the Fire Safety Committee.	
Central reporting of all fire related incidents *Mandatory*	Compliant- As mandatory there is a central internal reporting system, that is monitored and logged.	

Emergency evacuation procedures *Mandatory*	Compliant – Fire Safety Information Manuals are broadly in place. A strategic building evacuation group is working up evacuation plans for major buildings	
Adequate fire alarm and detection systems *Mandatory*	Compliant, with additional systems installed or upgraded as necessary	
Staff training programme appropriate to level of risk and duties *Mandatory*	Basic compliance- programme in place to continually improve attendance levels (Table 3).	
Annual audit of fire safety provisions and report to Board *Recommendation*	Compliant	
Access to a Fire Safety Adviser *Recommendation*	Currently partially compliant, this is due to retirement of team members. Currently recruiting to the positions.	
Formation of Fire Safety Committee *Recommendation*	Compliant. Fire, Health & Safety & Security Committee reporting to the Non-Clinical Quality Committee.	
Provision of Fire Wardens *Recommendation*	Improving steadily but not always in place during 'off peak' periods.	
Liaison with External Bodies *Mandatory*	Compliant – six monthly HFRS Service level meetings	
Authorising Engineer (Fire) [External Specialist) *Recommendation*	Compliant – a suitable competent and qualified person has been appointed	
HTM 05-03 Operational Provisions *All are Recommendations*		
Monitoring and mitigation of Unwanted Fire Signals	Compliant via shared file databases	
Arson Policy	Compliant – see main fire policy CP034	
Textures and furniture purchasing policy.	Compliant – see main fire policy CP034	
Planned preventative maintenance programme	Compliant- Improved fire door completion rates and trained staff in place.	

4.0 Risk management

4.1 Risk Register

There is currently one fire-related 'open' scored risk on the Trust Operational Risk Register.

Risk ID 4158 is titled ‘There is a risk that that the fire structure integrity could be breached resulting in a spread of smoke or fire’ which relates to the Risk Subtype ‘Trust property and environment’.

The risk is currently assessed as ‘Low’. Appropriate risk mitigation measures and resources are in place to help achieve a long term resolution to this matter.

4.2 Fire Risk Assessments

The Regulatory Reform (Fire Safety) Order 2005 requires a suitable and sufficient fire risk assessment of all relevant Trust premises covered by the Order. Trust premises have been assessed in accordance with the regulations using the Fire code and national risk assessment standards. All assessments are reviewed periodically by the Fire Safety Team.

The Trust Fire Team web-based system (BORIS) is used for the vast majority of FRAs. A small number are currently on the shared drive in Word format. New buildings are inputted onto BORIS as a matter of course.

At peak times in certain areas it remains an accepted practice by some staff to leave storage cages, beds etc. causing obstruction and fire loading to primary escape routes. Such breaches could lead to further enforcement action against the Trust by HFRS. The Fire Safety Team periodically carry out spot checks and advise staff and may issue internal fire action notices as necessary.

4.3 HFRS Fire Safety Audits

During the year 2023 to 2024 HFRS carried three routine compliance fire safety audits at CHH with none carried out at HRI, Harrow Street or Sykes Street in Hull.

An acceptable level of minor deficiencies were noted by HFRS at CHH. These deficiencies were forwarded to the Trust for action with no enforcement measures issued.

Consultation with HFRS shows that for 2024/25 they have four fire safety compliance visits planned for CHH and the same for HRI. The full HRI Tower Block is included in the inspection programme for that site.

4.4 Local Plans and Fire Safety Manuals

Fire Safety Information Manuals have been previously produced for all wards and departments. Ongoing department changes etc. routinely result in some new or amended Manuals. The Fire Safety Team continues to action this matter as resources permit.

Current Trust fire safety plans do not always reflect changes in wards or departments as they occur. This is due to a current resource issue and a lack of information being made available in a timely manner.

A gap in compliance remains with the nominated departmental Fire Warden arrangements. Deputies are not always nominated or trained for the warden role, particularly when staffs are on annual leave or sick or they change post. Problems occasionally arise as ward/department management changes. Fire Risk Assessments identify such shortfalls but all relevant managers should be proactive to reduce such shortfalls.

4.5 Fire compartments

Department of Health Estates & Facilities Alert ref. DH/2014/003 identified the need to survey and audit fire compartment integrity in Trust premises. Fire stopping survey works and monitoring system updates have now recommenced. Further resources and working arrangements have been confirmed for this important aspect of building fire safety to continue. Identified in Operational Risk Register item 4158 (see 4/4.1 above). The routine programmed testing of ventilation system fire dampers continues.

During this financial year a passive fire survey was undertaken across eight ward areas of the Tower Block, which identified 1242 penetrations to wall, ceilings and floors. Since receiving these reports 1242 of the identified penetrations have now been rectified and logged on the "Bolster system", with further ongoing surveys across the Trust to be arranged. The total cost of this work this financial year for passive fire surveys and remedial fire stopping work was £48k.

4.6 Training *(Trust figures from Education & Development)*

Table 3

2023-24	Certified	Not Certified	Establishment Totals	% In Date	% Out Of Date
Clinical Support Services	1835	273	2108	87.1	12.9
Corporate Directorates	2340	574	2914	80.3	19.7
Emergency Medicine	224	45	269	83.3	16.7
Estates & Facilities	557	34	591	94.3	5.7
Cardiology	204	49	253	80.6	19.4
Family & Women's Health	1256	187	1443	87.0	13.0
Medicine	960	216	1176	81.6	18.4
Surgery	1911	413	2324	85.8	14.2
Totals	**9287**	**1791**	**11078**	**84.55**	**15.45**

On average, of the Trust's 194 fire first responders 149 were compliant with the full training course. This represents a compliance level of 76.8%.

On average, of the Trust's 1894 recorded Fire Wardens 1806 had completed the appropriate course. This represents a compliance level of 95.3%.

5.0 Unwanted fire signals (UwFS) and fire incidents

The Trust report database has recently been comprehensively reviewed and updated by the EF&D administration team and the Business Information Manager.

The database shows that there were three reportable fires during the year. These were all at HRI. There was one arson incident and one electrical fault in the new Tower Block front foyer and an additional electrical fault in the Women's and Children's labour ward. There was one non-reportable external bin fire at HRI.

The incident was dealt with by staff and no call was made to HFRS. There were no incidents at CHH nor at the Harrow Street and Sykes Street satellite sites in Hull.

Trust fire records show a total of 170 fire incidents/alarm activations in 2023 , this is an increase in comparison to the previous year of 143 giving an increase of some 18.8%.

The largest category (28 calls) in 2023-24 was 'environmental effect and other, which includes dust, aerosols, steam etc. as potential causes in addition, there were 26 accidental activations by patients or members of the public.

A further 21 of activations were from unknown causes and 16 activations caused by procedures not being adhered to i.e. contractors not isolating local fire alarm systems during programmes of work.

Ongoing cooperation and coordination between all stakeholders (Estates, PFI providers, contractors) is therefore essential to reduce and eliminate such largely avoidable causes.

Of the 170 fire activations (59%) were within Trust call filtering periods (Monday-Friday 8am to 6pm). During these times, fire alarm activations are held back by Switchboard for six minutes, unless there is a further alarm activation or a verbal confirmation of a fire is received. Staff and first responders then investigate within defined safety parameters and can confirm any fires and false alarms as necessary.

Subsequently 87(62%) were successfully filtered by Switchboard and although HFRS were mobilised 34 times, they were 'stood down" 25 times before arriving.

HFRS have attended site 3 times for reportable fires and also 3 times for false alarms at HRI.

Ongoing discussions with HFRS business safety managers have indicated that HFRS are extending their current policy of call challenging and charging for some attendances which are confirmed as UwFS.

Although there may be some dispensation for sleeping risks, especially at night, this cannot be guaranteed for all Trust sites and buildings indefinitely.

Previous charges were:

- One fire tender + 3 Crew + 1 Crew Manager = £311.75 per hour*
- Administration costs per call out = £82*

The call challenging policy is now used across the business community. However, six monthly Service level liaison meetings with HFRS are held and have positively ed to mitigate any significant effect on the Trust to date.

Call filtering principles are adopted to;

- Reduce calls and impact on service delivery and Key Performance Indicators (Fire) for both organisations.
- Avoid placing members of the public at risk during incidents and attendances.
- Damage to the environment

6.0 Premises assurance model (PAM) data for fire safety

The PAM assurance model for fire comprises of ten questions, based on how the Trust can evidence the fire information it holds. The following are a summary of the questions, the ratings given and any subsequent actions required to strengthen the current position.

6.1 Policies and Procedures

The current rating judgement is Amber (Requires Moderate Improvement)

Actions -

The Trust has a Fire Policy, which is in the process of ratification at the relevant committee.

The Fire Safety Manuals, protocols and documentation are to be reviewed by the fire team to strengthen assurance.

The fire safety procedures are to be developed by the fire team and to be presented for approval at the relevant committee.

6.2 Roles and Responsibilities

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions-

There needs to be a confirmed identification of the roles, with the recent reorganisation of the E,F&D re-structure, with confirmation given in writing.

There needs to be a more robust fire warden and Senior Management coverage to wards and multi-occupancy office areas.

6.3 Governance

The current rating judgement is Yellow (Requires minimal Improvement)

Actions -

A final Fire Authorising Engineers (AE) report will be distributed to the HUTH Governance & Assurance Committee, upon completion of the senior management interviews with the Fire AE.

6.4 Enforcement

The current rating judgement is Green (Good)

Actions -

No actions identified

6.5 Fire Risk Assessment

The current rating judgement Orange (Requires Moderate Improvement)

Actions -

The Fire AE is to be commissioned to approve the proposed fire compartmentations at HRI from the ground to the third floor of the Tower Block and North Blocks

The Building fire risk assessment and Ward Risk Assessment programme is to be reviewed and developed to enable monitoring and compliance to provide the appropriate level of assurance to the E,F&D Management Committee/Trust Fire, Health & Security Committee.

6.6 Maintenance

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions -

A costed action plan for passive fire surveys and remedial works is to be developed by the fire team.

6.7 Training and Development

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions -

The fire team are to carry out passive fire inspection qualifications to allow the fire compartmentation surveys to be undertaken “In-House”.

Fire evacuation training needs to be implemented throughout the Trust, with a particular emphasis on senior managers who would assume the role of the Person in Charge in a fire situation, in line with the latest HTM guidance.

6.8 Resilience, Emergency Planning and Business Continuity

The current rating judgement is Yellow (Requires Minimal Improvement)

Action -

Evacuation drills are required to be undertaken and recorded in both clinical and administration areas where possible, with the option of a “Table-Top” exercise in critical care and Theatre areas.

6.9 Review Process

The current final rating judgement is Amber (Requires Moderate Improvement)

Actions -

To review the current electronic recording system for both passive fire and fire audit purposes.

6.10 Costed Action Plans

The current position is No.

Action -

A costed plan is to be established for the passive fire surveys and associated remedial work.

7.0 Fire safety improvement and development

The Trust Fire team were audited by a nominated Authorising Engineer (Fire) from Healthcarefire Ltd. in 2023 with the draft Report received during March 2024.

The full report and its overall rating are to be confirmed once all necessary interviews have been carried out and relevant information is collated by the Engineer.

Estates/PFI agreed cyclical fire alarm system improvements remain in place for all Trust sites to help reduce false alarms/ UwFS and to improve system reliability and property protection. It is important to continue this impetus to maintain the effectiveness of the Trust fire alarm systems and to maintain suitable statutory compliance levels.

The Hercules Fire Alarm Management System is showing some issues regarding its performance and the ability to programme the system to display appropriate locations is restricted with the current system. The system should be reviewed to determine whether it can be upgraded (ideally to a cloud based system) or a new system is required. This would allow the system to be re-addressed should areas change or new builds added to the system.

New developments and major refurbishment or extensions are prioritised as far as practicable for a new or updated FRA after appropriate consultations between the Trust Capital Development and Fire Teams, relevant Building Control Bodies and HFRS as necessary.`

The Capital Development and Fire Safety teams need to reconvene to confirm a previous scheme to consolidate the fire compartment lines for the HRI Tower Block ground to third floor inclusive, as well as the issues with the cause and effect in the ED department. This would also require a review of the Cause & Effect (C&E) of the alarm system on these floors as some anomalies have been identified whereby the system activates the evacuation signal in more than one adjacent zone instead of an advisory signal.

The scheme was previously agreed in principle, however it was not ratified by the Trust’s previous Authorised Engineer (Fire) [Trenton Fire Engineers].

This matter remains outstanding and is expected to be reviewed during the year with the current Authorised Engineer (Fire).

8.0 Ongoing fire safety priorities for 2024-25

Confirm and address the Healthcare Fire Authorising Engineer (Fire) report and findings.

Continue liaison with HFRS regarding false alarm fire calls, attendances and potential charges etc.

Promote joint working with Learning and Development, Health Groups and other stakeholders to further improve global fire training figures.

Further improve and refine the Trust Fire Safety Risk Based Inspection Programme and the BORIS database.

Maintain and further develop HFRS statutory fire safety and operational risk information site visits and Service level liaison meetings.

Increase and monitor the numbers and frequencies of local ward and department fire drills and fire plan exercises etc.

The fire team has reduced considerably, due to the retirement of four of the five part-time staff within the team, which has left one full time member of staff. This is impacting on the passive fire survey work and the ability to maintain the fire risk assessments on the annual programme.

Whilst a recruitment programme was undertaken only one full time candidate was due to the standard of the interviewees This candidate is due to commence with the Trust in June 2024 and requires further training relating HTM healthcare fire safety requirements. Additionally, two of the retired members of the fire team have requested to be put on the “Bank” staff, which is currently in process which will improve resources. However, there may still be an impact on the programme.

9.0 Conclusion

This report shows that the service had a good operational presence, however the recent reduction of the fire team, coupled with recruitment approval processes has left the fire team with a large workload and small workforce. Continued support and funding must be made available to complete the current recruitment process to return the fire team to an operational capacity.

Once recruitment is completed, the recent audit and accompanying actions will set a direction of travel for the new team.

Additionally, good progress has been made this year with regard to the actions detailed in the fire compartmentation / fire stopping Alert, It is hoped that the funding for these fire stopping works will continue to be available to mitigate the risks identified in the Alert.

10.0 Recommendations

The committee is asked to note the content of this report and support the actions identified within the report and listed below -

10.1 The Hercules Fire Alarm Management System is showing a deterioration in performance and restricted ability to give more detailed address details indicating location of fire alarm activation. This is leading in some instances, to a delay in locating the exact location and increasing the amount of Unwanted Fire Calls (UwFS). This may result in an incident where Humberside Fire & Rescue Services (HFRS) may determine that informal action (in the form of a letter or deficiency notice) or formal action (i.e. Alterations or improvement/prohibition notice) may be required. The system should be upgraded to a cloud based version or replaced to maintain compliance with the HTM and FSO.

10.2 Some problems have been identified within the alarm cause & effect (C&E) affecting the first four floors of the Tower Block at HRI meaning that on some alarm activations the alarm has sounded in more than one zone. This gives rise to an increased risk of harm to patients being moved when not required and the C&E needs to be reviewed for this area by an appropriate third party (as there is no in-house resource currently). Whilst this issue does not increase the risk of fires not being detected, it nevertheless needs to be addressed to maintain assurance that C&E is appropriate for these areas.

10.3 The Fire Team has suffered a significant reduction in resources due to retirements and resignations. This has impacted on the ability to maintain passive fire surveys and fire risk assessments being update according to the annual programme. Whilst steps are being made to address in the short term it is recommended that additional resources are employed and existing staff are trained to the required competency levels required. Resources across the Group are also being reviewed to determine a longer resolution and give greater flexibility and “independent” assurance to the Group Directors.

10.4 Review the newly issued HTM regarding fire training and revised training content appropriately with the Training Department and Fire Team.

10.5 Increase the number of fire wardens and trained senior management across the Trust to ensure that there is adequate cover.

10.6 Review and update the fire risk assessments which are due to be reviewed within the 24/25 period.

10.7 Work collaboratively with the NLaG fire teams to adopt a more consistent approach to fire safety management across the group where practicable.

Authors:

Hedley Wilson
Deputy Head of Operational Estates

Nick Harrison
Head of Operational Estates

June 2024

Appendix 1 – HUTH Annual Fire Statement

HUTH ANNUAL FIRE STATEMENT **FOR PERIOD – April 2023 – March 2024**		NHS Hull University Teaching Hospitals NHS Trust
I confirm that for the period 1st April 2023 to 31st March 2024, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)		
1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessments	N/A
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	✓
* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk Date: Quarter 3 (24/25)		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	No
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.	✓
Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail: bill.parkinson@nhs.net	Date:
Chief Executive	Name: Signature:	
	Contact e-mail	Date:
Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.		
None		
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any		

proposed further actions need to comply, costs incurred and additional costs required to comply.
Humberside Fire and Rescue Service (HFRS) last issued a statutory FSO Enforcement Order to the Trust in late 2017 pertaining to the storage of beds on the link bridge from the Women's and Children's Hospital to the main Tower Block HRI. The Notice was lifted in March 2018, however this still remains an ongoing issue within the Trust as a specific bed storage issue has not been rectified.
NB Statement to be retained for external fire authority audits.

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates & Facilities

Annual Fire Report

1st April 2023 to 31st March 2024

CONTENTS

1.0 INTRODUCTION

The responsibility for compliance with the Fire Regulatory Reform (Safety Order) referred to as the FSO rests with the “responsible person” (RP) which in the case of Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) is the Group Chief Executive Officer or in the event of remote buildings off site buildings this may be the person in control of those premises.

Generally, the RP is responsible for ensuring that, through appropriate delegation, current fire statutory requirements are met. In addition, for areas within the definition of clinical activities, that the requirements of Health Technical Memorandum (HTM) 05-01 (Fire Safety Management within Healthcare) are also complied with (as well as the accompanying HTMs linked to 05-01.

Under the Firecode (i.e. HTM 05 suite), the primary responsibility for ensuring that there is an effective policy rests with the board-level director assisted by the Fire Safety Manager.

This report has been developed to provide information to the Trust Board of Directors concerning the management of fire safety for the period **1st April 2023 to 31st March 2024** and to also identify potential issues for the next 12 months.

This report will also assist with the formulation of annual statement within this report and may also assist with demonstrating performance against Regulation 15 of the Care Quality Commission (CQC) Essential Standards of Quality & Safety. This report should therefore be retained along with the workplan as the assurance to external authorities in terms of fire safety management within the Trust.

It should also be noted that the HTM 05 suite of documents have been revised and the updated documents will be issued during the 2024/25 period. These documents when issued will need to be reviewed and appropriate amendments made to the relevant policies and procedures. In addition, it is not presently known what (if any) changes may be required to the annual report as the relevant HTM part has not been published at the time of producing this report. Any changes will therefore be made in future reports.

Likewise the Group Estates, Facilities and Development structure across NLaG and HUTH is not yet complete and the impact on responsibilities to comply with the HTM will be reviewed when this is finalised.

2.0 EXECUTIVE SUMMARY

Fires within acute Trusts are not common but should they occur then there could be significant risk to life and so the fire safety management strategy should be to:

- Prevent fires occurring
- Detect them at the earliest stage possible
- Ensure appropriate responses are made when a fire is detected
- Contain a fire to the immediate area and reduce the risk of spreading to other areas
- Should a fire spread then ensure that there is the ability to move to a safe place as soon as possible
- Ensure areas of high dependency such as Intensive Care Units (ICU) are constructed with additional measures, so the evacuation of these patients is regarded as the last resort

As a result of the capital investment made and completed in 2023/24 DPoW now has a full digital system which will give detection and protection for the next two decades. This investment has continued in the period this report covers, as the detection and alarm system has been replaced at SGH during 2023/24 with the strip-out of the old alarm being completed in 2024/25.

The impact of the replacement is not fully seen yet as the SGH system replacement is not completed until March 24 so the effect on system faults for SGH will be reported in future reports.

The breakdown of system faults per site is shown in Figure 1

Figure 1 - Comparison of System Faults

The number of system faults for DPOW has increased slightly as third-party interface issues are being identified and resolved. In all the new AFD system at DPOW is performing well. Also figure 1 shows the continuing deterioration in the performance of the fire alarm system at SGH which has increased on the same period previously. This should reduce in 24/25 as the new AFD system is commissioned and the old system is switched off and stripped out.

Other causes of fire alarm activations are covered below within this report. In addition fire safety related risks which are on the risk register are also covered below.

The Group reports to the Health, Fire & Safety Group (HFSG) the escalation from the HFSG to groups above is part of the Group meeting structure which is to be finalised in Q1 in 24/25 but during the 23/24 period any issues have been escalated to the Trust Board (TB) in accordance with HTM 05-01.

Within the detailed report below the following recommendations are made:

1. The revised part of the HTM relating to training needs to be fully reviewed across the Group to determine changes required to the training needs for staff and those with additional responsibilities.
2. The number of fire wardens has reduced significantly since pre-covid levels and an initial campaign to increase the overall numbers has had some limited success. A more concerted campaign needs to be launched (once the training elements from the revised standard has been reviewed)
3. The fire risk assessments (which incorporate passive fire elements) should be reviewed in accordance with the programme and reminders generated from the electronic system.
4. Whist collaborative work across the Group is already in place there is scope for greater working together to address the common fire safety management issues in both partner organisations. This will also result in a more consistent approach to reducing the risks and protecting staff, patients, visitors alike.

Finally, acknowledgement must be made for the capital investment made to replace the aged alarm fire alarm systems at DPOW and SGH to increase the protection and early detection of a fire occurring before it can significantly affect patient care.

3.0 REPORT

3.1 Fire Risks on Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below in Table 1.

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating
2038	SGH	Risk of failure of SGH fire alarm leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff (*NB this risk will be removed when installation of new alarm system is completed).* ***This risk has now been closed and a new moderate (score of 12) risk created for Goole Fire alarm system***	• SGH funding allocation now secured and enabling surveys and work underway. • Some old panels replaced until full replacement.	20
2464	Trust-wide	Trust estates alarms not being effectively covered especially within the boiler-house which requires monitoring 24/7. Gaps in switchboard cover and estates staff cover difficulties are raising concerns that cover can be maintained. ***This risk is linked to the digital strategy and upgrades to the E&F Building Management System (BMS). The latter is estimated to be completed by March 2025 subject to any funding priorities which may change the current timescales***	• Currently gaps are covered but are resources are increasingly strained due to illness and vacancies. • Upgrades to BMS ongoing including notifications of alarms to on call staff	12
2952	Trust-wide	Water Safety Compliance – fire ring main. Currently there are several Domestic Water Systems (DWS) connected to	• Upgrades to water systems ongoing to remove DWS	

		the fire ring main making it non-compliant with water supply regulations and fire safety requirements. ***Confirmation from the Water supply company that the water configuration is compliant and from HFRS that pressures and reserves are adequate.***	connections from fire ring main • Testing of fire hydrants for pressure and flow ongoing • Designers not engaged to take forward removal of DWS connections from ring main at SGH	12

Table 1 - Fire risks on Trust Risk Register

Entry 2308 is now closed as the SGH alarm was replaced in March 2024 and this leaves the Goole District Hospital (GDH) alarm only needing replacement. The funding allocation for 24/25 is insufficient for the alarm to be replaced , following a risk review meeting a new risk for GDH fire alarm has been created and is a moderate risk however monitoring of system faults will be ongoing and reviewed every quarter.

In terms of entry 2952 the DWS connections are non-compliant with the Water Supply Regulations which require a water feed with only hydrant connections. The Fire Authority and/pr the water supplier can issue enforcement action. However, confirmation from the water company has been received that they are satisfied with the system configuration and that the pressures and water reserves onsite meet the requirements from Humberside Fire and Rescue Service (HFRS).

Fire hydrants are required to be tested to ensure that they are able to supply the required flow and pressure which is between 800 – 1500 litres per minutes. If the supply is a dedicated fire ring main with no other connections the Trust would be able to reclaim the costs from the water supplier (as stated within the regulations) but currently this cannot be achieved so the use of the water and sewerage costs are not recoverable.

Operational risks that sit within the functional responsibilities of the Estates Department are identified through the E&F Operational Risk Register. These risks are separate from the Trust Risk Register and cover specific issues (rather than generalised) and enable appropriate prioritisation to be undertaken so the funding allocation is used to tackle the higher risks as a priority. This operational risk register also includes costed options which will allow any additional allocations received to be quickly utilised avoiding undue delay.

The Coronation Block at SGH still requires further work to comply with the requirements of the FSO and the majority of the work was completed under capital projects. There is still some work to be completed and this may be linked to the relocation of the operations centre.

There is a current agreement with HFRS to allow the fracture clinic to maintain its current position at present. However, in the long term HFRS do expect this service to be relocated so that no clinical services are undertaken within the Coronation Block. This will then enable the area to comply with statutory requirements as far as is reasonably practicable.

There are also, still, compliance issues within the Ward 2 block and Planned Investigation Unit (PIU) at SGH. These areas are some of the oldest buildings within the SGH footprint and were never designed for current fire requirements. The Trust was granted permission to utilise Ward 2 for a temporary SDEC area under the express restriction of no patients being housed overnight. This permission expires when the new dedicated SDEC opens for patients and this area will no longer be able to be used for clinical use without further agreement from the Fire Authority. This is due to the configuration of the areas and the lack of means of Progressive Horizontal Evacuation (PHE). To bring these areas into compliance would require extensive reconfiguration and significant capital works which is not justified given the current funding available to the Trust.

3.2 Fire Safety Technical Group

The Fire Safety Technical Group (FSTG) has met monthly during 23/24 to review the detailed technical aspects in relation to fire safety management. It also considers and reviews compliance against the statutory provisions within the FSO and also the HTM fire safety documents. The FTSG will also consider requested derogations from HTM based on risk assessments. The group reports to the Health, Fire & Safety Group and allows the HFSG to oversee fire safety rather than get too detailed which could detract from other agenda items.

The HSFG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the higher groups when the Group meeting structures are finalised to enable issues to be escalated when appropriate.

3.3 Fire Safety Management Polices

The Trust has been working towards the appointment of an Authorising Engineer (AE) for fire safety management (as recommended within the HTM) and in June 2023 the first audit was undertaken by the AE. Whilst a number of actions where raised there were only two significant issues identified. These were:

- The fire compartment between the ED and SDEC areas had been compromised and fire could have spread between the two compartments. This

had been raised to the contractor and promptly dealt with to keep the two 60 min compartments fire integrity intact.

- There was insufficient fire separation in the roof void at GDH between the estates' office and the children's nursery. The addition requirement options were appraised and suitable fire stopping installed and signed off.

3.4 Management of Fire Risks

There are currently 151 active fire risk assessments covering the Trust and units which are currently being used by NLaG staff. There are a number of assessments which have been temporarily archived due capital projects where those areas are currently undergoing refurbishment or are new buildings. Once the work has been completed then these areas will be re-assessed.

In addition, new requirements under the Building Safety Act and regulations now require fire risk assessments to be undertaken for whole buildings so as to be able to include common areas such as corridors, general reception and entrances etc.

There are 74 assessments currently being reviewed or are coming into the review period of which some will be archived as they relate to areas which are being replaced by the new ED/AAU units.

The current review periods for assessments are:

- In-patient areas - 12 months
- Out-patient areas - 24 months
- Admin areas - 36 months

The assessments are maintained on an electronic system which is cloud-based system containing a number of assessment types (service provided by Evotix) and updated by the Fire Safety Officer (FSO) and Fire Safety Manager (FSM). New areas such the new ED and SDEC projects have either had their initial assessments completed or will be undertaken in Q1 of 24/25. The previous assessments covering the areas prior to completion of these projects will have their assessments archived on the system.

3.5 Structural Fire Protection

Changes made to the FSO and the introduction of the Building Safety Act, implementation of the Fire Safety (England) Regulations (2022) have strengthened fire safety requirement particular in relation to residential premises (especially those over 18m in height).

The effect of these changes on healthcare premises is predominately aimed at residential blocks and there are more stringent requirements in relation to "high" residential buildings regarding fire door installation, inspection etc. There is a reference to high risk buildings but currently this definition still requires them to contain

at least two residential dwellings to fall within the legal requirements. It is anticipated that this definition will change or be amended to include hospitals within the high risk definition and subject to the Building Safety Regulations

Within the current requirements is the need to retain information relating to fire safety on an electronic format so that it can be easily retrieved by the fire services when called to a fire. This information will help fire services in terms of their firefighting strategy and also identify entry routes etc.

The Trust is currently undertaking work to make full use of the MiCad electronic system using this as a means of holding relevant fire safety information in a format that satisfies the requirements of the Building Safety Act. This process entails a significant amount of resources to fully achieve and the work required will continue into 24/25 (and beyond) and continues the work in relation to updating drawings so the structural fire protection can be confirmed in respect of the 60 min compartment lines. This work has continued to be developed within the 23/24 period and will be completed within the 24/25 period.

3.6 Fire Doors Inspection & Maintenance

The maintenance of fire doors is important as they are potentially the weakest element within the strategy of fire compartmentation. Damage to the door or the architrave itself can mean the fire retaining properties of the door set are severely compromised. Fire doors when damaged beyond repair will be required to be replaced as a door set and this can cost the Trust between £3,000 to £6,000 per door set.

In 23/24 fire door inspection reports were reviewed and all 60 min doors sets which had failed one or more elements of the inspection were reviewed to determine if they needed replacing, could be repaired or needed further review. Of the 304 doors it was considered that at least 286 could be repaired with 123 needing a further review and 18 that definitely needed to be replaced. In addition, 44 doors could be redesignated as final exit doors meaning they no longer needed to be fire rated. Funding was available to replace 32 double door sets predominately at SGH. Also a business case was proposed to employ two craftsmen as approved fire door repairers within the BM-trada scheme. This would allow approved repair techniques to be used rather than incur the cost of replacement for a large number of doors.

During the 23/24 period this review has been extended to the circa 2800 30 min fire doors trustwide to undertake a similar review. Currently, all of DPOW 30 min doors have been reviewed and nearly all of SGH doors with GDH left to complete. At the point of writing this report it has been identified that of the doors checked:

DPOW	57%	Repairable
	32%	Potentially repairable (need a further review)
	12%	Need replacing
SGH	40%	Repairable
	51%	Potentially repairable (need a further review)
	8%	Need replacing

Taking into account possible repair cost (and the cost of those that need replacing) the ability to undertake approved repairs in-house could result in avoiding costs of circa £2.5m by not replacing those doors which have failed the inspection with new doors. The business case has been further proposed for 24/25 FY and this figure is likely to increase when the full review of all the fire doors is completed within the 24/25 period.

3.7 Fire Response Management

The FSO and HTM requirements in relation to a response to an alarm activation require organisations to deal with the initial stages of fires and alarm activations without relying on the attendance of the fire services. The Covid-19 pandemic affected nearly all Trusts in their ability to respond and work commenced in 22/23 to address this gap by increasing the amount of fire wardens etc. available to respond. The training and method of delivery has been updated and further work with HUTH on a group approach is part of the 24/25 workplan so that both organisations can respond appropriately in the initial stage of alarm activation and/or actual fire.

In addition, the regulations require regular drills to check the effectiveness of arrangements and review where further improvements can be made. It is however, extremely difficult to carry out live drills in clinical areas where patients are located (especially in those areas with overnight patients, immobile patients or those who are seriously ill). In these areas it is generally agreed with the fire authority that tabletop exercises should be undertaken and in 24/25 all areas where table top exercises are needed will be identified and a programme of exercises will be implemented.

More details are also included in the sections below and timescales shown within the workplan attached in Appendix 2.

3.8 Fire Training

During the 23/24 period face to face training sessions were increased as such training is required under the HTM and e-learning cannot be repeated twice in a row. This is enforceable by the Fire Authority and some other NHS Trusts have been picked up on this issue.

The number of training sessions for face-to-face training is calculated using the records of those who will come out of compliance in the next 12 months. A safety factor to allow for non-attenders has been implemented so that 1200 additional places are available for staff to access.

The fire training compliance for the 23-24 period is included in Table 2 below.

Period	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
% staff trained	80	79	78	84	84	91*	77**	75

Table 2 - Fire Training Compliance

* - no face-to-face training

** face to face training reintroduced

As shown in Table 2 there has been a reduction in the percentage of staff trained in the 23/24 period. This is the lowest in the last 8 years and whilst this is favourable in comparison to some peer Trusts it means that nearly 25% of NLaG staff are not compliant with training requirements. There is a potential risk that the fire authority may consider this worthy of enforcement action this is a low risk, but the Trust may be served a “deficiency” notice requiring improvements to be made.

The training requirements themselves will need to be reviewed as the HTM documents covering fire safety are being updated and re-issued. There is also an additional HTM which is dedicated to training requirements that had been issued at the time if compiling this report. The whole training programme will therefore be reviewed and adjustments made as part of the 24/25 work programme.

3.9 Fire Alarm Activations and Unwanted Fire Signals

Over the years there has been some discussions and different definitions of what an Unwanted Fire Signal is and how it should be reported. In 2014 the Chief Fire Officers Association (CFOA) published guidance as to what the Fire Authorities defined the difference between false alarms Unwanted Fire Signals (UwFS). These definitions are outlined below:

- Fire Alarm Activation (known as false alarms) – where an AFD system is activated either via the sensor head or via a manual call point activation (or system fault) which sends the main fire panel (and local panels) into alarm.

- UwFS – where an alarm activation causes a requirement for the local fire & rescue services to attend the organisation's premises unnecessarily and which impacts on the fire cover for the local population potentially putting lives at risk.

The CFOA is concerned that UwFS can (and do) reduce resources available to tackle actual fires due to Fire & Rescue Services (FRS) attending a UwFS where there is no fire. The amount of resources that can be called to attend an UwFS depends on the organisation but in premises where there is a high risk to life should a fire occur, there will be a greater response and the minimum for NLaG is three fire tenders (there is an automatic escalation every five minutes for two more tenders until a stop call is made).

In an effort to reduce the number of UwFS the UK Government introduced legislation that allow FRS services to recover costs of attending organisations where there were persistent UwFS which were not being addressed or reduced. Currently Humberside Fire & Rescue Services (HFRS) has adopted the following charges that will be levied against organisations that have more than 4 UwFS call outs in a rolling 12 month period.

- One fire tender + 3 Crew + 1 Crew Manager = £311.75 per hour*
- Administration costs per call out = £82*

* These costs are due to be reviewed and are likely to be increased in line with inflation at some point in 24/25.

The minimum attendance for NLaG would be 3 fire tenders plus crew (including a crew manager per tender).

The number of UwFS each year is shown in Table 3 below. This does not include an actual fire at the DPOW site which would not be classified as an UwFS. Of the 2 recorded for GDH one is regarded as being with "good intent" in that a fire could not be located but HFRS felt that attendance was required (as the alarm activation was indicated to be within a roof void).

The Trust uses a "call filtering" system whereby HFRS are not called for the first 5-6 mins of an alarm activation so a check can be made to determine if the activation was a false alarm. In the 22/23 there was a total of 282 alarm activations which only resulted in 4 UwFS which shows the effectiveness of the call filtering system (and response by staff and the security team). If there was no such system in place, then the cost of charges would be in excess of £250,000. It is hoped that the installation of new fire alarms will reduce the number of UwFS to zero in future years and with call filtering in place HFRS have not attended any fire call for a period of 7 months consecutively.

UwFS Calls on a rolling fiscal year

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
SGH	3	7	4	3	10	10	7	7	1	2
DPOW	4	9	8	9	8	17	3	9	1	5
GDH	0	0	2	2	0	1	0	0	2*	2
Total	7	16	14	14	18	28	10	16	4	9

Table 3 - UwFS for NLaG

* Classed as “good intent” but HFRS attended despite “stop” call

There were a further 5 activations that would have been classed as UwFS but stop calls by switchboard were made in time to prevent attendance. In relation as a percentage of total activations the UwFS is 3.5% of activations and is considerably lower than the fire authority guidelines for enforcement intervention (i.e. Fire Protection Association (FPA) guidance is no more than one UwFS per 20 detectors)

In relation to the number of alarm activations there were 329 (compared to 282 for the same period last year). The breakdown of the alarm activations is seen in Figure 2 below:

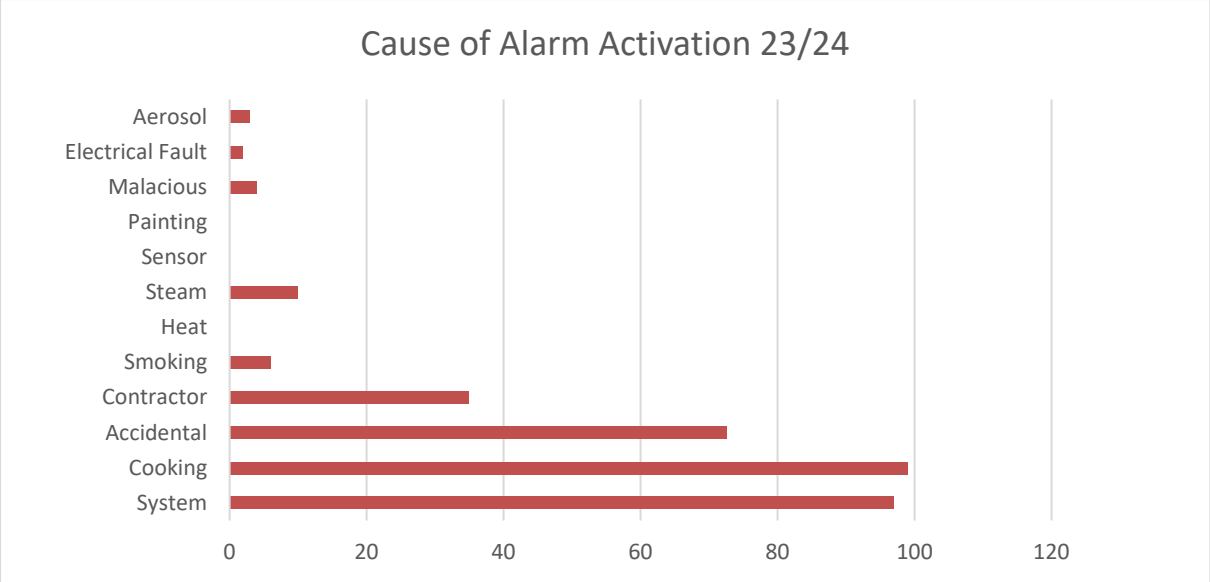


Figure 2 - Breakdown of activations 23/24

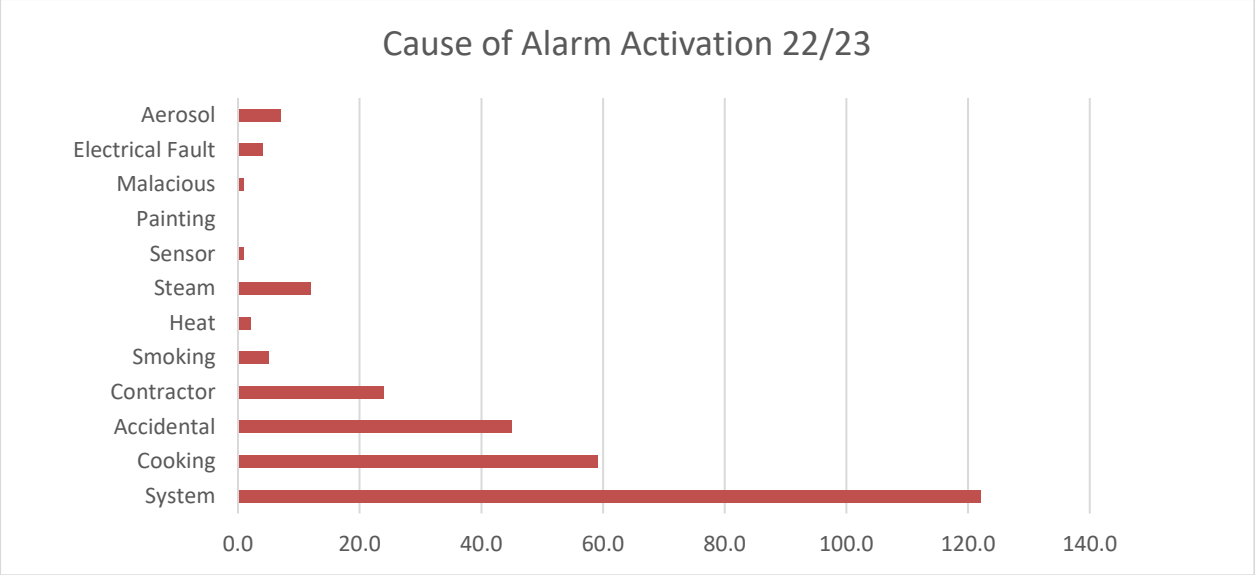


Figure 3 - Breakdown of activations 22/23

Comparing the activations with 22/23 (see Figure 3 above) it can be seen that cooking is now the highest cause of alarm activation across NLaG. Given the replacement of systems at DPOW and SGH the reduction in activations due to system faults it is not surprising to see such a fall and it is anticipated that this trend will continue in 24/25 as the full effect of the new AFD system at SGH is seen.

The comparison of "cooking" alarm activations compared to 22/23 is shown in Fig 4.

Figure 4 - Activations due to cooking

Nearly 70% of the "cooking" incidents have occurred at DPOW and of those incidents 62% have occurred within the Roost accommodation with the other 38% on the wards. Of the cooking activations at SGH 60% occurred within the accommodation blocks and 40% in ward areas.

A reduction in these types of alarm activation could significantly reduce the number of alarm activations and there are simple ways to do this such as keep the doors closed where cooking activities are undertaken and not leaving anything unattended that is being cooked such as toast (which is by far the biggest cause of cooking activations).

In order to try and reduce the number of alarm activations a pareto chart can quickly identify those categories that cause 80% of all alarm activations. The pareto chart for the 23/24 period is shown below in Figure 4.

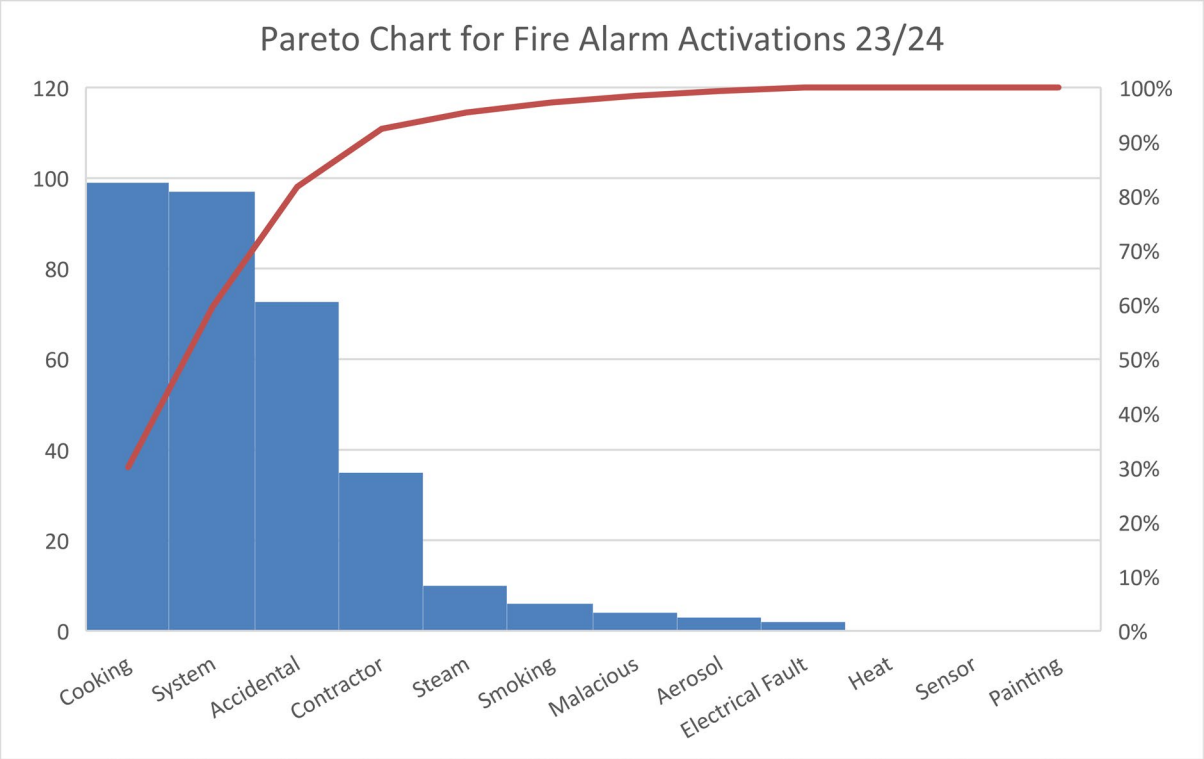


Figure 5 - Pareto Chart of alarm activations

From Figure 4 three causes of alarm activations account for 80% of all activations of which two have already been discussed above. The number of system faults is linked to the replacement programme for SGH and 24/25 should see a reduction in this category.

For accidental activations some work was undertaken to reduce the number of activations in this category. Generally, these are when patients or members of the public mistake manual call points (MCP) for door release buttons. Various attempts to reduce these have only been partially successful but the move towards a proximity door release does appear to be reducing this type of activation in some areas. Work will continue in 24/24 to further reduce activations in this category.

Activations due to sensor heads should be minimised by the rolling replacement of sensor heads which have a working life of 10 years before they start to develop faults leading to false detections and alarm activations. The Trust has a rolling programme of replacing 10% of detector heads per year to mitigate the sensor issues. There will be an exception to this due to the installation of the new fire alarm system at SGH which means that new detectors have been fitted and so will be included in the replacement programme after their warranty period expires.

3.10 Enforcement Activities by Local Fire Authorities

There has been no enforcement action undertaken by HFRS in respect of fire safety within NLaG premises. There have been a number of physical audits by the Fire Authority at all three sites with no items of concern raised. Minor issues were raised in relation to improving signage and communications to the workforce and work for this is incorporated into the workplan attached to this report

In respect of neighbouring Trusts all outstanding enforcement notices have now been signed off and there are currently none “in force”

3.11 Capital Investment

The working of a commercial AFD is between 20 – 30 years and this is dependant on the fire alarm type, availability of replacement detectors, alarm panels and the ability to reprogramme zones etc. due to changes in use.

AFDs tend to show their condition via the number of system faults which are occurring and these are monitored along with other reasons for alarms activations. The AFD at SGH was identified in 21/22 as deteriorating at a rate where it was likely to result in a catastrophic failure and threaten the ability of SGH to remain open (as it is a legal requirement to have a Level 1 AFD system in operation at all times). The Trust Board released circa £6m in capital funds to replace the system at SGH and strip out the old system. The installation of the new system for SGH was completed and commissioned in March 2024. Work in 24/25 will continue to remove the old system and ensure all third party interfaces are functioning correctly.

As GDH’s system is similar in age to that of the old SGH system more will be required to ensure that there is no significant deterioration in the performance which raises the risk of failure. Given the age of the system, unavailability of replacement parts capital funding will be required within the next few years to replace the system.

In addition, all three sites are required to have a water supply for firefighting purposes only under the Water Industry Act. Currently, all sites have other connections on the fire ring main which could result in enforcement action, however Anglian Water Authority have confirmed they are content with the water system configuration. Having other connections does also mean that this pipework is subject to legionella control requirements so should be flushed appropriately. The fire hydrants on these systems are also required to be tested regularly meaning that a large amount of water is used for this purpose over the course of 12 months. If there were no other connections the Trust could reclaim the cost of this water usage from the water supplier under the regulations but currently cannot.

3.12 Actual Fires Recorded

There are two actual fires and one incident which did not result in a fire but was linked to the other. All three incidents related to Lithium-Ion battery recharging incidents. The actual fire incidents were

1. 8/7/23 – Ward C5/C6 entrance DPOW
   The Workstation on Wheels (WoW) trolley batteries were being recharged when the battery cell caught fire. The fire brigade attended although the fire had been extinguished by that time and a partial ward evacuation was undertaken to allow the smoke to be dispersed.
2. 30/8/23 – Ward 25 SGH
   Lithium-Ion batteries were being recharged in a cupboard when the fire alarm was activated. On investigation it was found that one or more of the charging units was on fire.

A further incident occurred whereby the Li-ion battery pack exploded but no fire was caused.

NHS Estates issued guidance on use and storage to assist Trusts and also advice was sought from Humberside Fire & Rescue Services (HFRS). The advice from HFRS was not to have designated charging areas for a large number of batteries or to put them into cupboards as early detection is required to prevent thermal runaway. Fires involving multi-cell Li-Ion batteries result in a chemical fire which does not require oxygen to sustain it (as it produces its own within the chemical reaction).

After advice form HFRS batteries are charged in areas where they can be observed and the batteries are removed off the charger when fully charged. Since the incident no further incidents have occurred.

4.0 Work Plan for 23/24

The workplan for the next period (24/25) is attached in Appendix 2. It should be noted that this workplan may be further developed and added to after the next AE(Fire) audit depending on the findings and action plan developed. In addition, as the various parts of the revised HTM documents for fire are issued the action plan will be reviewed and addition items added where appropriate.

5.0 Conclusions & Recommendations

Management of fire safety within NLaG is an ongoing development and the workplan shown in Appendix 2 gives more detail on the various elements that need to be further developed. The level of capital investment over the last 36 months (and over the next 24 months) will mean over £10m has been invested in bringing the systems up to date with more modern and flexible systems. The Trust should be recognised for this level of investment and demonstrates how important fire safety is considered within NLaG.

The appointment of an AE(Fire) further demonstrates the Trust's approach to fire safety as currently this is not a legal requirement but is seen as a positive benefit to the Trust having an independent expert available to further develop fire safety management with the Trust.

The recommendations of this report are:

- Review the newly issued HTM regarding fire training and revised training content appropriately
- Increase the number of fire wardens across the Trust to ensure that there is adequate cover
- Review and update those fire risk assessments which are due to be reviewed within the 24/25 period
- Work collaboratively with the HUTH fire teams to adopt a more consistent approach to fire safety management across the group where practicable

Author:

Bill Parkinson

Associate Director of Safety and Statutory Compliance

Appendix 1 – Annual Fire Safety Statement

ANNUAL FIRE STATEMENT FOR PERIOD – April 2023 – March 2024	NHS Northern Lincolnshire and Goole NHS Foundation Trust

I confirm that for the period 1st April 2023 to 31st March 2024, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)

1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessment (see appendix 2)	✓
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	N/A

* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk
Date:

4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	No
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.	✓

Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail: bill.parkinson@nhs.net	Date:
Chief Executive	Name: Signature:	
	Contact e-mail	Date:

Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.
None
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any proposed further actions need to comply, costs incurred and additional costs required to comply.
None
NB Statement to be retained for external fire authority audits.

As a Foundation Trust annual fire safety statements are not required to be submitted to the Department of Health & Social Care. However, the completion of an annual statement signed off by the Trust Board is seen as good practice and allows the Board to gain assurance in relation to fire safety that adequate systems and controls are in place to reduce the risk of fire within the Trust premises.

2024/25 Work Plan for Fire Safety Management

Item	Area	Task / Objective	Target Dates	Completed/Progress
Review of Policies				
1.1	Review fire safety management policies and guidance with revised HTM 05 suite of documents and 24/25 AE	• Review against new training HTM requirements • AE Action plan arising from 24 audit • Update AE Audit action plan for policy requirements • Present annual report & workplan to appropriate groups prior to submitting to Trust Board • Submit annual report and workplan to Trust Board	May 2024 October 2024 October 24 May 2024 July 2024	
1.2	Humberside fire & rescue services need to keep their operational plans for each site up to date	• Arrange operational plan review visit (annual). • Fire audits with HFRS • Complete any actions arising from HFRS audits	July 2024 March 2025 March 2025	
1.3	Review Technical Fire Safety Terms of Reference after 12 months of operational meetings	• Ensure FSTG continues to develop and review technical fire safety issues • Schedule meetings for 24/25 period	July 2024 April 2024	**Completed**
1.4	Review annual report to Trust Board and requirements of HTM that need to be within the report.	• Review annual reporting requirements within HTM • Complete draft annual report for consultation • Finalise annual report and send to CIC PEF for recommendation for Board Approval • Approval by Trust Board	July 2024 April 2024 June 2024 July 2024	**In progress**
Fire Training				
2.1	Review annually face to face training content for delivery of fire lecture	• Revise training presentation and content in light of new HTM • Highlight reports on fire training attendance	May 2024 Ongoing throughout 24/25	**In progress**

2.2	Review fire wardens training and methods of maintaining register of fire wardens to ensure appropriate cover	• Increase number of fire wardens per area • Develop & maintain new register of fire wardens • Review and revise fire warden training content • Implement recruitment campaign for fire wardens	March 2025 July 2024 May 2024 June 2024	**In progress** **In progress** **In progress**
Fire Drills and Exercises				
3.1	Fire drills or desktop exercises need to be undertaken (where fire drills cannot be held due to potential risk to patient)	• Identify areas where no fire drills or desktop exercises have been undertaken in last 24 months • Engage with fire wardens training scenarios for clinical areas requiring desktop exercises • Implement series of desktop exercises	June 2024 July 2024 September 2024	
Fire Alarm Tests				
4.1	Regular fire alarm tests are required to be undertaken and testing of manual call points (MCP)	• Review fire alarm testing capabilities on new advanced system • Consider digital communications strategy and fire alarm communications integration • Review with AE (Fire) alarm testing strategy and notification processes	May 2024 December 2024 June 2024	
4.2	Communication regarding alarm testing schedule will need to be sent on regular basis to all areas	• Liaise with communications when schedule finalised • Monthly publication of date & time of testing to be drawn up	June 2024 June 2024	
Fire Action Plans				
5.1	Localised fire action plans are required to assist with emergency responses in the event of a fire	• Audit areas to ensure fire action plans are in place and updated • Fire action cards to be located in each area	June 2024 June 2023	
5.2	Fire safety response kits should be developed and rolled out to each area	• Identify fire response kit requirements and source supplies • Roll out response kits to all areas identified where required	June 2024 January 2025	
Fire Strategy Development				
6.1	Work with HUTH to align fire safety management principles.	• Review training content across both organisations to align so more transferable workforce	July 2024 September 2024	

		• Review general safety management policies across both organisations and standardise where appropriate • Review fire inspection processes across the organisations to determine if single process can be applied • Review reporting process and format of reports to determine if standard report can be utilised for Group performance on fire safety management	December 2024 February 2024	
6.2	Development of fire strategy to improve fire safety across the Trust	• Work with AE (Fire) to ensure fire safety strategy appropriate for all areas in light of new HTMs • Fire strategy drawings to be drawn up on MiCad • Undertake fire stopping surveys and ensure appropriate fire stopping in place • Use MiCad to develop appropriate "layers" of information to enable fire strategy drawings to be available to all areas/ • Update and maintain fire risk assessments in-line with the fire safety policy • Continue and further develop working relationship with HFRS to avoid any enforcement action	October 2024 March 2025 December 2024 March 2025 Throughout 24/25 Throughout 24/25	

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)202

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10th October 2024
Director Lead	Mark Brearley – Group Chief Financial Officer
Contact Officer / Author	Craig Hodgson Group Deputy Director of Commercial and Facilities Services
Title of Report	**Annual Security Report**
Executive Summary	An Executive Summary is included within the papers, attention is drawn to lone worker devices usage and patient safety watch services used across the group
Background Information and/or Supporting Document(s) (if applicable)	The Executive summary supports the separate reports, highlighting key points. Huth Annual Report – Appendix 1 NLaG Annual Report – Appendix 2
Prior Approval Process	HUTH Fire, Security Heath and Safety Group NLaG – Security Group Performance, Estates and Finance CiC
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 Front Sheet

Agenda Item No: 4.5

Name of the Meeting	Performance, Estates & Finance **Committees-in-Common**
Date of the Meeting	25th September 2024
Director Lead	Mark Brearley
Contact Officer/Author	Craig Hodgson
Title of the Report	**Annual Security Reports**
Executive Summary	An executive summary is included within the papers but attention is drawn to lone worker devices usage and patient safety watch services used across the group
Background Information and/or Supporting Document(s) (if applicable)	The executive summary supports the separate reports by highlighting the key points HuTH Annual Report – Appendix 1 NLaG Annual Report – Appendix 2
Prior Approval Process	HUTH – Fire, Security, Health & Safety Group. NLaG – Security Group
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Directorate of Estates, Facilities & Development

Annual Security Reports

1st April 2023 to 31st March 2024

Combined Executive Summary

This executive summary is formulated from the two reports relating to Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) Each partner organisation produces its own annual security report in order to satisfy its statutory obligations.

However, to assist those working across the Group this executive summary considers both reports to identify key points/issues and to adopt a more consistent approach to security management across the Group.

There are differences in terms of the information given and the structure of security management within the two organisations. Some recommendations are made after considering the two reports to assist in the development of a Group Strategy across both organisations.

Both partner organisations have in the recent past undertaken work to upgrade their surveillance systems and build in the capacity to switch control of the CCTV system to an alternative site should the need arise. These upgrades will increase the reliability and image quality of the systems and give better opportunities to pursue perpetrators and provide evidential quality for the police and crown prosecution services for their investigations and court cases.

Key Points

1. The responsibilities and structure differ in that in HUTH all security management elements are within the same section whilst at NLaG operational security management sits within Facilities (as in HUTH) but the security management strategy sits within the Statutory Compliance functions through the appointment of a Local Security Management Specialist (LSMS) allowing a degree of independence and development of a security strategy, as well as an auditing function without conflicts of interest. Evidence of this can be seen in development of the Joint Working Agreement (JWA) which is a written agreement between NLaG, Humberside Police and the local Crown Prosecution Services (CPS) to take positive action against individuals through the use of police sanctions or via the courts. Currently, work is ongoing to extend the JWA across the Group
2. There is a significant difference across the organisations regarding relating to patients who may be at risk of self-harm. At NLaG there are only a few occasions where a patient watcher is considered as required and this is requested through the operational teams. At HUTH the enhanced care team undertake a risk assessment and request a level 5 patient watch through the security provider and is recharged to the area the patient is located. The

number of recorded incidents across both organisations of persons self-harming do not appear to be significantly disproportionate but some 13500 hours at HUTH entailed additional cost to the organisation and group. An independent review of this area should be undertaken to identify what is an appropriate level of service and which gives value relating to the cost of such a service.

3. Resources at both organisations are split between car parking and security duties and are delivered by different organisations on each side of the river. As these contracts come up for renewal/review it may be prudent to consider a single contractor for both organisations to deliver a more consistent approach across the group and whether a single contract covering car parking and security or separate car parking and security contracts is of more benefit as there are a number of specialist providers that only provide one service but are well established in that field.
4. The level of incidents in each organisation is comparable given the crime profile across the areas involved. There has been an increase in the number of incidents across the group although the majority of incidents on the north side are reported by the security staff whilst on the south side are via the staff. Incidents on the north side are recorded as one of three categories; malicious; non-malicious or unknown. A larger number of categories are used to be able to identify incidents such as sexual assaults etc. The categories used should be reviewed to ensure that they are consistent and allow direct comparisons across the sites.
5. Lone working devices are used across the group however due to the level of community services provided on the south side the number used is significantly higher. The take up of these devices is concerning as both organisations are trying to increase the usage. The need for a device should be via a lone working risk assessment and where the need for a device is identified then the use of it becomes a mandatory requirement on the individual. Usage on the south side is at circa 25 – 28 % (the level of usage on the north side is not reported but there are a large number of devices that are still with the security team. A concerted campaign on the south side has since usage rise from 18% to 28% but this still means that some 300 devices are not in use when risk assessments identify them as needed. The use of lone worker devices needs to be reviewed across the group as enforcement action may be taken in the event of an incident.

The above points and recommendations are made to ensure that adequate assurance can continue to be given and more consistent detail is contained within future reports for each partner organisation and the group.

Bill Parkinson

Associate Director of Safety & Statutory Compliance

Directorate of Estates and Facilities

Hull University Teaching Hospitals NHS Trust

Security Annual Management Report 2023- 2024

Report Date:	June 2024
Number of Pages:	
Report Author:	David May Deputy Head of Facilities (Logistics)
Director Sign-Off:	

Contents

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1. Background and Introduction

The purpose of this document is to update Hull University Teaching Hospitals NHS Trust (HUTH) annual security report (2023 calendar year) into the financial year (Apr 2023- Mar 2024) This will align HUTH and Northern Lincolnshire and Goole (NLaG) annual security reports across the Humber Health Partnership.

Hull University Teaching Hospitals NHS Trust is committed to the provision of a safe, secure environment for staff, patients, visitors and the security and protection of its premises and assets.

The Trust aims to achieve this objective through the implementation of appropriate systems and arrangements which meet national, legislative and code of practice requirements issued from various bodies.

Objectives

a. Provide a safe environment for staff to work and patients to receive treatment, and visitors to be afforded sensible access, so far as is reasonably practicable
b. Protect Trust property and assets from theft, damage or vandalism
c. Reduce to the lowest practicable level, violence and aggression, and other criminality on Trust premises, or towards Trust staff and patients
d. To support Trust operations to deliver care to patients.

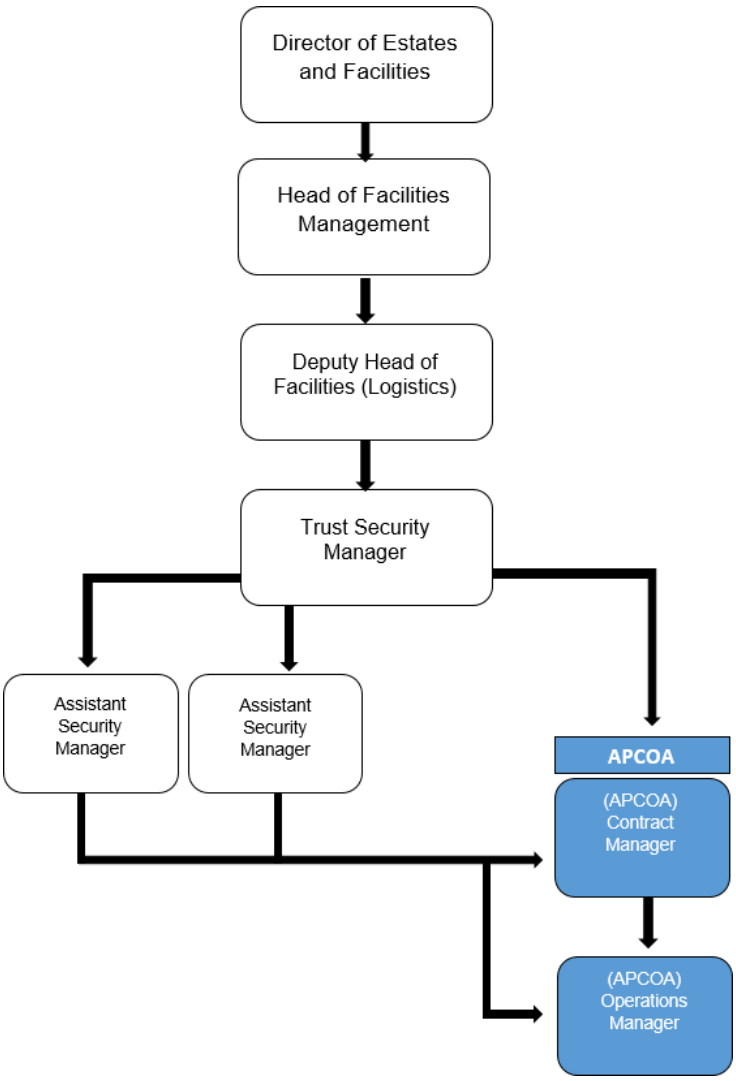
Mission Statement

Provide a physical security presence, including a reaction capability to the two main hospital sites, in support of the Trust and Facilities Strategy.

This report covers aspects of Security Management at a local level and provides an update on the work streams that have been completed between the 1st April 2023 and the 31st March 2024.

2. Security Management Structure

The Trust's Security Management structure sits within the Directorate of Estates and Facilities. This consists of the nominated roles of: Head of Facilities Management, Deputy Head of Facilities (Logistics), Trust Security Manager and Assistant Security Manager(s). The Trust Security Manager and Assistant Security Manager(s) work closely with the operational security functions that are delivered through the Trust contracted security provider. The security contractor is APCOA Parking (UK) Limited, for the Provision of Site Security and Car Parking – Combined Managed Service.



Security Management Structure

3. Compliance

The Trust Surveillance Camera Policy (CP420) and Trust Security Management Policy (CP110) have been reviewed, updated and published. These are valid for three years, with annual review. The Trust Car Parking & Traffic Management Policy & Procedure was approved at the Estates & Facilities Governance and Assurance Committee December 2023. This policy is now following the identified ratification process for Trust approval with ratification at Trust Health Safety Security & Fire Committee June 2024.

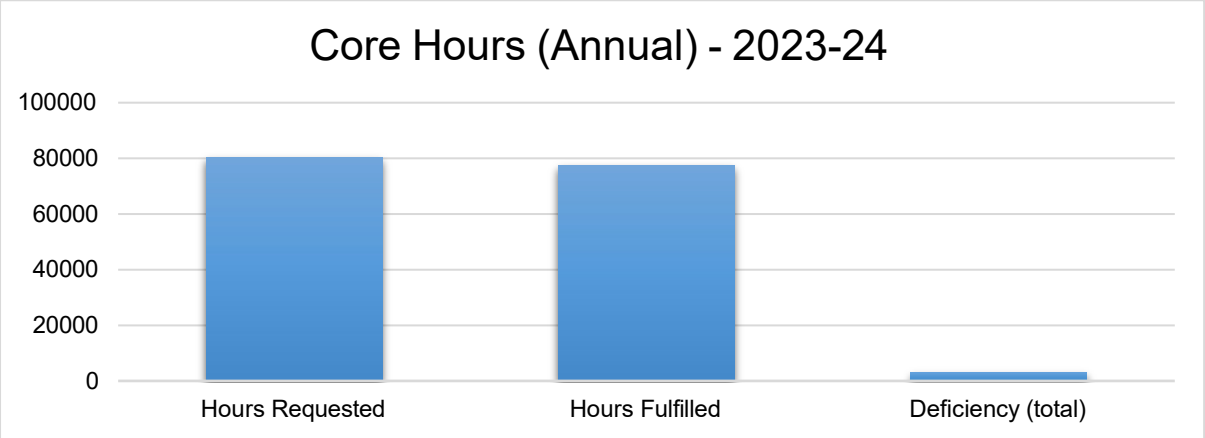
4. Security Provision

APCOA Parking (UK) Limited delivers the Contract for the Provision of Site Security and Car Parking – Combined Managed Service. This contract (HEY/19/238) is reviewed annually and is currently in year 5, with an option to extend for up to 24 months.

The protection of patients, staff, visitors and property on Trust premises is the primary function of Security. This protection responsibility includes control of access / egress points, monitoring of CCTV and alarms, preventative and pro-active patrols, escorts, smoking challenge, response to incidents and calls for assistance and incident investigation.

Security Operations are fully integrated across the Trust from the Security Control Rooms and operates 24 hours per day, 365/6 days per year at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH), with two satellite sites requiring an ad-hoc response service to Harrow Street (Central Decontamination Unit & Medical Records) and Sykes Street. (Artificial Limb Unit)

Graph 1 - 96.4% APCOA Core Contract Hours Fulfilment



Provision of additional security officer duties to support hospital services have increased throughout 2023/24. Additional duties include:

- Urgent Treatment Centre 0700-2300hrs. (CHCP new build facility 2024)
- Level 5 enhanced care patient watch

Urgent Treatment Centre (UTC)
The new UTC facility opened Feb 2024 and is occupied by City Health Care Partnership (CHCP) It has been agreed as part of the provided UTC service, that a dedicated security officer is required for the prevention and reduction of violence and aggression which may occur in the premises.
The provision requirements of a security officer at UTC increased from 12hrs to 16hrs per day from 1st April 2024. Updated costs supplied to CHCP with a contract variation uplift of 112hrs is being put in place with APCOA for the provision of a core contracted security officer pending contract variation approval.

Level 5 Enhanced Care
Any patient identified requiring a level 5 (security patient watch) supervision using the Enhanced Care assessment tool is fulfilled via Apcoa for an agency security officer.

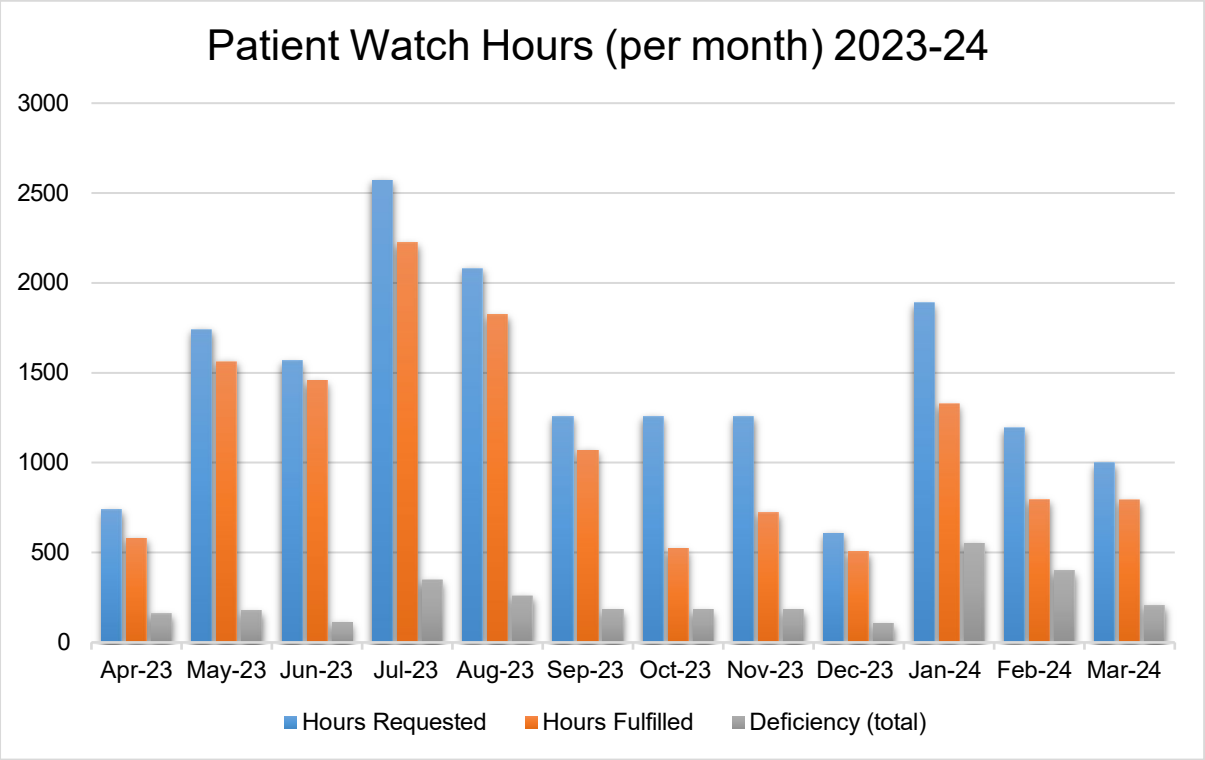
Level 5 enhanced care patient watches are ad hoc documented requests from clinical teams. These are often out of hours, short notice and can be for prolonged periods which requires one officer per patient watch. The cost is recharged to the requesting dept. Patient watch requests are reviewed the following working day by the enhanced care team (ECT) to clarify if a level 5 patient watch is still required, or if the level can be reduced to not require security support. Security officers on a patient watch can only restrain in emergencies only,

when a patient is self-harming, or harming others. Their role during a security patient watch is not to provide care intervention.

77.9% of requested patient watches were fulfilled Apr 23- Mar 24. The remaining 22.1% of unfulfilled requests were reviewed by the site management team to decide if an officer can be redeployed, and security patrols increased to the affected dept.

An improvement plan to manage the requirements for requesting level 5 (security) patient watches is currently being progressed with the enhanced care team lead.

Graph 2 – 77.9% Patient Watch Hours Fulfilment 2023



5. Security Performance

Trust Security Management undertake monitoring and audits of the provision of the services delivered by the APCOA Parking (UK) Limited and allocates scores to each contract standard set out. Monitoring, audits and scores are presented and discussed in the security operations meeting monthly, with minutes and actions presented to the Governance and Assurance Committee.

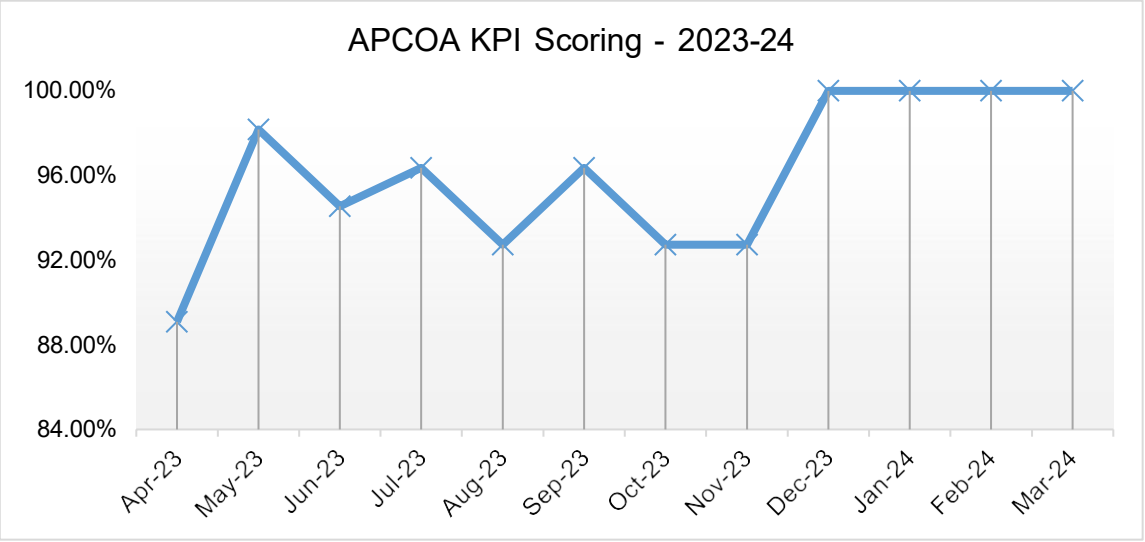
The Trust's expectation is that the APCOA Parking (UK) Limited will aim to achieve 100% score in each of the performance factor groups. Where a threshold for performance of less than 100% is set, this represents a narrow margin for error to accommodate acceptable shortcomings in complex services, or the consequences of subjective assessments.

These methods of measurement were developed jointly by the Trust and APCOA Parking (UK) Limited while recognising the Trust's desire to consistently receive the specified level of services. The compliance rating of Key Performance Indicators (KPIs) is set at 90% and is scored monthly.

A drop below 90% triggers a warning notice being issued by the Trust with a mutually agreed improvement plan. A monthly KPI score less than 85% automatically triggers a financial penalty of the monthly billing being forfeited. If, following an agreed improvement plan, the monthly KPI score remains below 90%, an increased financial penalty of the monthly billing is applied for each monthly billing period. Any extended (beyond 3 months) period of failing to meet the 90% threshold triggers an extra-ordinary contract review meeting which could potentially lead to contract termination.

During 2023/24 year, APCOA Parking (UK) Limited achieved an average score of 95.6% with one month falling below the 90% agreed compliance level. This drop was accepted and a warning notice or improvement plan was not presented on the basis that there was a transition change from one Contract Manager to another in this month.

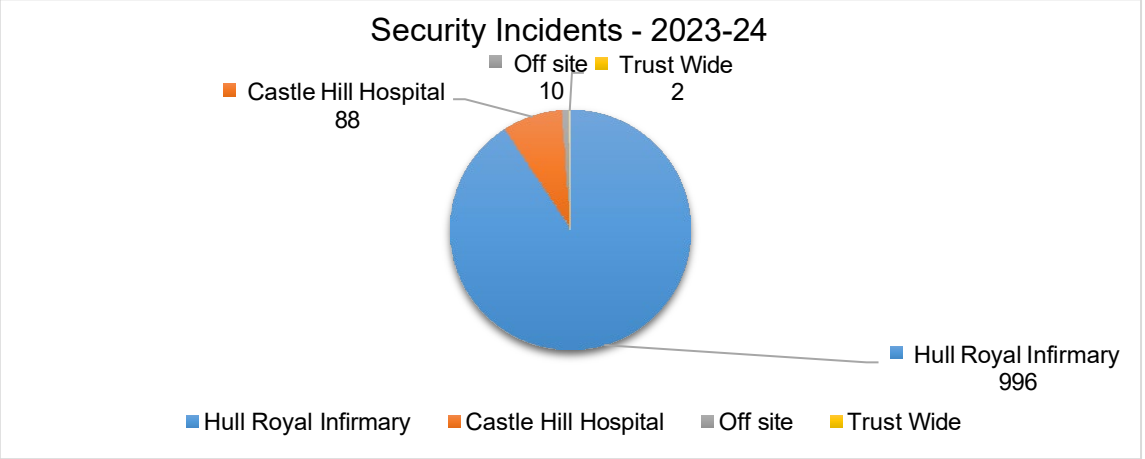
Graph 3: KPI performance average 95.6%



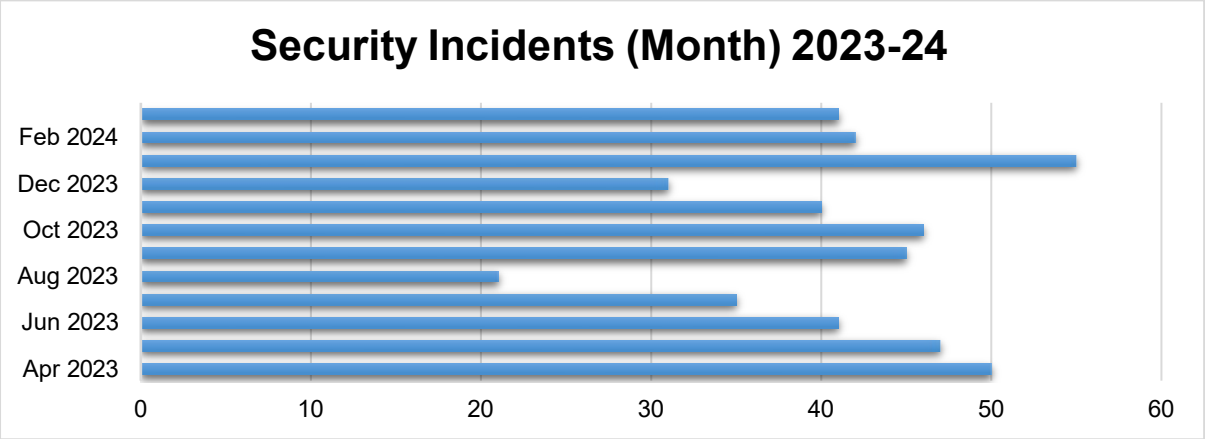
6. Security Incidents

Recorded datix incidents during 2023/24 for Security Intervention and / or assistance were a total of 1,096 Trust wide. This was an average of 91 reported incidents per month. In comparison to 2022/23, this is an increase in incidents reported from 700, but also an improvement in reporting of incidents.

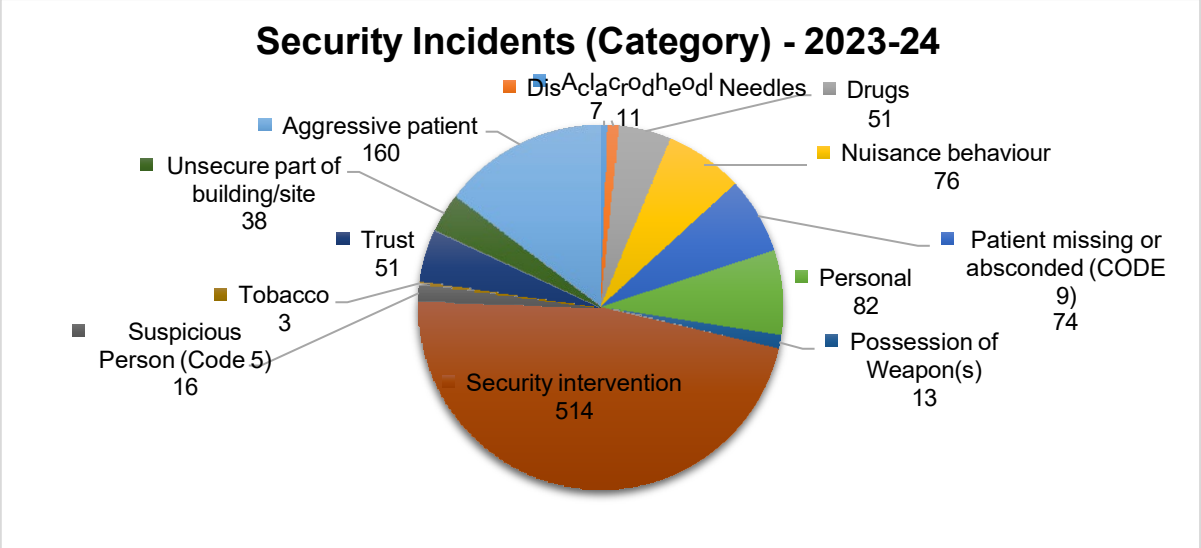
Graph 4: Security Incidents 2023/24



Graph 5: Security Incidents by Month



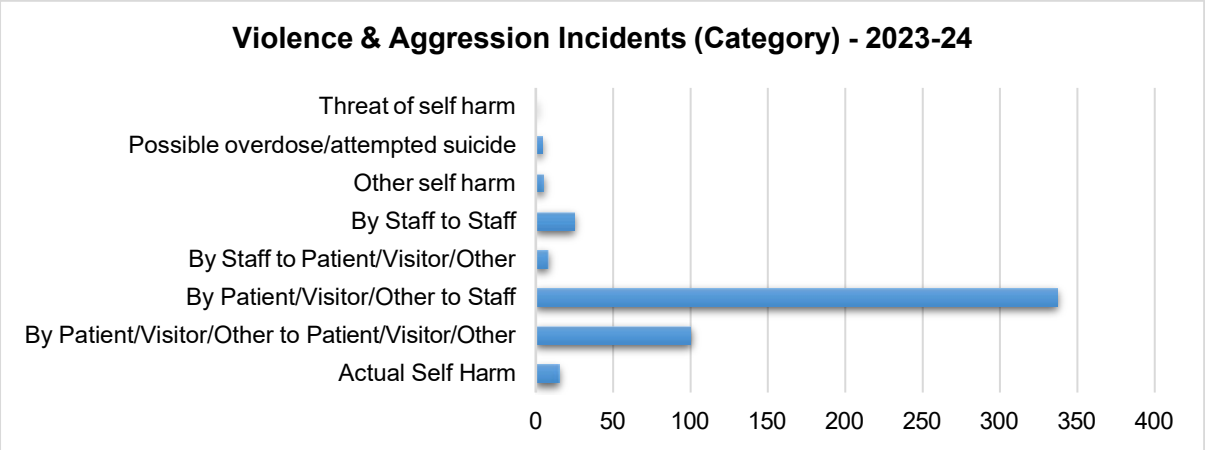
Graph 6 Security Incidents by Category



The above chart includes all incidents that were categorised through DATIX as Security; it is inclusive of all violent and / or aggressive behaviour that is also including / related to medical conditions which may impact a person(s) capacity status. The Trust Security Management Team proactively encourage reporting of incidents and there is a strong belief that the Trust is good at reporting incidents and near misses.
Most Incidents reported on Datix were by security staff , with some departments also reporting the same incident. There is merit in still encouraging NHS staff to use the DATIX reporting platform more routinely for security reporting. The top 5 category of security incidents accounted for 906 incidents in total.

The below chart shows the volume of incidents reported via Datix for category of violence and aggression. 495 of all Datix incidents reported in 2023/24 were of a violent and / or aggressive nature. This equates to 45% of all incidents reported. Violence and aggression is categorised into Malicious. Non Malicious (i.e,no capacity/ accidental) or unknown. All incidents of this nature are investigated by the Trust Security Management Team, who endeavour to provide support to staff throughout any process which may need to be followed during investigation and / or criminal proceedings.

Graph 7: Violence and Aggression Incidents 2023/24



Following an incident of violence/ aggression at CHH in Jan-24,which required police assistance and arrest, a vulnerability assessment of Cardiology building was conducted. Although the incident was not directly related to access control, the review did highlight areas to improve the security of the building which were shared with senior management and cardiology matron. The recommendations of amended access control have been actioned and are now in place.

A number of other actions were also undertaken from this incident, including implementation of a code system for staff to use, to quickly reference the type of incident being reported for security to respond to. i.e. “Code 9” equals a missing or absconded patient. A selection of codes and their designation have been provided to the clinical teams to be able to quote the reference code to enable a streamlined response in the event of time sensitive incidents.

7. Anti-social Behaviour Letters

Hull University Teaching Hospitals (HUTH) NHS Trust has a duty to its employees under the Health and Safety at Work Act 1974 to ensure:

- A safe place to work, access and egress
- A safe working environment, with adequate welfare facilities

HUTH NHS Trust Security Department have re-introduced Anti-social Behaviour (ASB) letters from April 2023 to those who have presented themselves in such a way, that their behaviour is deemed inappropriate.

Patient Advisory Liaison Service (PALS) are included in the process of ASB letters as well as Trust departments into the proof reading of drafted ASB letters.

ASB letters are sent out following the evidence provided from the DATIX reports in collaboration with the reporting department management / Head of Service and PALS. In addition, ASB letters issued are also shared with Hull City Council (HCC) and Humberside Police, with copies forwarded to them for information gathering and future progression. ASB letters are formatted using the NHSE template.

In 2023, a total of 8 formal ASB letters were issued, 3 less than the 11 issued in 2022.

8. Violence Prevention and Reduction Standards

Throughout 2023 Trust Security Management have chaired quarterly Violence Prevention and Reduction Strategy meetings with key stakeholders including Safeguarding, Health & Safety, Education and Clinical representation.

The objective of the meetings was to discuss implementation of the Violence Prevention and Reduction Standards.

A key focus is training of staff, to improve on existing conflict resolution skills through de-escalation training for complex situations with patients. Both Enhanced Care team and Education and Training departments have taken an active role in the implementation of training clinical staff to meet the standard with face to face training sessions held. In the last quarter of 2023, 57 staff have completed De-escalation and Management Intervention (DMI) training. Further training is to be agreed from April 2024, with further clinical groups being identified as a priority following a Training Needs Analysis (TNA) by Education dept.

Attendance at the violence prevention and reduction standards meetings has been limited from some stakeholders, which has delayed the progression of the training.

A violence prevention and reduction standard policy is to be drafted in 2024 with meetings to be scheduled between security management and Trust Health & Safety Department.

9. Lone Worker Devices

The Trust Security Department has commenced a formal review of the Trust Lone Worker Device service. Three meetings have been held between the Trust Security Department and the provider, Reliance Protect, to discuss an action plan to bring the service to the expected standard.

Trust Security currently hold a large number of the contracted 150 devices supplied by Reliance Protect. An action plan has been devised and broken down into progression stages to enable the remaining devices to be issued out. Any staff member requiring a a lone worker device will undergo a lone worker risk assessment for approval, prior to issuing of device.

The current position is Stage 3 of the action plan. The objective is to complete all stages of the action plan by Dec 2024. This will include an action for a Lone Worker Device handbook to assist HUTH staff.

ACTION PLAN	
Stage #1	Update all user profiles (staff members) on the Reliance Protect portal with updated information to reflect up-to-date job roles / titles, departments, line managers & escalation paths.
Stage #2	Update all users (staff members) on the Trust Security lone worker device audit tracker with updated information to reflect up-to-date job roles / titles, departments, line managers & escalation paths, lone worker device serial numbers and indicated ‘pool’ or ‘individual’ lone worker device.

Stage #3	Identify departments with a majority of device users using 'pool' devices and communicate with line managers to confirm issuance of 'individual' devices.
Stage #4	Trust Security to work with Reliance Protect to develop a user guide manual to be issued to device users to enable full familiarisation with the device and processes
Stage #5	Assign selected device users with a new 'individual' device via the Reliance Protect portal and update the information on the Trust Security lone worker device audit tracker.
Stage #6	Issue devices and user guide manuals to line managers to be delivered to selected staff members.

10. Surveillance Systems

The Trust currently operates 3 Security Surveillance Systems which are included under the Surveillance Camera Policy (CP420).

- CCTV,
- Body Worn Camera (BWC) devices
- Automatic Number Plate Recognition (ANPR)

June 2023, the Security Network Video Recording (NVR) dedicated PC failed. This resulted in 95% of the Hull Royal Infirmary CCTV coverage being lost. (Excluding Women's & Children's Hospital) For context, this meant that a significant number of HRI cameras were no longer visible for live viewing or reviewing by the CCTV Operators. (CCTV recording was still operational) The remaining 5% was recovered in the interim for live viewing by way of running an NVR direct to a monitor via a HDMI.

During this failure, there was also a 'Product Discontinuation Notice' which meant repair of the current system was not possible. Increased patrols were implemented by Security Officers, although due to the geographical footprint of the campus, this implementation was a limitation strategy until replacement of the PC.

During the timeframe in which the CCTV system failure was ongoing, the system was placed onto the Trust Operational Risk Register (Risk 4230). The identified risk to the organisation being categorised as 'High' with a risk rating of 15.

To resolve, a server and client PC were installed to replace the IVMs system. The root cause failure was a result of the existing PC running software which was end of life and through an old operating system. The security system provider had also stopped the support and updates for the IVMs software. The rectification and repair works were inclusive of:

- Updated security system server, pre-installed with software and camera licence.
- 136 additional camera licences.
- One PC with a client system version installed.
- One multiway graphics interface to run the existing monitors in Security Control.

To ensure future resilience for business continuity planning, an intra-site CCTV viewing link is currently in progress. This will install a fibre link to run directly between Hull Royal

Infirmary and Castle Hill Hospital Control rooms. This will provide a live view and reviewing of Hull Royal Infirmary CCTV from Castle Hill Hospital and vice versa.

Further work on surveillance systems is planned by way of:

- Replacement of DVRs. Three historic DVRs to be removed and replaced with two high specification hybrid recorders – two new DVRs to be utilised to add resilience to system failures and future-proof for future CCTV projects / installations.
- Replacement of 'Cat-5' cables. Historic 'Cat-5' cables to be removed and replaced with up to date 'Cat-6' cables to allow faster and smoother transition of data to the CCTV server.

July 2023, Castle Hill Hospital Control room was upgraded, allowing improved visibility of the CHH site for crime prevention and detection monitoring via CCTV.

January 2024 vulnerability security assessment was conducted on Cardiology building which included CCTV coverage.

March 2024, vulnerability security assessments have been conducted at HRI & CHH Mortuary. Internal and external building assessments were completed in partnership with Humberside Police. Recommendations were made and costed to improve the security of the mortuary buildings. Capital projects are progressing the works with additional CCTV, fire door alarms and roller shutters to be installed.

A site review of CCTV and security systems is planned during quarter 2 of 2024 with recommendations to be presented to Estates, Facilities and Capital Committee August 2024

Joint Working

Throughout 2023, the Trust Security Management have prioritised working relationships with key internal stakeholders and external partners. This has been successfully achieved with positive outcomes now being seen across the Trust. Security are also involved at design/ installation stage of all new capital projects including, Allam Digestive Diseases building, Day Surgery Centre, Urgent treatment Centre(UTC) A new capital project has also commenced with security management input for a Community Diagnostics Centre (CDC) to open in Hull City 2025.

Humberside Police

Monthly Police Liaison Officer meetings continue between the Trust Security Management and Humberside Police. Meetings continue to prove beneficial with community and Trust trends shared. Input is also provided on how to mitigate and/ or completely reduce the concerns being tabled as a joint collaborative approach to reducing crime in the wider community.

Following a change in Humberside Police process on collection of illicit substances, a review of the process was conducted in liaison with Humberside Police and HUTH Pharmacy. A new SOP has been created by security management and approved by the HUTH NHS Trust Accountable Officer. (Chief Pharmacist). The new SOP ensures the Pharmacy department take receipt of any illicit substances which Humberside Police do not require for an active Police investigation.

There has been a significant rise in cycle thefts, particularly at Hull Royal Infirmary. HUTH and Humberside Police have jointly devised a plan to launch the 'Bicycle Track Project' in

the last quarter of 2023. The project saw a bicycle with Global Positioning System (GPS) tracking positioned at the hospital in strategic positions.

If a person took the opportunity to steal the cycle, the GPS would be tracked by Humberside Police and the perpetrator arrested, the bike is then returned to the hospital. When previously used in other cities, Humberside Police have seen a dramatic decrease in cycle thefts from the area the cycle is being utilised.

Alongside this approach to tackling cycle theft at Hull Royal Infirmary, a proactive approach of holding a regular cycle marking event has also been implemented. Humberside Police set up a canopy at the front of Hull Royal Infirmary which allows any person to walk up with a cycle and have it uniquely marked and added to the national database. The first event was considered a success, with 13 staff members in attendance within 2 hours.

To support a collaborative approach with Humberside police to tackle crime, a mobile knife arch is proposed for a date tbc in 2024 located at HRI Atrium. This would be staffed by Humberside police for an agreed time and period. Further dates will then be confirmed.

Trade Union(s)
In the last 12 months, significant work has been conducted to improve staff engagement. This in particular has been noted in JNCC and LNC where security service updates are part of the agenda

Councils
In an effort to create a collaborative approach to tackling crime, violence and aggression. HUTH recognises that what happens on our properties, can often also impact the local communities.

6th November 2023, the Trust Security Manager held a meeting with Council partners. Quarterly meetings are now implemented to meet with Hull City Council (HCC), East Riding Council and Parish Council. Implementation of these meetings afford the opportunity to discuss recent concerns, trends and potential future concerns which have, or may occur not only within our environment on sites ,but also the wider environment, affording all parties to proactively approach issues.

11. Future Services

Community Diagnostic Centre (CDC)

Facilities department are working with Capital Projects and Hull City Council for the planning and building of a new CDC building in Hull City Centre. Security management have reviewed proposed designs and provided input on security system recommendations. Security management are also working on plans with departmental leads for a proposal on future security arrangements at the building when it opens in 2025

Solar Farm Castle Road
A physical security provision has been identified for the Trust PV farm. Costs and options have been supplied to provide a service provision under the APCOA Parking (UK) Limited

contract. Options presented and costed for, include a 24/7 service and a 12 hour option with the utilisation of an already existing establishment. It is worth noting however, the Solar field, despite being operational for 18 months has not required a 24/7 presence and is monitored from the CHH control room which has CCTV visibility of the site.

During the operational period, only one attempted break-in occurred. Due to the lack of visibility at the time prior to the CHH control room upgrade, no individuals were identified. APCOA have also taken a significant amount of time to put forward their costs and it is suggested by the costs received, this does not provide value for money and the new security provision whilst charged against the energy budget, would in effect be undertaking additional duties.

Action Required

The Trust Finance and Performance Board is asked to:

a. Note the contents of this report

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates, Facilities & Development

Annual Report for Security Management 2023/24

Report Date:	
Number of Pages:	31
Report Author:	Philip Young, Security (LSMS) & Safety Compliance Officer
Director Sign-Off:	

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Section **Page**

Executive Foreword

The NHS Constitution states you have the right to be cared for in a safe, secure, and suitable environment, in addition to legal obligation to protect our staff, patients have a right to be cared for in a safe and secure environment. The security and safety of staff, patients, visitors, and property are a priority to enable the effective delivery of healthcare services. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has continued to develop its security management arrangements as part of a structured work programme identified in last year's Annual Report. This has included:

- A proactive approach to the issuing of informal and formal warning letters to offenders of violence and abuse against staff, which links into compliance with the NHS Violence Prevention and Reduction Standards.
- Review of Trust wide CCTV system, a new system was installed at Grimsby, Scunthorpe and Goole in 2022 with new cameras which provide enhanced footage, the CCTV system is now fit for purpose and is reviewed annually.
- The organisation continues to develop and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property, and assets; the LSMS is working closely with Humberside Police, Local Authorities and Safeguarding teams. There is also Improved sharing and analysis of crime data between NLAG, Humberside Police and North East Lincolnshire and North Lincolnshire Community Safety Partnerships.
- The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g., refurbishment or refitting) of existing premises, this has taken place with the upgrading of the CCTV system, the new Emergency Departments and SDEC buildings that are now fully operational.

There have been a number of successful criminal sanctions and Trust policy sanctions applied during 2023/2024. The criminal sanctions include convictions against offenders for verbal and physical assaults, criminal damage, and theft. The Trust has issued 47 informal warning letters which is 18 more than in 2022/2023, which were sent to patients and visitors warning them of inappropriate behaviour towards staff. The Trust issued 8 formal warning letters to patients due to the severity of their behaviour towards staff, which is 5 more than 2022/2023, no exclusions have been issues to any patients or visitors during 2023/24.

The 6 Point Promise for victims of intentional physical assaults whilst at work was implemented late 2021, we continue to work within the Joint Working Agreement (JWA) between the Trust, the Yorkshire and Humberside Crown Prosecution Service, and Humberside Police.

The Trust continues to work within the NHS Violence Prevention and Reduction Standards which were published in December 2020.

1.0 Background and Introduction

This report covers all aspects of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) Security Management at a local level and provides an update on the work streams that have been completed between the 1st April 2023 and the 31st March 2024.

The Trust and the Local Security Management Specialist is committed to improving the provision of a secure environment for staff, patients and visitors and the security and protection of its premises and assets, whilst recognising the need for accessible clinical services and the desirability of a welcoming non-threatening environment. The Trust and LSMS aims to achieve this objective through the implementation of appropriate systems and arrangements which meet national, legislative and code of practice requirements issued from various bodies.

The **NHS Standard Contract** no longer exists as it finally came to an end in 2021/2022, however in respect of services provided to NHS Commissioners and the Standards that were previously set by NHS Protect, the four priority areas for the Trust to continue to develop a secure environment are:

- **Strategic Governance**
- **Inform and Involve**
- **Prevent and Deter**
- **Hold to Account**

The Trust and LSMS now work within the NHS Violence Prevention and Reduction Standards which were published in December 2020 and the Guidance notes published in June 2022.

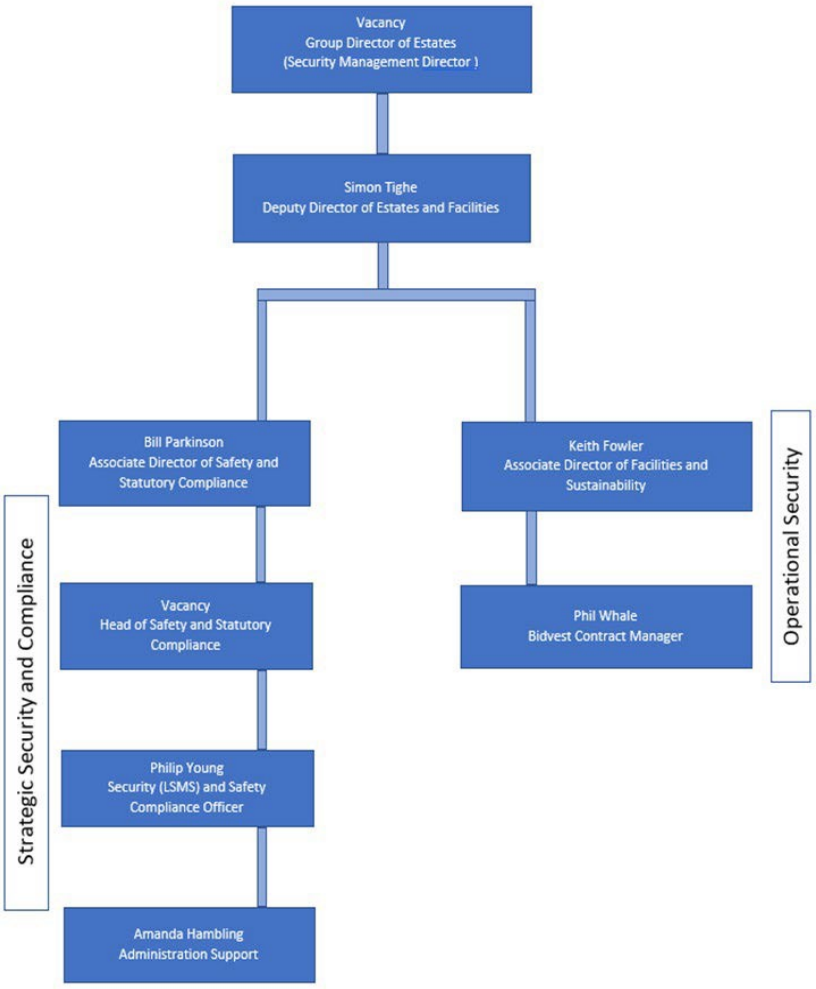
The Trusts Security Strategy, which is coordinated at a local level by the Local Security Management Specialist (LSMS), focuses on seven generic areas for action:

- **Creating a pro-security culture** – to promote a culture in which the responsibility for security, including timely reporting of security incidents, is accepted by all.
- **Deterrence/Reduction** – Identifying and implementing ways to deter and reduce security incidents and breaches.
- **Prevention** – Identifying and implementing ways to prevent security incidents and breaches.
- **Detection** – Ensuring security breaches are detected and appropriate reporting systems are in place.

- **Investigation** – Initiating post incident reviews and criminal investigations.
- **Sanctions** – Providing advice on relevant sanctions and utilising Trust policies.
- **Redress** – Support the Trust to seek redress in all appropriate circumstances and assessing the true cost of security incidents to the NHS.

2.0 Security Management Structure

The Trust's security management structure sits within the Directorate of Estates and Facilities and consists of the nominated roles of Security Management Director (SMD) which is currently vacant, usually held by the Director of Estates and Facilities, and the Local Security Management Specialist (LSMS) role held by the Local Security Management Specialist (figure 1). These roles work closely with the operational security functions that are managed by the Associate Director Facilities & Sustainability and delivered through the Bidvest Noonan security contract.



(NB - As at 31st March 2024)

Figure 1 – Security Management Structure

2.1 Violence and Aggression against Staff

The number of reported security coded incidents during 2023/24 was a total of **706** incidents Trust wide, this is up from **647** in 2022/2023.

This includes all incidents that are coded as security incidents including behaviour that is related to medical condition, absconding from wards, and is not just coded to violence and aggressive behaviour. There appears to of been an increase on the figures that was reported during 2022/23, throughout the last 12 months the LSMS has been actively promoting the reporting of Ulysses throughout the Trust, making staff aware of the benefits of reporting incidents which include thorough investigations taking place, jointly working with the Police and other partner agencies, positive action being taken against offenders and the Trust identifying trends and acting upon them to make the Trust a safety place to work and visit, we have seen a rise in Mental Health patients as well as hate crime during 2023/2024.

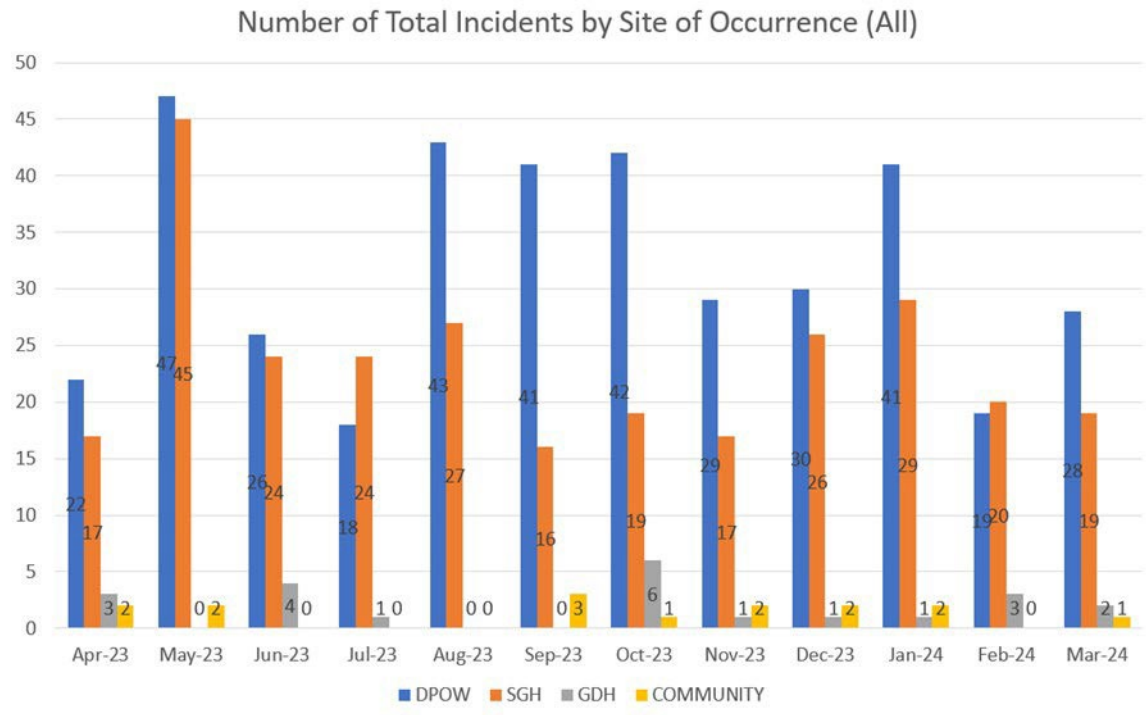
Staff have been made aware that they will be supported if they are a victim and violence and aggression and the LSMS will contact them.

Through evaluation with Partner Agencies including the Police, when a rise in certain types of crime has been seen within the community and it has been identified that when a rise occurs within the community it is also seen within NLaG.

It also may be that the figures have also increased due to footfall over the last 12 months as the Trust has been extremely busy with patient demand.

The chart below (figure 2) shows the number of incidents per month by site. The reported numbers show that there has been a steady number of incidents reported at both DPOW and SGH throughout the year, with May 2023 seeing the largest number of incidents reported at both DPOW and SGH.
DPOW had a slight drop in numbers in July and February 2023 and SGH had a slight drop in numbers in April, Sept, and November 2023.
Community figures sit in single figures each month with the highest in a month being 3 in Sept 2023.

GDH also sits in single figures with the highest month being 4 in June 2023.



Calendar Month	Community	DPOWH	GDH	SGH	TOTAL
Apr - 23	2	22	3	17	44
May - 23	2	47	0	45	94
Jun - 23	0	26	4	24	54
Jul - 23	0	18	1	24	43
Aug - 23	0	43	0	27	70
Sep - 23	3	41	0	16	60
Oct - 23	1	42	6	19	68
Nov - 23	2	29	1	17	49
Dec - 23	2	30	1	26	59
Jan - 23	2	41	1	29	73
Feb -23	0	19	3	20	42
Mar - 23	1	28	2	19	50
Total	15	386	22	283	706

Figure 2 – Number of incidents per month by site

It should be noted that of the total 706 behaviour incidents reported during 2023/24, 21.10% related to behaviour that included violence and assault and 34.28% in relation to aggressive behaviour and Verbal Abuse which also includes Verbal abuse with Racial Content, we have seen a rise is this type of offence during 2023/2024 with it contributing to 4.95% of the total figures for 2023/2024.
The remaining 44.62% was relating to Anti-Social Behaviour, absconders, Self-harm, drug use and Harassment.

The next chart (figure 3) shows the percentage of incidents per category for the year.

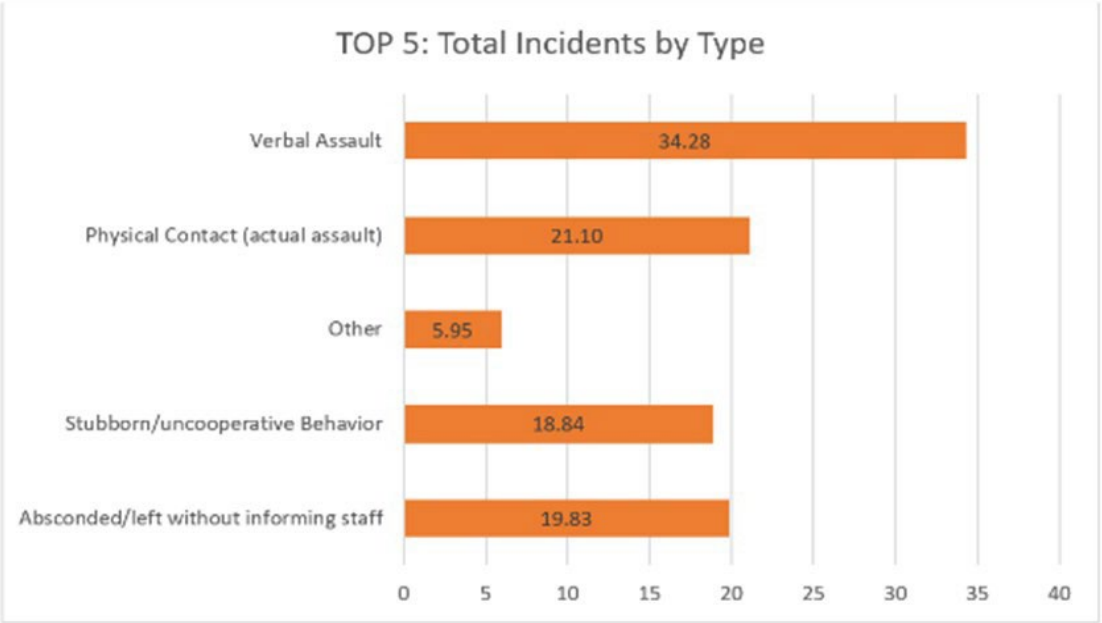


Figure 3

The percentage of reported physical assaults is 21.10% which is down from 24.24% on 2023/2024. The type of physical violence ranges from pushing and lashing out to punching and kicking, this also includes sexual assault incidents. A number of these incidents will relate to patients that are suffering from a medical episode so lack capacity to understand their behaviour so no action is taken by the LSMS but should be reviewed by the medical team in charge of their care to ensure correct care package has been provided to support the patient and staff, the LSMS provides advise and support to the medical teams to unsure that both the staff and the patient are safeguarded appropriately.

Most incidents that are reported relate to both Emergency Departments could be due to the patient and visitors they have within their departments and the acute treatment and care been delivered. The incidents that don't include clinical factors, the LSMS and Police will endeavour to take strong action to try to prevent these incidents reoccurring.

Work is undertaken to support victims of these incidents and to put relevant actions in place against the aggressors in the hope of positive outcomes, and to try and prevent any further reoccurrence. Details of some of the work in progress are included in other sections of this report and the 2024/2025 LSMS workplan.

During 2023/2024 the LSMS has worked closely with Humberside Police to raise the amount of Sanctioned detections (Convictions and Cautions) as the LSMS identified that the figure was low and wanted to see more positive outcomes for offender behaviour, so that this could be published as a toll to deter crime being committed at the Trust sites.

The LSMS is keen to promote to staff that they are supported if they are a victim of violence and aggression and that the LSMS can be a point of contact for them throughout the investigation, every incident will be taken seriously by the Trust and the LSMS and reviewed and acted upon by the LSMS.

2.2 Joint Working Agreement

The Joint Working Agreement (JWA) between the Trust, Yorkshire and Humberside Crown Prosecution Service and Humberside Police is currently undergoing a full review and once reviewed, amended, and published the new JWA will be promoted by the LSMS within Humberside Police Crown Prosecution Service and the Trust, the review process has been delayed due to organisational changes within Humberside Police.

Once the NLaG JWA has been reviewed and amended there will then be joint working with HUTH to include them in the JWA so that it supports both NLaG and HUTH, Humberside Police and Yorkshire and Humber Crown Prosecution Service.
The LSMS will work closely with Inspector Claire Jacobs at Grimsby and Inspector Thomas Stevens at Scunthorpe from Humberside Police to implement and raise awareness of the JWA and its principles to ensure it makes an impact at frontline services.

A 6-Point Promise was approved in 2021 between NLAG and Humberside Police that details the six key points that NLAG staff will receive should they become a victim of an intentional physical assault whilst at work. These include the support that will be made available to them and that NLAG and Humberside Police will work together to achieve a positive outcome for the victim wherever possible.

2.3 Warning Letters for Unacceptable Behaviour

The Trust does not tolerate any acts of criminal violence or aggression towards our staff and in support of this the Trust has a Policy for the management of Violent, Aggressive and Intimidating Behaviour which contains an exclusion procedure. The exclusion procedure consists of four stages, verbal warning, informal warning letter, formal warning letter and then an exclusion letter.

The LSMS has taken a proactive approach to challenging unacceptable behaviour as an early intervention to try and prevent the escalation of behaviour and reoccurrence of incidents.
This proactive approach has led to 47 informal warning letters being sent to patients and visitors warning them of inappropriate behaviour towards staff during 2022/23, which is an increase of 29 from 2021/2022. In addition, the Trust also issued 8 formal warning letters to patients due to the severity of their behaviour towards staff, 3 formal warnings were issued in 2022/2023.

The Trust has not issued any exclusions to patients or visitors during 2023/24. The types of behaviour that can lead to the informal and formal warning letters being issued include being verbally aggressive, threatening staff, physically assaulting staff, and racial abuse. Informal and Formal Warning for unacceptable behaviour are also sent if the offender is being investigated for criminal offences by the Police.

This year's figures are up from 2022/23, this was to be expected as the LSMS has actively promoting the reporting of Ulysses Incidents for inappropriate behaviour throughout 2023/2024 and providing more support to staff when they become victims, the LSMS is also taking a more robust approach to unacceptable behaviour due to the increase in incident figures within the Trust and within the Community.

The LSMS Monitors the incident figures with a monthly report provided by the Ulysses Team.

Monitoring of the number of incidents that occurred prior to the warning letter and after the warning letter, provides evidence that in most cases there has been no reoccurrence of incidents involving the individuals after the letter has been issued, The Trust do have a small number of repeat offenders, which then leads to collaborative working between the LSMS and Humberside Police to positively deal with the repeat offender, more often the offender is also committing repeat offending within the community so it's in the best interest of both the Trust and Police to work together.

When there is opportunity arising through the individual contacting the LSMS, the LSMS promotes constructive discussion to positively educate the individual to deter inappropriate behaviour in the future.

The LSMS reviews Body Camera footage and CCTV footage on a weekly basis which provides valuable evidence and Information for the purpose of the exclusion procedure and its four stages, the footage is also valuable if reported to the Police.

2.4 Community Lone Working

The Peoplesafe Lone Worker devices currently in use contain the latest lone working technology, are linked to a 24/7 specialist alarm receiving centre and feature GPS locating technology that can be directly linked to the Police Command Centre Dispatchers during an emergency to ensure the quickest response possible for staff requiring help. The feedback received from staff has been positive regarding training, service provided by Peoplesafe and the device functionality.

There are approximately **543** staff that have received face-to-face or on-line training and have been issued or have access to a device, this figure is down from **608** in 2022/2023. Currently the Trust has **537** devices in total although only **38** active devices are currently in use that are assigned to staff with a mixture of individuals and pooled units, this is down from **61** in 2021/2022 however we must be mindful that the number of users we have has dropped from 2022/2023 due to the audit of users and devices, the **38** active users are providing a usage figure of 30%.

A root to branch gap analysis took place in 2022 by the LSMS, this took place due to evidence of units not being used or being allocated to staff that had either left the Trust or moved to alternative posts. As a result of this analysis (along with an exchange programme taking place the number of units not in use and no longer required),the user database and allocated units was dramatically tidied up and reflected a true picture of the Community Lone working allocation and user groups.

Despite carrying out the gap analysis and the exchange programme the usage of the devices fell sharply during the year, notwithstanding support from Peoplesafe and the divisions, promotion of the usage of the devices via Communications on the Trust Intranet and Social Media pages, violence against staff awareness workshops and the issue being escalated to Trust Management Board the number of active users and the usage did not increase during 2023/2024.

The LSMS along with Peoplesafe continued to look at ways to promote the use of the devices with users so that the devices are being used to their full potential, the promotion is and continues to be supported by Peoplesafe who provide weekly workshops, case studies of incidents involving the use of the device to show the positive benefits of using the device. During January 2024 the Peoplesafe are providing weekly usage reports which will show who has not used their device, this will then be escalated to the Line Manager of the users and the users themselves.

The LSMS was joined by the Peoplesafe Accounts Manager for a day of action at Scunthorpe in January 2024 whereby they attended a Community Nurses away day at Forest Pines Hotel where they presented training on the devices and discussed the usage and carrying of devices, they also attended Global House and provided an open attendance workshop for user to attend.

The LSMS has been invited to visit Peoplesafe HQ and see the 24 hour Monitoring Centre and speak with Peoplesafe staff in relation to Violence and Aggression, Peoplesafe have also asked the LSMS to be a case study and have conducted a promotional interviewed about using the devices and the support it provides lone workers, the LSMS is also a point of contact for other NHS Trusts who are considering using Peoplesafe, they can now contact the LSMS and obtain guidance, advise and support whilst carrying out their tender process.

2.5 Surveillance Systems

The Trust currently operates 3 Security Surveillance Systems, CCTV, Body Worn Video (BWV) devices and non-recording patient cameras and monitors. The Trust also has Automatic Number Plate Recognition (ANPR) in use on our car park barriers which, although not a security system, is still classed as a surveillance system.

The current CCTV system is Digital at DPOWH and GDH, and SGH, we are also using Digital High-Definition Cameras. The previous systems at DPOWH and GDH used to regularly fail with issues associated with the hardware, including the recording units, the cameras, and the controller units prior to the upgrade that occurred during 2022/2023. The system at DPOW, SGH and GDH is now fully upgraded with new software and cameras, new cameras have been replaced within the buildings and outside, camara positions have also been rationalised to provide better coverage both in and outside the Hospital, the new cameras provide a much better-quality picture and can also take still shots. The rationalisation also provides assurance that the Trust has taken all reasonable measures to reduce unnecessary surveillance, which is in line with the Surveillance Camera Commissioner (SCC) Code of Practice.

The feedback form partner agencies that have accessed and obtained footage gas been very positive, with comments relating to the quality of evidence that has assisted in a prosecution.

Fisheye Camaras are installed throughout the Hospital sites which give a full 360-degree view with a good quality image, and they can also be broken down into zones so more than

one view can be monitored at any one time, so one camera can put up to six different screen zones up for the controller to view, these are used in high footfall areas and where there are multiple location that need monitoring at any one time within both the building and outside.

The fisheye cameras have also been installed in the new Emergency Departments at both DPWO and SGH and they are linked to the Security Office that is monitored 24 hours a day, 7 days a week, with CCTV images retained for a period of 30 days. Images are deleted once their purpose has been discharged and they are no longer required for the stated purpose of a Surveillance system.

Body worn video devices are worn by the Security officers and the amount in service has increased during 2023/2024 with the purchase of more cameras and have the following body worn cameras in use –

- DPOW x 3 Body Worn Cameras – All active
- SGH x 3 Body Worn Cameras – All active
- GDH x 1 Body Worn Camera – Active

In addition there is a one spare and a unit currently being repaired after an incident with a violent patient.

These numbers were valid at the time this report was compiled but there are plans to increase the numbers available.

No covert cameras were deployed during the 2023/24 period (use of covert surveillance must be authorised by the Police).

2.6 National NHS Security Management and NHSE Standards

In December 2020 NHSE/I released a new set of standards for security management, in the form of the Violence Prevention and Reduction Standard to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence. which has replaced the previous standards and guidance issued by NHS Protect before they were disbanded in 2018. The Trust continues to work to these standards to ensure compliance and the work plan for Security Management for the 2024/2025 reflects the standard, the work plan is attached as Appendix A.

During 2024/2025 the LSMS will create a Violence Prevention and Reduction Strategy and Workplan for the Trust. The LSMS was planning on attending and completing a recognised

Violence Prevention and Reduction and Public Health qualification, however a course was not available during 2023/2024. There is currently a pilot course being tested but this is not available at present for general use. As soon as a course is available the LSMS will attend, this will be added to the work plan for 2024/2025.

The LSMS has completed the NEBOSH Incident Investigation course to support his role as LSMS, the LSMS is currently enrolled and completing a Level 4 Security Management Course. The Accredited LSMS course ceased some years ago.

2.7 Counter Terrorism

The many terrorist incidents that have occurred in the UK over the past few years reminds us of the continued need to ensure our sites and staff are prepared to respond to an incident and to be aware of the warning signs leading to an event. The Trust continues to work closely with the National Counter Terrorism Policing: North East Counter Terrorism Unit in providing up to date advise and appropriate training sessions for Trust staff. The Trust is in the process of adding the Action Counter Terrorism training (ACT Training) which incorporates SCaN (See, Check and Notify) onto ESR as an E-Learning package which will become mandatory training once Martyn's Law has become legislation the trust must comply to once draft bill is passed.

All Trust staff have been made aware of the available ACT Training via a communication release on the Hub and sign posted to the Counter Terrorism Policing website whilst work is carried out to make the training available via ESR is progressed.

2.8 Terrorism (Protection of premises) (Draft Bill) (Martyn's Law / Protect Duty)

The government have published the Terrorism (Protection of premises) Draft Bill in May 2023, now referred to as 'Martyn's Law' and is a response to the Manchester Arena Bombing. A publicly accessible location is defined as any place to which the public or any section of the public has access, on payment or otherwise, as of right or by virtue of express or implied permission. Publicly accessible locations include a wide variety of everyday locations such as: sports stadiums; festivals and music venues; hotels; pubs; clubs; bars and casinos; high streets; retail stores; shopping centres and markets; schools and universities; medical centres and hospitals; places of worship; Government offices; job centres; transport hubs; parks; beaches; public squares and other open spaces. This list is by no means exhaustive, but it does demonstrate the diverse nature of publicly accessible locations.

Martyn's Law is a new legislation that had inclusion in the King's Speech on November 2023 and in February 2024 a six week consultation took place and it's expected to be introduced for parliamentary scrutiny during the spring of 2024.

The government's intention is clear; it wants 'Martyn's Law' to be enacted as part of its legislative programme.

This means that, within the next 12 months, universities and hospitals could find themselves subject to new security and safety requirements. They'll have to comply with whatever inspection and enforcement regime is introduced after the law is passed. That may not happen immediately, but it is now looking much more likely, so preparing early is advisable.

This legislation, and the changes it brings, will enhance the protection of the United Kingdom's publicly accessible places from terrorist attacks and ensure that businesses and organisations are prepared to deal with incidents.

The Legislation will require the Trust to:

- Engage with freely available counter-terrorism advice and training.
- To conduct an enhanced terrorism risk assessments of operating places and spaces.
- To mitigate the risks created by these vulnerabilities.
- To put in place a counter-terrorism plan.
- Work with local authorities to plan accordingly for the threat of terrorism.

The LSMS will continue attend online briefings and conferences delivered by the Home Office and Homeland Security in relation to the current position of Martyn's Law.
The LSMS is also working closely with both North Lincolnshire and North East Lincolnshire on their preparation for the law being passed.

2.9 Joint Working

During the last 12 months the LSMS has continued to build positive working relationships within the Trust and with external partners, this has been successfully achieved with positive outcomes now being seen across trust and with all its partners.

Trust/Police working relationship.
The working relationship we have built with both the Grimsby and Scunthorpe Neighbourhood Policing Teams is really reassuring and has progressing well, we have implemented a number of better working practices to support each other, we have bi-

monthly Police surgeries at both DPOW and SGH where we display a joint presence to the public and staff, we are also involving the Safer Streets Team from North Lincolnshire Council.

There has been good evidence of the benefit of the working relationship we now have which has shown very positive outcomes on Police Investigations where convictions have been secured.

Although both DPOW and SGH are the highest locations in the Park Ward at Grimsby and Town Centre Ward at Scunthorpe have the highest crime rates, we are now seeing a rise in detections of crime whereby the offenders are positively dealt with (by use of a caution or court disposal).

During 2023 there was a rise in Hate Crime with the Security Team being the main victims, on every occasion the Trust worked closely with the Police to provide comprehensive evidence including body camera footage that has led to a number of successful prosecutions.

Unison/Trust

A number of joint violence at work events have taken place on all 3 sites during 2023/24, whereby Unison representative Alex Hutchinson, Julian Corlett and the LSMS attended the restaurants and café areas at DPOW, SGH and GDH with information to provide support and advise in relation to violence at work. This also supported the Violence prevention and Reduction Strategy that is being written and is the second year that the Trust and Unison have carried out the events which are considered to be highly successful and worthwhile.

Safeguarding

Close positive working relationship has during 2023/2024 with the Trust Safeguarding Teams and the Mental Health teams.

The LSMS is invited to strategy meetings and members of the team contact LSMS regarding patients that pose a risk to other to plan their visit/inpatient stay and obtain advise.

The LSMS writes management plans when required to support and protect Safeguarding, ward staff, ward management, the patient, visitors and the Security team, the management plan is security focused and details the risk the patient presents and how it can be managed

within the Trust and with support of partner agencies when required, the plan also details routes of escalation when required.

The LSMS works closely with the Adult Safeguarding Team when supporting Domestic Abuse victims, the included both patients and Staff. This joint working has been positively acknowledged by Head of Safeguarding who has commended the LSMS during minuted meetings.

The LSMS supplies written reports and attends the Safeguarding and Vulnerabilities Operational Forum and the Vulnerabilities Oversight Board. In addition, there is also direct contact with partner agencies in relation to Safeguarding including the Blue Door, probation, and the Local Authorities Social Care Teams.

The LSMS has completed the Level 3 Childrens Safeguarding and Level 3 Adults Safeguarding course.

Community Safety Partnership

The LSMS is an active member of both the North East Lincolnshire Community Safety Partnership and North Lincolnshire Community Safety Partnership, and chairs the Violence at Work Group (VAWG) and on the serious Violent Crime working group and serious Youth Violence working groups at both Community Safety Partnerships. They also Chair the North East Lincolnshire Violence Against Women (VAWG) Working Group.

3.0 2024/2025 Work Plan for Security Management

The 2024/2025 Work Plan for Security Management outlines the key actions against each security management objective, has been attached (see Appendix A).

4.0 Summary and Next Steps

In summary, there continues to be a considerable amount of work in developing the Trust's security management arrangements to improve the safety of our services for staff, patients, and visitors, and to protect NHS property and assets. The work being carried out by the LSMS in partnership with Trust Partners is crucial to the development of security management and the prevention and reduction of violence and criminal offences against staff and Trust property.

The focus areas incorporated into the 2024/25 Work Plan for Security Management are continuing the close collaborative working with partner agencies to increase incident

reporting and investigation outcomes, support for staff who become victims of crime, and progressing new technology and improvements to surveillance systems. The national focus on reducing violence against NHS staff in relation to the Violence Prevention and Reduction Standards is likely to see new sets of security management standards and improved sharing of incident data and analysis across NHS organisations in the very near future.

There is also focus on the Martyn's Law Legislation and how the Trust will ensure compliance, The LSMS will prioritise Marty's Law within the workplan as its anticipated that the responsibility put on the Trust will impact on the Trust, as part of the preparation process for the new Legislation effort is being made to provide Trust staff with up-to-date training on Counter Terrorism via the approved ACT Training (currently being added to e-learning on ESR). In addition, work will continue with partner agencies to promote positive community involvement with regard to the rehabilitation and the diversion from committing further crime of people that commit offences on trust property, when this is suitable via the Restorative Justice process.

5.0 Trust Board Action Required

The Trust Board is asked to:

- Note the contents of the report.
- Note the 2024/25 Work Plan for Security Management at Appendix A.

Appendix A

2024/2025 Work Plan for Security Management

Standard	Area	Task / Objective	Target Dates	Completed Date
Strategic Governance				
1.1	A member of the Executive Board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation. This person is nominated to NHS England	• LSMS to meet at least quarterly with SMD or as required. • Quarterly Security Group Meeting • Investigation or management reports to be provided as required. • Security Management Annual Report to the Trust Board	Quarterly Quarterly As required. April each year	
1.2	The organisation employs or contracts a qualified, accredited and nominated security specialist to oversee and undertake the delivery of the full range of security management work	• LSMS to attend relevant conferences and CPD events. • LSMS to attend and complete a recognised Security Management Course • LSMS to attend and complete a recognised Violence Prevention and Reduction and public health qualification when one becomes available. • LSMS to attend Regional LSMS Forum • LSMS to become an approved and accredited Trainer for VAWG – CPS responsibility and enable training to be delivered within the Trust.	As required. March 2024 December 2024 Quarterly March 2024	
1.3	The organisation employs or contracts a qualified, accredited and nominated Health & Safety Specialist to oversee and undertake the delivery of the full range of Health & Safety work	• LSMS to attend and completed the NEBOSH General Certificate Course	March 2025	

1.4	The organisation allocates resources and investment to security management in line with its identified risks	• Funding is allocated to security issues as identified through security risk assessments and incident reporting. • LSMS to carry out Privacy Impact Risk Assessment for the Trust CCTV System and the cameras. • LSMS to carry out a Privacy Risk Assessment for Trust Body Worn Video Cameras • LSMS to create a Privacy Impact Statement • LSMS to conduct a CCTV audit at each site during 2024/2025 to comply with the Surveillance Codes of Practice, the LSMS will carry out an annual review and audit of the surveillance camera system to review the necessity, proportionality and effectiveness, the locations of the cameras will form part of the review to assess whether the location of cameras remain justified in meeting the stated purpose and whether there is a case for removal or relocation • LSMS to support the Trust wide CCTV 12 Monthly review and escalate any changes required to the Security Group.	Ongoing October 2024 October 2024 October 2024 October 2024 In progress	
1.5	The organisation reports annually to its Executive Board, or equivalent body, on how it has met the standards set by NHS England in relation to security management, and its local priorities as identified in its work plan	• Work within the NHS Violence Prevention and Reduction Standards published in December 2020 and using the guidance notes which were published in June 2022, reporting compliance to the Security	Ongoing	

		Group. • Results of compliance in relation to the NHS Violence Prevention and Reduction Standards published in December 2020 and using the guidance notes which were published in June 2022 to be included in Security Management Annual Report to the Trust Board. Incorporating the Trust Strategy and workplan currently being written.	April 2025	
1.6	The organisation has a security management strategy aligned to NHS England Violence Prevention and Reduction Standards. The strategy has been approved by the executive body or equivalent body and is reviewed, evaluated, and updated as required	• Review Policy and Strategy for Security (DCP197) in line with review schedule • Create and publish a Trust Violence Prevention and Reduction Strategy • Create and Publish a Trust Violence Prevention and Reduction Workplan • Security Management Annual Report to the Trust Board	February 2027 November 2024 November 2024 April 2025	
1.7	LSMS to monitor Trust Policies and TOR'S – • DCP203 Policy for the Security and Management of Assets. • DCT077 Security Group – membership and terms of reference. • DCP154 Policy for the Management of Violent, Aggressive, and Intimidating Behaviour. • DCP197 Security Policy & Strategy. • DCP148 Internal & External Surveillance systems policy. • DCP149 Policy & Procedure for bomb threats and suspect packages. • DCP150 Policy & Procedure for deployment of armed Police	• LSMS to review policies and TORS when made aware of any legislation, change to guidance or changes to Trust sites that will require the document to be updated. • To action required changes to the document. • To review Documents periodically before the review date in case of any required changes.	DCP203 – April 25 DCT077 – Sept 26 DCP154 – Feb 27 DCP197 – Feb 27 DCP148 – April 27 DCP149 – July 24 DCP150 – July 24	

	officers. • DCP162 Policy & Procedure for the use of directed Surveillance. • DCP195 Policy & Procedure for Lockdown. • DCP140 Lone Working Policy and Procedure		DCP162 – Oct 24 DCP162 – Oct 24 DCP195 – March 25 DCP140 – Jan 26	
1.8	Martyn's Law formally Protect Duty is a new legislation under Government consultation that will require many businesses to formally assess terrorism risk for the first time. The Home Office estimates that 650,000 UK businesses could be affected by Protect Duty.	• LSMS to monitor the progress of the legislation going through parliament and attend seminars and meetings in relation to the legislation.	Ongoing	

Standard	Area	Task / Objective	Target Dates	Completed Date
Inform and Involve				
2.1	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property, and assets	• Joint Working Agreement in place with Humberside Police and CPS which is being reviewed and updated by all partners. • Promote the Joint Working Agreement once reviewed, updated, and published within Humberside Police, CPS and the Trust	December 2024 December 2024	

		• LSMS meets with senior Police representative to progress collaborative working. • LSMS attends relevant Community Safety Partnership work groups	Quarterly Bi-Monthly	
2.2	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff. As part of this, the organisation participates in all national and local publicity initiatives, as required by NHS England Violence Prevention and Reduction Standard, to improve security awareness. This programme of work will be reviewed, evaluated, and updated as appropriate to ensure that it is effective	• LSMS to update all security related posters throughout the Trust with latest contact details. • Security bulletins and alerts to be published in the weekly all-staff team brief newsletter. • LSMS to provide security stands on each site promoting Violence Prevention and Reduction • Security bulletins published on the Trust Intranet Hub • Staff to be made aware of crime trends including County Lines and anti-terrorism training and sign posted to relevant training and information.	Ongoing when required. Ongoing Annually with Unison and Partner Agencies As required Ongoing with Humberside Police.	
2.3	The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises. The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external stakeholders to discuss security weaknesses and to agree a response	• LSMS to liaise with project teams of new builds and refurbishments. • LSMS to liaise with Humberside Police Safer by Design Officer • LSMS to conduct security assessments on existing buildings as required and place on Evotix.	As required. As required. As required	

2.4	All staff know how to report a violent incident, theft, criminal damage, or security breach. Their knowledge and understanding in this area are regularly checked and improvements in staff training are made where necessary	• LSMS reviews all security incidents reported through the Ulysses reporting system, coding and grading where appropriate. • Feedback provided to incident reporters. • LSMS to support relevant incidents reported on Ulysses and if required be lead investigator. • Awareness campaign to be launched to provide guidance to all staff on which incidents should be reported to the Police. • LSMS to start presenting on behalf of the Safety and Compliance Team at the Staff Induction, to include Incident reporting.	Ongoing Ongoing Ongoing Ongoing June 2024	
2.5	All staff who has been a victim of a violent incident have access to support services if required	• Victims of physical assault while at work to be sent a letter from CEO that contains the contact details of the LSMS and support on offer. • LSMS proactively contacts those identified as victims through Ulysses reporting.	Ongoing Ongoing	
2.6	The organisation uses the Security Incident Reporting System (SIRS) to record details of physical assaults against staff in a systematic and comprehensive manner. This process is reviewed, evaluated and improvements are made when necessary	• LSMS to review all reports of physical assaults. • LSMS reports physical assault and all Security related incidents including Violence and Aggression data to the Trust Security Group	Ongoing Quarterly	

Prevent and Deter				
3.1	The organisation risk assesses job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the level of training on prevention of violence and aggression is delivered to them in accordance with NHS guidance on conflict resolution training. The training is monitored, reviewed, and evaluated for effectiveness	• Training compliance to be monitored through the Trust Security Group • ACT Counter Terrorism Training to be placed on ESR and available for delivery to all trust Staff. • Counter Terrorism training to be published on the Hub and all staff signposted to available information and e-learning training, work with Training to design and create a training package that can be available on ESR. • County Lines training package to be created and training/awareness sessions to be arranged with support from Humberside Police for Trust staff. •	Quarterly August 2024 Staff to be signposted each quarter of where to find e-learning. December 2024	
3.2	The organisation ensures that staff whose work brings them into contact with NHS patients are trained in the prevention and management of clinically related challenging behaviour, in accordance with NHS England Violence Prevention and Reduction Standard. Training is monitored, reviewed, and evaluated for their effectiveness	• Training compliance to be monitored through the Trust Security Group • LSMS to link in with clinically challenging behaviour restraint training project. • New project launched to develop to risk assess patients on admission for risk of violent/aggressive behaviour and security incidents – VAS Score To form part of the Violence Prevention and Reduction Trust Strategy and Workplan.	Quarterly In progress November 2024	

3.3	The organisation assesses the risks to its lone workers including the risk of violence. It takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed, and evaluated for their effectiveness	• Issuing and training staff in the lone working devices • Promote the usage of Peoplesafe Lone Working devices with support from, Divisions, Staff Unions and Peoplesafe • Community lone working device usage to be monitored through the Trust Security Group	Ongoing Ongoing Quarterly	
3.4	The organisation distributes national and regional NHS alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored reviewed and evaluated	• LSMS to review alerts received from other NHS organisations and partner agencies and disseminate within the Trust as appropriate. • LSMS to receive alerts from the Cross-sector Safety and Security Communications (CSSC) and disseminate as appropriate.	Ongoing Ongoing	
3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings, and any associated grounds	• LSMS to advise on access control as areas are refurbished or risks identified. • LSMS to complete annual audit of CCTV releases.	As required. Ongoing	
3.6	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal	• Review of DCP203 Policy for the Security and Management of Assets	April 2025	
3.7	The organisation operates a corporate asset register for assets worth £5,000 or more	• Review of DCP203 Policy for the Security and Management of Assets	April 2025	
3.8	The organisation has departmental asset registers and records for business-critical	• Service leads to review their business continuity plans as part of the annual	Ongoing	

	assets worth less than £5,000	review schedule		
3.9	The organisation has clear policies and procedures in place for the security of medicines and controlled drugs	• Any breaches of medicines security are notified to the LSMS	Ongoing	
3.10	The organisation has policies and procedures in place to ensure prescription forms are protected against theft and misuse. These policies and procedures are reviewed, evaluated, and updated as required	• The Medicines Code and associated policies are in place	Ongoing	
3.11	Staff and patients have access to safe and secure facilities for the storage of their personal property. Patient lockers / Self Administration Patients Own Drug (SAMPOD) digital lock upgrades installed at DPOW Staff to have access to access-controlled staff only changing/locker rooms in their work areas where there is a risk of public having access and there being a high footfall.	• Monitor the use of the access-controlled door systems and escalate when faults are identified. • Work with specialities when there are incidents of theft occurring from the changing/locker rooms	Ongoing As required	
3.12	The organisation records all security related incidents affecting staff, property, and assets in a comprehensive and systematic manner. Records made inform security management priorities and the development of security policies	• The Trust uses the Ulysses incident reporting system for all incidents and security related incidents are reviewed by the LSMS	Ongoing	
3.13	The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is included in the organisation's policies and procedures	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.14	In the event of an increased security threat level, the organisation is able to increase its security resources and responses	• Bidvest Noonan Contract Review meetings • Review of DCP149 Policy for Bomb Threats and Suspect Packages	Quarterly July 2024	
3.15	The organisation has suitable lockdown arrangements for each of its sites, or for other specific buildings or areas	• Review the Policy and Procedure for Lockdown	March 2025	
3.16	Where applicable, the organisation has clear policies and procedures to prevent a	• A test of the child abduction procedures to be completed at DPOWH and SGH	Annually or when required.	

	potential child or infant abduction, and these are regularly tested, monitored, and reviewed	• LSMS to work closely with Safeguarding when risks are identified.	Ongoing	
3.17	Security scenarios to be conducted to test resilience and provide feedback	• Night-time suspicious person on site scenario to be carried out by LSMS with debrief. • Night-time in building suspicious person in building scenario to be carried out by LSMS with debrief.	October 2024 December 2024	
3.18	LSMS to work with Youth Offending team and create a working partnership for the rehabilitation of first-time offenders who are eligible to take part in the diversion programme as it is their first offence, work on victim awareness and consequences of their behaviour. As part of this, explain to them the real impact of his behaviour on staff, other patients and visitors and the impact it has on services we provide for care and treatment of other patients, the programme can be carried out via a face-to-face meeting or letter from persons involved to the offender. The Trust will be supporting the Community in the rehabilitation of Offenders of Crime which occur on Trust Sites and will positively work with offenders to actively deter reoffending.	• Build a working relationship with the Youth Offending Team • Create a working agreement with the Youth Offending Team. • Once the programme is operational with the Trust and Youth Offending team with the assistance of the Trust Communication team promote it to the Trust staff.	Sept 2024	

Standard	Area	Task / Objective	Target Dates	Completed Date
Hold to Account				
4.1	The organisation has arrangements in place to ensure that allegations of security related incidents are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed, and evaluated	• LSMS reviews all security incidents reported through the Ulysses reporting system, coding and grading where appropriate.	Ongoing	
4.2	The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents	• LSMS to assist Police with investigations and be primary police liaison for the Trust.	Ongoing As required.	

		• LSMS to attend court, case conferences and other sanction hearings. • LSMS to manage the warning letter system for unacceptable behaviour as part of the Trust's exclusion process. • LSMS to send informal / formal warning letters on behalf of the Trust and support managers in sending informal warning letters	Ongoing Ongoing	
4.3	Where appropriate, the organisation publicises sanctions successfully applied following security related incidents	• Criminal sanctions to be published internally and externally as appropriate.	As required.	
4.4	The organisation has a clear policy on the recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness	• Standing Financial Instructions are due review by the Finance Directorate • LSMS to provide evidential statements to the CPS on behalf of the Trust when any financial lose is suffered as a result of a crime, LSMS also provides supporting evidence that is exhibited within the loser statement. • LSMS to liaise with CPS in all cases of financial lose when an offender is charged to court. • LSMS to attend court as a professional witness when the trust suffers a loss and make an application via court for compensation as part of the criminal investigation and conviction.	Ongoing As required. As required. As required.	
4.5	Collaborative working with Safeguarding team for – • Post incident reviewing • Planning for potential incidents • Advice and guidance with	• Communication with Safeguarding team when a risk is identified. • Write an operational plan with safeguarding and Security when	When required. When required.	

	safeguarding team when supporting at risk/vulnerable patients are visiting a Trust site.	required. • Attending Vulnerabilities Oversight Board meetings • Being a member of the NEL/NL Community Safety Partnership Board and subgroups which incorporates working with the ICB Safeguarding team.	 Bi-Monthly Ongoing	

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)203

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 10th October
Director Lead	Tony Curry, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-In-Common held on Thursday 25th July
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Workforce, Education and Culture Committees-In-Common held on Thursday 29th August 2024
Financial Implication(s) (if applicable)	**N.A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N.A**
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 25th July 2024 at 13:30 to 17:00 at Boardroom, Diana Princess of Wales Hospital, Grimsby

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (Chair)
Sue Liburd	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Simon Nearney	Group Chief People Officer
Jo Ledger	Deputy Chief Nurse (HUTH) (Deputy for Group Chief Nurse)
Dr Kate Wood	Group Chief Medical Officer
Amanda Stanford	Group Chief Nurse
Linda Jackson	Vice-Chair (NLaG)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (HUTH) (Minute Taker)
Leah Coneyworth	Head of Quality Compliance and Patient Experience (HUTH) (item 3.3.1)
Jennifer Granger	Head of Compliance and Assurance (NLaG) (Item 3.3.1)
Lucy Vere	Group Director of Learning and Organisational Development (Item 4.7, Item 4.8)
Jo Ledger	Group Deputy Chief Nurse
David Sharif	Group Director of Assurance
Ashok Pathak	Associate Non-Executive Director
Elizabeth Houchin	Freedom to Speak up Guardian (NLaG) (Item 4.5.2)
David Sprawka	Head of Recruitment and Employment services
Jane Heaton	Associate Director – Strategic Medical Workforce (Item 4.2)
Robert Pickersgill	Governor Observer - NLaG

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting. Apologies noted were Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing and Improvement (HUTH), Kate Truscott, Non-Executive Director (NLaG)

(represented by Linda Jackson, Vice Chair (NLaG), Fran Moverley, HUTH Freedom to Speak Up Guardian.

1.2 **Declarations of Interest**

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

1.3 **To approve the minutes of the meetings held on 27th June 2024**

The minutes of the meetings held on the 27th June were accepted as a true and accurate record following the below amendment:

Robert Pickersgill to be added as an observer in the attendance list.

1.4 **Matters Arising**
The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. There were no matters arising to be reported.

1.5 **Committees-in-Common Action Tracker**
The following updates to the Action Tracker were noted:

4.5 – Medical Workforce Strategy
Dr Kate Wood informed the Committees-In-Common that the action would need to be updated to Group wide and not NLaG specific. She stated this wouldn't be coming to August's meeting, and the date will be advised.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

There were no matters referred to other CIC's. .

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

David Sharif took the report as read. The two risks relevant to this CiC had not changed following an executive review and remained 16. The report was revised to include an insight of corporate risks relating to workforce matters their rating, and risks that had had gone past action dates.

Ashok Pathak highlighted a number of problem areas and queried whether there was a time plan to mitigate risks, and if so was this realistic. David noted that work was underway to harmonise risk management activities across the Group and a newly formed risk management group should help to improve focus and the management of risks.

Tony Curry asked for more assurance on the progress of the risk action plans and David Sharif advised that more work was required with the Care Groups first.

David Sulch queried the risk relating to demand and capacity, particularly in relation to elective services, and whether there are opportunities to manage demand rather than exceeding service capacity etc. For example not accepting referrals and /or referring patients to other service providers. The 'flow' initiative underway across the Group(and the ICB) should help to manage some service pressures Simon Nearney noted that workforce plans and activity plans are in place and that services do refer patients to other trusts but not often enough.

Amanda Stanford mentioned her previous experience with mutal-aid in other Trusts and that it can be effective. However, it only really works if there is capacity in the system. Amanda (as relatively new in position) was unclear what the local situation is at this time.

Davis Sulch also queried the validity of some referrals and whether we carry out unnecessary procedures particularly diagnostics, such as DEXA.

Amanda Stanford in response thought there was scope for increasing clinical validation of referrals as well as understanding the clinical risk associated with backlogs. These matters were however largely for the Quality CIC to consider.

Tony Curry made a point about skill gaps in some service areas due to recruitment problems and the impact this may have on capacity and demand. He queried whether there was a way of recognising chronic skill shortages and developing alternative strategies to deal with these gaps such as re-skilling and or changing practice.

Amanda Stanford agreed there was scope for a different approach.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit report and recommendations to note.

3.3 **Review of relevant External Reports, Recommendations & Assurances as appropriate**

There were no external reports to note.

3.3.1 **NLaG and HUTH: CQC Actions Progress Report for June 2024**

NLaG:
Jennifer Granger took the report as read and highlighted the actions for this CiC. There were 22 actions open, 10 green and 12 amber.

Jennifer highlighted that Amanda Stanford had been conducting review meetings of all the open and closed CQC actions across the group which was resulting in good discussions and changes in how actions are addressed and rated. The next report would reflect those changes.

NLaG had seen some deterioration in the nursing appraisals, and safeguarding training in maternity services both of which had been downgraded to an amber rating.

Linda Jackson noted from the report that there was issues regarding Governance Leads aligning with the Care Groups and wondered whether this was part of the reason performance was slipping. An exercise was being undertaken to ensure there were not any gaps in updates to the actions without owners.

Sub Liburd questioned if there was any additional resource being made available to help with the target of 40% of maternity staff with completion of training by October. Jennifer explained this was being discussed with the maternity team, the community midwifes were the first priority. There are plans to review whether the training could be combined with the safeguarding adults training and extra training sessions had also been created.

David Sulch queried whether the reporting data and training in surgery and paediatrics should be moved to red as there had been no movement. Jennifer explained this had been addressed and would be moved to red on the next report.

Amanda Stanford praised Leah and Jennifer for all the work they had achieved. She assured Committee members that they would start to see changes and a more consistent approach across the organisation.

Tony Curry appreciated the approach but wanted assurance that there were people and processes in place to ensure this did not become an issue again. Amanda explained this had been discussed in the review meetings. Surgery had been through all their actions on the 24th July which had been challenging but productive. There were a few things coming out from the reviews with the Care Groups, and following the reviews Amanda and her team were identifying key issues and themes to then work alongside Simon Nearney and his team to ensure good data management is in place to enable further conversations.

HUTH:

Leah Coneyworth took the report as read. There were 14 actions relating to this CiC, 12 amber and 2 red. 1 maternity action been rerated as red. Security staff training in ED had also rerated from amber to red. Maternity training had improved to 88% since publication of the report

Linda Jackson noted that maternity was a primary concern and asked what was being done to address this. Amanda explained that her team were working on a position paper to Cabinet that would benchmark where the maternity service at HUTH was culturally, including the staffing issues and the impact of this on postnatal wards. It had been shared with Johnathon Lofthouse in the first instance.

Dr Kate Wood stated that regular meetings where in place with Jennifer and Leah regarding the ownerships within the Care Groups and all assurance would be coming back to this meeting.
Simon Nearny, responded to a query about progress with ED actions (specifically security training) and felt it was reasonable to insist on a completion date for this and to task managers to make sure it was achieved otherwise it should be escalated to an Exec for explanation at the CiC.

Leah Coneyworth explained that some elements of the action had changed but she would take the concerns of the CiC back to the team about progress.

4 Kate Wood referred to the work underway to reset the CQC actions and also the meeting Amanda Stanford is now holding with key players to drive progress within the Care Groups who need to be accountable for the actions. This should lead to a more focussed narrative at CiC about assurance.

The Committees-In-Common agreed that improvements and progress were being made but overall decided that limited assurance should be given for both Trusts due to the amount of work still to do.

COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Workforce Integrated Performance Report

David Sprawka took the report as read. He highlighted that the consultant vacancy position was under the 15% target, but with significantly more vacancies at NLaG than HUTH.

The Band 5 nurse vacancy position was at 4.2%, once again with the majority vacancies at NLaG, however, there are a significant number of newly qualified nurses starting in September and November which will improve this position.

Sickness is ahead of the Group target of 4%.

Staff turnover at HUTH was on target. NLAG staff turnover exceeded the target.

Sue Liburd asked if the staff who were leaving had worked for the NHS before or were they mostly new to the NHS. David explained that this data was not currently available but could provide this for future meetings. Sue asked if long term sickness was reducing and David explained that the sickness data was broken down by long and short term sickness on the report.

Linda queried the status of exit interviews and couldn't understand why exit interviews were not happening to provide feedback.

Simon Nearney confirmed that the number of first year leavers was alarming. Two people promise managers had been appointed since the last meeting and their goal was to get traction on this. Amanda raised that stay interviews would be a good initiative to have, including gathering data on the people who do stay and understand what it is that makes them stay. She noted this was a common theme across lots of organisations.
Amanda Stanford raised the opportunity of stay interviews as a mechanism for understanding the positive aspects of working with the Group,

Linda Jackson queried what was being done to help with the Acute Medicine vacancy position. David Sprawka expressed this area was a challenging area to recruit too for consultant vacancies, but the Care Group was being supported with a lot of focus on recruitment. A number of newly qualified nurses were set to be recruited to this area.

Linda Jackson queried the number of steps on the recruitment process for consultants and the potential for delays and barriers to getting things done. Some changes have been made to the AAC process.

In terms of the IPR, she felt that the report was too detailed and needed a refresh. A dashboard style report would work well.
Committee members commented further on the IPR report and the need for improved focus and brevity. David Sharif offered to get involved in the design of a revised report alongside Simon Nearney and David Sprawka

David Sharif specifically queried when we would see the EDI lens within the recruitment statistics. David Sprawka stated he would look at providing this update in the next report.

Ashok Pathak raised a point about the status of consultant job planning and acknowledged some delay because of the Group Structure but felt there was a need to make sure this activity was now completed.

Action:

David Spawka, Simon Nearney and David Sulch to develop revised IPR reporting with input from NED(s)

David Sprawka/Paul Bunyan to provide an EDI information to recruitment statistics in the next report.

The Committees-In-Common acknowledged progress on a number of fronts, but decide that only limited assurance largely given challenges in recruitment of establishment for consultants, pharmacists, midwifes, and unregistered staff etc.

4.2 **Update on Consultants without CCT**

Jane Heaton gave a brief overview of the report. It provided the numbers within HUTH and NLaG of consultants that are not currently on the specialist register and gave assurance that work was continuing at Care Group level to address certification / registration.
The numbers of numbers had doubled since collating all the information together since May 2024. Care Groups were still providing updates regularly to the team, and HR business partners were aware of the current numbers and were prepared to support the Care Groups. Locum start and leaver information is being captured. There had been 1 locum Consultant recently start at Scunthorpe in emergency medicine who was not on the specialist register. Jane explained she was collating the information and reviewing which consultants were on their Certificate of Eligibility for Specialist Registration (CESR) Pathway.

Ashok Pathak noted there were a significant number of CCT locums. He queried which departments where recruiting CESR consultants, and whether those consultants had a career plan or an option to opt out of training. Jane explained she was waiting for the information to feed this back into the Care Groups, but

explained that any Care Groups who take a locum Consultants without CCT were clear that it could not be for more than 12 months. Ashok queried whether they had employment rights. It was discussed that they did, but to be a substantive consultant they needed to be on the specialist register.

The Committees-In-Common agreed they had reasonable assurance regarding this process.

4.3 **Update on CDC Recruitment**

David Sprawka took the report as read. Recruitment plans were in place, and NHSE were involved in international recruitment but there was a significant risk for Cardiac and Respiratory services on the South bank. Conversations were taking place that afternoon around mitigations.

Linda Jackson wondered what the significant risks were on the South bank were for Cardiac and Respiratory. David Sprawka explained it was purely down to recruitment to roles that had been out to advert unsuccessfully. The plan was to now look into development roles.

Ashok questioned if there were any plans to move staff from their current working areas. David Sprawka confirmed that there were plans to move staff around potentially taking acute staff to CDC's in the short term.

Dr Kate Wood informed the Committees-In-Common that all new CDC posts were being advertised and offered on a rotational basis and were not site specific.

Tony Curry queried the timelines, and whether the CIC should be concerned. David Sprawka advised that the only immediate issues were for Cardiac and Respiratory and plans were in place to mitigate the longer timeframes.

The Committees-In-Common agreed limited assurance for this item.

4.4 **Registered Nurse & Midwifery Staffing**

4.4.1 **Registered Nurse & Midwifery Staffing (HUTH)**

Jo Ledger took the report as read. Care hours had seen a reduction and the additional capacity had closed. Vacancies were 10 over established which was a reduction from June.

There were 50 vacancies for non-registered staff, but 40 were being held for apprentices and other healthcare workers.

There was a positive recruitment position with 83 of the newly qualified nurses from the University appointed, as well as 24 whole time equivalent midwifery students.

Jo Ledger highlighted the negative feedback received from the international nurses regarding the team behaviours. Jo and Amanda were holding drop in sessions to identify concerns. Cultural competency training had been put into place for all managers and junior staff and this had also been delivered at the University.

HUTHs staff turnover was good and a piece of work had been completed with the University called the Stars Project which helped identify issues and identified why people were leaving within the first year. Jo felt this needed revisiting as a part of the retention strategy within the Group.

The Committees-In-Common agreed reasonable assurance.

4.4.2 **Registered Nurse & Midwifery Staffing (NLaG)**

Jo Ledger took the report as read. NLaG have 142 vacancies, with 76 being a band 5.

Maternity leave has been built into the workforce model, which allow students to be allocated accordingly.

There is a need to look at resilience because gaps can arise which would otherwise mean there are not enough registered nurses in the right places.

Jo indicated the need to review and understand why there were issues recruiting unregistered staff. She added that they were looking at having an 'Our Voices Group' across the North and South to solicit vies and feedback

Recruitment within midwifery was positive and the majority of the midwifery students recently appointed will start in September.

Turnover was high but was making good progress to what it was previously.

NLaGs care hours were positive, and one of the best for the ICS. There was additional workforce put in place from a retention point of view, and benefits were hoping to be seen.

Linda Jackson asked to see a plan regarding the 108 wte unregistered vacancies at NLAG. Jo agreed to review the position and bring a plan back to the CIC.

Sue Liburd wondered whether information was being fed through to the workforce regarding the over establishment position. She also asked whether the legacy mentor would be evaluated. Jo agreed to check with the South Bank team regarding the legacy mentor and advised that staffing positions were fed back and messages were being reinforced to help with staff morale.

Amanda Stanford pointed out that the professional nursing and midwifery advocates were making really good progress with the legacy mentors and embedding clinical educators.

The Committees-In-Common agreed reasonable assurance for this item.

4.5 **Freedom to Speak up Quarterly Reports**

4.5.1 **Freedom to Speak up Quarterly Reports (HUTH)**

Elizabeth Houchin presented the report on behalf of Fran Moverley. There had been 62 cases reported in Quarter 1 which was a reduction from the last quarter. The top reasons were HR processes, inappropriate behaviours and patient safety and nurses and midwifes where the highest professional group raising concerns. There had only been 2 concerns raised anonymously and this was lower than the national average.

It was raised that 4.8% of staff members reported being subject to detriment and inappropriate behaviours after speaking up.

Fran and Elizabeth are continuing to work well together across the Group, that the approach and reporting was now aligned.
Elizabeth concluded that both she and Fran had been involved at a national level with NHSE to discuss how the Guardians are operating as a group.

Elizabeth kindly asked members of the Committee if they had any questions regarding the HUTH report to please direct them to Fran.

The Committees-In-Common agreed reasonable assurance for this item.

4.5.2 **Freedom to Speak up Quarterly Reports (NLaG)**

Elizabeth Houchin took the report as read. She highlighted that NLaG had received 96 concerns in Quarter 1, 3 of which were anonymous. 35% of concerns were closed on the same day after giving advice and signposting.

The main themes were inappropriate behaviours, HR processes and general concerns.

Elizabeth specified she had completed a piece of work which shows that NLaG is currently up to 110 concerns, and out of those concerns 32 mentioned the impact of the Group restructure, culture and leadership. She further added that morale was still low and people were still adjusting to the change.

Some concerns highlighted the financial controls and the impact on day to day staffing. Staff also spoke about not feeling valued, and staff were concerned how finance and performance were becoming key drivers rather than patient safety.

The national guardian office's annual figures had been released and there was a national increase of 27% of cases of staff approaching guardians from the previous year. Nationally 38% had an element of inappropriate behaviours, NLaG was 49%. Patient safety nationally was reported at 19%, NLaG was 18%. It was noted that inappropriate behaviours were being reported more than bullying and harassment.

Linda Jackson expressed it was concerning to hear that a third of comments were regarding the Group restructure. She voiced that both reports highlighted inappropriate behaviour and HR process being the main concerns and this needed to be addressed. She queried the background to HR process issues. Elizabeth explained that it was mainly poor communication and sometimes poor advice regarding HR processes.

The Committees-In-Common agreed reasonable assurance. Linda Jackson raised that some of the trends across the group should be highlighted to the Board.

4.6 **Medical Revalidation/Responsible Officer Report**

Dr Kate Wood presented two separate reports for NLAG and HUTH to provide the annual organisational audit.

NLaG had standard compliance, with an action plan to address anomalies. There were no doctors within NLaG that were missing an appraisal without an agreed exception in place.

At HUTH there is a current lack of appraisers, and Dr Kate Wood assured the CIC that the team were developing a paper to address the gap

A single Group Responsible Officer (RO) role came into effect on the 1st of July. They will be doing their training in October. As per NHSE they have been allowed to start their role and practice under the close oversight of Dr Kate Wood. This had made the flow of information much easier.

She added that next year the report would be in the same format for both Trusts.

Dr Kate Wood expressed gratitude to the North team and South Bank team.

The CIC discussed the lack of appraisers and Dr Kate Wood advised that the gap had been identified this year and the alignment of processes North and South would mean that the appraisers would eventually be spread across the Group which would mitigate current shortages.

David Sulch commented that the model for the Group Chief Medical Officer (CMO) was the right thing to do as it took a lot of work away from the RO and allowed focus on appraisals. He remarked that he was pleased with the quality of the appraisals from the appraisers.

The Committees-In-Common agreed they had significant assurance for NLAG and reasonable assurance for HUTH on the Medical Revalidation/Responsible Officer Report.

Dr Kate Wood expressed thanks to Simon and his team for their support.

4.7 **Deep Diver – Staff Culture, Engagement and Values**

Simon Nearney introduced the deep dive pointing out that since the last meeting it was clear that things were not where they needed to be in relation to ' culture'. He noted that staff were struggling, and the Group was focusing on performance such as reducing waiting lists, cancer times, diagnostics etc, that staff were feeling the demands and were struggling.

The national staff survey report completed in November showed that NLaG and HUTH were in the bottom 4th quartile. The main challenges were around compassion and inclusion, being recognised and rewarded etc.

Always learning was reported to be the best area.

A further pulse survey check with HUTH saw the score reducing from 6.65 to 6.4 and NLAG also saw a reduction to 5.33 for their engagement score.

Simon Nearney advised that the new Group values had been launched and a staff charter was also being developed which was the behavioural framework of the do's and don'ts in the Organisation.

Over 3000 staff when asked their personal values they gave their top 10, and was asked how they assess their current values to the Organisational values. The current top 10 values were reported as hierarchal, focussed on cost reduction rather than quality, it was bureaucratic, there was confusion and blame and there was bullying etc. The positives highlighted were accountability and diversity across the Group. Simon concluded that the Barret Team who ran the survey were particularly concerned about this organisation.

Lucy Vere added that there were consequences for not getting this right in terms of finance and safety.

Simon reported that he had taken the paper to cabinet and felt it was well received. A further paper would be taken to the next Cabinet time out in August to focus on staff experience and culture. It was expressed that the Group needed to find a way to create a cultural framework.

Two People Promise managers had been recruited following funding from NHSE. They were to focus their attention on flexible working, health and wellbeing and engagement and making sure staff have a voice.

Lucy Vere advised that this was not aimed just at middle managers but all leaders including senior management. The OD team would be reviewing a way of measuring how managers and staff lived the Group values.

Linda Jackson expressed it was good to see that there was several things that triangulated and saying the same thing. She stated that she was not surprised that the NLaG score had fallen as she had received feedback that the Trust was moving backwards and had lost something. She further added that culture was not talked about at the Board and it was important that this happened. It was agreed to escalate that cultural conversations should be happening at the Trust Boards in Common meetings.

David Sulch felt the report was valuable and was grateful to Lucy and Simon for bringing it to the Committee. He supported the view of ensuring that culture was a conversation for the Board.

Amanda Stanford specified that if culture was to be discussed at the Board, that a discussion around how everyone personally behaves would be beneficial. She felt it would be a good opportunity for everyone to reflect on their own behaviours.

Ashok expressed his concerns regarding the lack of diversity at the executive level and felt this had not been perceived well within the Group
Sue Liburd emphasised that the problems were known and it was now time to act. She added that she supported that addressing culture was a Board priority.

The Committees-In-Common agreed that they were not assured and culture should be escalated to the Boards in Common as a matter of urgency.

4.8 **Group Leadership Programmes**

Lucy Vere gave an overview of the Group Leadership Programmes. A current review had been completed across the Group, and the team harmonising the 'bite size' courses which should be online in couple of weeks.

The 'great leaders' course will be rebranded to a more cohesive group offer. Internal programmes were being developed for supervisors, team leaders and experienced leaders. Currently the senior leadership programme is focused on supporting the Care Group development programmes.

Positive feedback had been received about these programmes particularly from minority ethnic staff. These programmes will be recommissioned to deliver a baseline training package including disability, leadership, medical leadership etc..

Lucy did raise that she could not provide 8 experience leader programmes this year given the capacity constraints of the OD team and their work on supporting Care Groups.

Lucy expressed that she would be bring a comprehensive written update to the meeting in October. Assurance would be given once that report was received.

4.9 **Medical Engagement and Leadership Strategy**

Dr Kate Wood informed the CiC that the report was in its final stages. She gave a presentation at the meeting and ran through the highlight summary.

It was reported that 50% of physicians report burnout, and 33% of doctors in training reported burnout. Good medical leadership was the key to tackling this issue.

The faculty of Medical Leadership and Management talked about 4 key principles of; Self, Team, Group and System. This is going to be the central tenant for everything the Group do and they were going to build on the principles of compassionate leadership and regenerative leadership.

Dr Kate expressed that if we could encourage our doctors to stimulate and support the rest of the teams it would make everything a lot easier, but this wouldn't come easy.

Harmonisation for medical leadership training and developing professional leadership programmes for medical staff had been scoped out with the University.

Dr Kate Wood summarised that this was co-produced and co-designed, and would complement the leadership programmes outlined by Lucy.

Ashok Pathak stated it was wonderful to hear about the University engagement. He queried what the local figure of dissatisfied doctors was compared to the national figure. Ashok also questioned what had been done to communicate and engage with doctors on the great work happening. Dr Kate Wood stated there was a number of different ways to communicate across the Group, and informed the CiC that it was still early days and will have to work and evolve as they go along in providing a local figure.

Tony Curry questioned whether there was any more support or resources required. Dr Kate Wood stated they had a small pot of money and external partners had been helping with the training on the South Bank, and felt that creativity would allow flow across the group.

Dr Kate Wood declared that she would send the paper out to the Committees-In-Common once completed.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 David Sharif mentioned that there was a time out session booked for September, and asked if colleagues could have a look at the work plan just to help align items that were planned for September.

6. ANY OTHER URGENT BUSINESS

6.1 Simon Nearney informed the CiC that the maternity support workers at NLaG were striking from the week commencing 29th July 2024 for 3 days. This was set to have an impact on services, however, the care teams were working hard to put plans in place to ensure patient safety was not compromised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- Culture emerged as significant cause for concern and concern a very high priority to be raised to the Trust Board.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Workforce, Education and Culture CiC meeting:

Thursday, 29th August 2024, at 13:30, in the Nightingale Room, Scunthorpe General Hospital.

The Committee chair closed the meeting at **16:55 hours**.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y								
Amanda Stanford	Group Chief Nurse	D	D	Y	Y								
Kate Wood	Group Chief Medical Officer	Y	N	Y	Y								
Tony Curry	Non-Executive Director (HUTH)	N	N	Y	Y								
Kate Truscott	Non-Executive Director (NLaG)	Y	Y	Y	N								
Linda Jackson	Vice-Chair (NLaG)				Y								
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y								
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y								
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y								

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)204

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 October 2024**
Director Lead	**Helen Wright & Gill Ponder, Non-Executive Directors Committee Chairs**
Contact Officer / Author	**Rebecca Thompson, Deputy Director of Assurance**
Title of Report	**Capital & Major Projects Committees-in-Common Minutes – February and April 2024**
Executive Summary	**Minutes taken at February 2024 and April 2024 Capital & Major Projects Committees-in-Common**
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	**Capital & Major Projects Committees-in-Common**
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON

Minutes of the meeting held on Tuesday, 20 February 2024
9.00am to 12.00pm, Boardroom, Hull Royal Infirmary
For the purpose of transacting the business set out below:

Present:

Core Members:

Mike Robson	Non-Executive Director, HUTH (Chair)
Lee Bond	Group Chief Financial Officer
Tony Curry	Non-Executive Director, HUTH
Gill Ponder	Non-Executive Director, NLaG
Shaun Stacey	Group Chief Delivery Officer

In Attendance:

Ivan McConnell	Group Chief Strategy & Partnership Officer
Alastair Pickering	Chief Medical Information Officer (rep. Group Chief Digital Officer)
Alison Hurley	Assistant Trust Secretary (rep. Group Director of Assurance)
Lynn Arefi	Personal Assistant (Minutes)

Observer(s):

Ian Reekie	Lead Governor, NLaG (Governor Observer)
Sean Lyons	Group Chair

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

Mike Robson welcomed those present to the first meeting of the Capital and Major Projects Committees-in-Common meeting and introductions followed.

The following apologies for absence were noted: Simon Parkes, NLaG Non-Executive Director (NED).

1.2 Declarations of Interest

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

1.3 To approve the Terms of Reference for the Capital & Major Projects Committees-in-Common (CaMP CiC)

Mike Robson referred members to the HUTH and NLaG CaMP CiC Terms of Reference and sought any comments or queries. Gill Ponder advised that she had several minor points which would be passed on to Alison Hurley for amendment. Lee Bond queried section four which related to the responsibilities of the Committees and whether the capital programme and major projects should be defined further with the associated set financial limits. A discussion ensued and it was agreed that Lee Bond would raise this at the Executive Group Cabinet meeting.

Following further discussion, the Committees received and noted the Terms of Reference, and it was agreed that Alison Hurley would liaise with Gill Ponder and Ivan McConnell to reflect the changes required which included:

- Removal of the Group Chief Clinical Design Officer
- Add a definition of Major Capital & Reconfiguration.

Subject to these changes the Committee were happy to approve the Terms of Reference.

ACTIONS:

- **Lee Bond to discuss whether the capital programme and major projects should be defined in the CaMP Terms of Reference at the Executive Group Cabinet meeting, together with associated financial limits**
- **Alison Hurley to liaise with Gill Ponder and Ivan McConnell to reflect changes required to the terms of reference.**

1.4 **Minutes of the previous meeting**

This was the inaugural meeting of the CaMP CiC therefore there were no previous minutes to review.

1.5 **Matters Arising**

No items were raised.

1.6 **Committees-in-Common (CiC) Action Tracker**

None to Note.

2. MATTERS REFERRED TO THE COMMITTEE

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

None to Note.

3. RISK & ASSURANCE

3.1a **Board Assurance Framework (BAF) - HUTH**

Alison Hurley advised that the BAF report for HUTH and NLaG was now in a new common format. It was noted that although individual Trust reports were included, a Group approach would be under development early in the new financial year. There were no recommendations for any changes to the HUTH BAF at present.

Lee Bond asked if the Committees were to receive the full BAF or only the items relevant to the Committees. Gill Ponder suggested that only the strategic objectives assigned to these Committees would be appropriate to avoid any overlap with other Committees.

3.1b **Board Assurance Framework (BAF) – NLaG**

The BAF for NLaG was received and noted with no recommendations for changes.

With reference to Lee Bond's earlier query, the Committees requested that the whole BAF be attached as an appendix for information with only the CiC specific BAF items on the agenda. The Committees agreed that consistency across the BAF's would be required to ensure alignment.

Following various queries and a discussion it was agreed that the disparity of the risk scores between HUTH and NLAG in relation to estates and facilities, finance and digital infrastructure should be reviewed and harmonised.

- *The disparity of the estates and facilities, finance and digital infrastructure issues risk scores to be reviewed and harmonised*
- *The complete BAF to be added to the agenda as a standing agenda item for information.*

3.2 **Risk Register Report**

It was noted that work is ongoing to align the Risk Register across the Group and Alison Hurley advised that a revised report was expected for the next meeting.

3.3 **Proposed Business Cases, Investments & Dis-investments**

3.3.1 **New Build at Hull Royal Infirmary (HRI) - HUTH**

Lee Bond referred the Committees to the circulated report and provided an overview of the proposal for a new build on the Hull Royal Infirmary (HRI) site. This would accommodate a number of priorities including Paediatric Day Surgery recovery, establish a Command Centre, address the displaced accommodation from the Interventional Radiology Theatre (IRT) for development on the second floor together with the relocation of therapies to the third floor. The changes would also facilitate a future development zone in a clinical environment on the second floor. This was noted as a critical path to allow for the expansion of other services.

Tony Curry queried whether this was part of a broader plan for the site or an expediency to resolve particular issues. Lee Bond confirmed that it was a response rather than a long-term estates strategy which would also provide

additional space within the Tower Block. Ivan McConnell concurred and provided an overview of the required refurbishments and confirmed that business cases were being drafted in support of this.

Following a discussion, Lee Bond informed members that a business case would be provided for the April meeting.

The Committees were asked to approve:

- Commencement of detailed designs and surveys
- Commencement of the tender process to ensure the construction could commence as soon as possible into the new financial year.

The HUTH CaMP Committee received and noted the presentation and approved commencement to the next stage.

ACTIONS:

- **Business case to be presented to the April meeting on the New Build at Hull Royal Infirmary (HRI) - HUTH**

3.3.2 **Replacement of Suite 22 at Castle Hill Hospital - HUTH**

The presentation outlined the Reinforced Autoclaved Aerated Concrete (RAAC) within Suite 22 at Castle Hill Hospital (CHH) and the demolition due during February 2024. It was noted that training and development activities had required cancellation due to the lack of this facility, and every effort was made to accommodate courses in other rooms available across both CHH & HRI where possible. Although £1million of capital funding had been received, it was confirmed this would need to be spent within the next 5 weeks and additional funding would also be required.

Lee Bond advised that following discussions with the training and development staff, it was clarified that 50% of the training would need to be on-site which influenced the options available. The area proposed to accommodate training and development would be the unused basement (under the croft), of the new Day Surgery Unit, which is option 1 within the presentation.

- A discussion took place about the need to secure additional capital funding, the impact the national elections may have and Lee Bond informed members that there may be the ability to be flexible to move capital commitments in 2025/26 if required. Positive discussions with NHS England around accessing slippage from the national RAAC monies in 2024/25 was also noted.

Shaun Stacey queried the £2.5million 'fit out' cost and Lee Bond confirmed this was based on the current tenders. A discussion ensued about the level of daylight and the temporary facilities being used.

In response to a query from Tony Curry about whether the impact of the cancelled training sessions was known, Lee Bond confirmed this would be addressed as a compliance issue at the Workforce, Education and Culture CiC.

Lee Bond then sought Committees approval for the following recommendations:

- To progress Option 1 as the most cost effective, timely, and least disruptive option
- To approve the financial risk with the shortfall in current capital funding of £1.5million
- To include the training facility replacement in the 2024/25 capital plan as an over-commitment against plan, and to seek funding in-year as a noted risk.

Mike Robson thanked Lee Bond for the detailed presentation which had been helpful for the Committee to gain a detailed understanding.

The HUTH CaMP Committee agreed to approve the plans to proceed to the next stage of the training facility replacement and approved in principle the over-commitment to the capital programme (£1.5mil), which was noted as a manageable risk.

3.4 **Capital Contract Approvals**

3.4.1 **Day Surgery Phase 2 & 3 Fit Out CHH - HUTH**

Lee Bond took the report as read and outlined the development provided additional theatre capacity at the Castle Hill site, allowing the existing two day case theatres at HRI to be re-provided in modern facilities. The net increase in day case capacity would facilitate a more efficient model and free up valuable inpatient theatre capacity as adult day case work is repatriated to the day case theatres. This would also support 52/104 week waits, the Cancer pathway and day case numbers.

It was noted that six contractors had been approached and tender returns were due mid-February 2024. Pre-tender estimates had been completed for each phase based on current market rates. The lowest tenders received totalled £5.5million, which was the cheapest option from contractors HELIX.

The HUTH CaMP Committee confirmed agreement to approve once the tender returns have been evaluated. This was to ensure orders are committed in March 2024 to mitigate the key risks of lead-in times and Capital Revenue Limit (CRL) for the 2023/24 financial year.

3.4.2 **Day Surgery Car Park CHH - HUTH**

Lee Bond took the report as read and informed the Committee that this had already been approved and signed off by the Group Chair, Group Chief Executive and was presented to the Committee for retrospective approval.

Gill Ponder queried if the Trust had sought testimonials as part of the quality and evaluation of the contractors. Lee Bond confirmed that all relevant checks are carried out and the Trust had worked with this contractor previously.

In response to a query from Sean Lyons, Lee Bond confirmed that an additional 100 parking spaces would be available.

The HUTH CaMP Committee received the report and approved the quotation as submitted by Ashcourt Demolition Ltd in the sum of £1,078,083 including VAT.

3.4.3 **Theatre 7 & Plant Room Hull Royal Infirmary - HUTH**

The Committee was referred to the report and Lee Bond provided a brief overview. It was noted that one of the critical risks on the HUTH estates risk register was the HRI trauma theatres and this was a continuation of the backlog maintenance (BLM) rolling refurbishment programme for the trauma theatres. The report noted the £3.1million requested to award the contract to Johnson Construction and pre-buy materials.

Gill Ponder queried the low contingency of £50k and Lee Bond advised this was not a huge risk and was expected to be managed within budget.

Lee Bond confirmed that a full evaluation would be carried out by the team in respect to changing the chiller manufacturer and any potential risks in response to a query from Gill Ponder.

The HUTH CaMP Committee received and noted the report. The competitive tender as submitted by Johnson Construction for the refurbishment of Theatre 7 and the build of phase 1 plant room 2 in the sum of £3,174,458.33 including VAT (20%), was approved by the HUTH CaMP Committee.

3.4.4 **North Lincs (NL) Community Diagnostic Centre (CDC) Fit Out & Materials - NLaG**

Lee Bond took the circulated paper as read and outlined the key points. Approval was sought to award the North Lincs CDC Fit out Tender to Helix CMS subject to final re-negotiation to ensure value for money was achieved. The tender review covered the initial tender cost and the reconciled tender sums. Lee Bond confirmed that the budget for the North Lincs CDC would be managed within a surplus from the NEL CDC scheme following a query from Mike Robson.

Gill Ponder queried the safe storage of equipment and Lee Bond confirmed that had been addressed and was not expected to be required for a long period. Ivan McConnell concurred and advised that storage facilities had already been identified.

The NLaG CaMP Committee received and noted the report and approved the North Lincs CDC Fit out Tender being awarded to Helix CMS subject to final re-negotiation to ensure value for money was achieved.

3.4.5 **North East Lincs (NEL) CDC Fit Out & Materials - NLaG**

The report was taken as read and Lee Bond advised that approval was sought to award the NEL CDC Fit out Tender in principle to Morgan Sindall subject to final re-negotiation to ensure value for money is achieved. Final approval would be sought at the April CaMP CiC meeting. Lee Bond advised that it was proposed to seek approval to increase the demolition budget by £750k plus VAT

as part of the enabling contract which will be used to purchase more materials, the demolition budget was noted as relatively small. Formal approval would be sought at this Committee at a later date, once the manufacturing and engineering (M&E) details are in place.

Tony Curry asked if there were any associated risks and Lee Bond confirmed there was very little risk with this. Lee Bond added that he would not recommend signing the contract with Morgan Sindall at this point in time until the Trust were confident with the M&E position. Ivan McConnell supported this position and provided an overview of work underway at Freshney Place in Grimsby.

The NLaG CaMP Committee received and noted the report and approved the Committal of £900,323.45 (of material pre-procurement under the enabling contract to mitigate lead-in times and meet CRL limit. The tender award to Morgan Sindall with the constraints noted was also approved in principle.

ACTIONS:

- **Contract to be presented to the April meeting on the North East Lincs CDC Fit Out & Materials – NLaG**

3.4.6 **Grimsby CDC Lease - NLaG**

The circulated CDC report for a 10-year lease was presented to the Committee for information. The report was noted as being approved at the Trust Board meeting in February 2024.

3.5 **Review & Evaluation of Existing Business Cases**

None to note.

3.6 **Review of Relevant External & Internal Audit Reports & Recommendations & Assurance as Appropriate**

None to note.

3.7 **Review of Relevant External Reports, Recommendations & Assurance as Appropriate**

None to note.

Review Assured, escalate or additional information requested.

The Committee agreed that the following would be included within the highlight report to the Trust Board:

- **Board Assurance Framework (BAF)** – the committees were concerned about the disparity of the risks in relation to estates and facilities, finance and digital infrastructure issues and requested that these risks be aligned for NLaG and HUTH

- **Estates Strategy** - the committees sought additional assurance on when the consolidated Estates Strategy would be established
- **Overall lack of capital** - especially in relation to the risks on estates, facilities and infrastructure.

At 10.40am a break ensued for 10 minutes

4. COMMITTEE SPECIFIC BUSINESS ITEMS

4.1 Monthly Capital Finance Report (NLaG/HUTH)

Lee Bond summarised the circulated monthly Capital Finance Report which provided the forecast capital spend for the financial year 2023/24, for both Trusts. Key points highlighted were the transfer of £3.8million from NLaG to HUTH, fully repayable in 2024/25 and the underspend on the CDC at NLaG. The Group capital position was noted on page two of the report and included the forecast to deliver the Integrated Care System (ICS) Capital Control Total of £39.7million and the overall Capital Departmental Expenditure Limit (CDEL) position which will be underspent by £4.7million due to slippage in the CDC scheme in Scunthorpe.

Gill Ponder queried the recurring behaviour to rapidly spend capital in quarter four before the year end and what could be done to break this cycle. Lee Bond confirmed that had been much improved this year apart from the CDC budget, which had caused difficulties. Looking at plans for next year Lee Bond added that he was more hopeful the Group may continue this improved approach for the quarter four period.

Sean Lyons asked if there had been any benefits from being a Group this financial year with having a larger amount of projects and funding. Lee Bond advised the key benefit was the ease of moving funding across the respective Trusts and other learning was ongoing.

Sean Lyons then referred to the potential underspend which had been discussed at previous meetings and queried whether the reasons for this underspend had been identified. Lee Bond advised that there were several reasons which included the capital team not having the necessary skill set or grip on the whole scheme. Lee Bond added that he would like to think lessons had been learnt moving into the new financial year.

Mike Robson acknowledged that the report had been very helpful and thanked Lee Bond and the team for progressing the Group to this position.

4.2 Draft Capital Plan 2024/25 (NLaG/HUTH)

Lee Bond referred the Committees to the previously circulated report and proceeded to provide an overview of the contents. The draft capital programme was highlighted for NLaG on page three which totalled £32million and for HUTH on page four which totalled £35million.

Lee Bond noted all is subject to change as the Group approached year end and risks and competing priorities would need to be managed. The biggest "unknown" and therefore the biggest single risk from a capital perspective at present, was noted as the Electronic Patient Record (EPR). A further risk with the capital programme was the Section 2 agreement of £12million with Hull City Council was not yet agreed. Work continued but was not yet transacted.

Gill Ponder queried if funding for urgent roof repairs had been allocated and Lee Bond confirmed £400k had been set aside within building, maintenance and compliance. However, if a competing priority came along then the roof work may slip but at present the roof repairs were noted as a priority.

Sean Lyons referred to the "spend to save" approach and queried whether this was an opportunity for the Group to ask staff for incentives to save in a consistent, systematic and measured way. Following a discussion Shaun Stacey agreed to take the lead on this along with Ivan McConnell and Lee Bond to explore an "invest to save" scheme for front line staff.

ACTION:

- **Shaun Stacey to lead on exploring an Invest to Save scheme for front line staff.**

Review Assured, escalate or additional information requested.

The Committees were generally assured about the management of the Capital programme, both in the current financial year and the coming financial year. However, the Committees were concerned about the Capital plan risks associated with the Digital Plan Delivery (including the outline business case (OBC) for the electronic patient record (EPR)).

5. MAJOR SERVICE CHANGE / TRANSFORMATION

5.1 Humber Acute Services – Capital Update

Ivan McConnell took members of the Committees through the presentation which provided an update on the Humber Acute Services (HAS) programme and set out an indicative timeline for decision-making following public consultation. The report also provided an overview of the capital requirements for the Trust to deliver the proposed changes. It was noted that finalisation of capital requirements is subject to post-consultation decision making.

Ivan McConnell noted that the anticipated capital funding requirement to deliver the HAS decision making business case (DMBC) was £10.04million (including backlog maintenance). Following a discussion, it was confirmed that this applied to an average of 6.2 patients per day.

Sean Lyons queried any expected impact of local elections and Ivan McConnell confirmed appropriate capacity was in place and no issues were anticipated to date.

The Committees received and noted the report and Mike Robson thanked Ivan McConnell and the team for the good progress to date.

5.2 **Community Diagnostic Centre (CDC) Programme**

The presentation was addressed by Ivan McConnell who advised that he had been asked by the Group Chief Executive to take on the overarching Senior Responsible Officer role for the CDC programme. The presentation provided an overview of the current CDC builds with key milestones and risks. It was noted that the Group needed to ensure the capacity and demand levels expected were appropriate and achievable as it moved forward.

Ivan McConnell noted associated risks for the Group with assumed activity levels from the "go live" date and advised the revenue position would change if the levels were not achieved. The Group would also need to be mindful of the staff training period.

Lee Bond referred to the Capital Investment Board meeting which took place the day before, where the Digital team flagged up the on-going requests for support to these services and suggested to Ivan McConnell that this be addressed.

Lee Bond advised the Committees that there was a requirement for the CDC to be up and running by 1 October 2024 (NLaG) and 1 March 2025 (HUTH), and there was a considerable amount of risk with the requirement to deliver 90% of activity to remain within the confines of the model.

Gill Ponder queried whether this was a greater risk than expected and both Lee Bond and Ivan McConnell confirmed it was very aspirational adding there had also been constant changes to the policy etc., which added challenges in relation to staffing requirements and recruitment. Sean Lyons confirmed the need for pragmatic plans to maximise the approach and output.

Review Assured, escalate or additional information requested.

The Committees noted they were assured about:

- the HAS programme and progress with the consultation
- the management of the CDC programme

The Committees agreed the following risks would be escalated to the Trust Board:

- Build Risks
- East Riding Community Hospital
- Workforce Recruitment Risk
- Revenue Risk

6. DIGITAL

6.1 **Digital Plan Delivery Bi-monthly Update**

Alastair Pickering referred members to the Digital Plan Delivery report and noted that the Digital Programme was currently delivering three critical projects across the Group:

- The PAS migration to a single Lorenzo system

- Implementation of the Badgernet Maternity system across all sites
- Phase one of the Data warehouse upgrade at NLaG.

It was highlighted to the Committees that migration of the Patient Administrative System (PAS) to LORENZO was currently in "full flight". Critical meetings were underway to ensure no live operational or clinical challenges would impact on the continuation of the 'go live' date and safe progress was made. The main area of risk from the PAS migration was noted as the switch off of the LORENZO system at HUTH for approximately 9 hours. Although digital and administrative teams would support all hospital sites from the 'go live' position with a three-week live support programme in place. Alastair Pickering added that he was confident with the plans and have mitigated the reduction in activity.

The maternity system go live across sites would take place in the following weeks.

It was noted that the electronic patient record (EPR) outline business case would be completely reviewed with the addition of new costings. This would be presented to the Capital Investment Board and brought to the CaMP CiC for assurance and information.

Mike Robson thanked Alastair Pickering for the comprehensive update.

Review **Assured, escalate or additional information requested.**

The Committee were assured with the progress made with the Digital Plan Delivery which was noted as "impressive".

7. HIGHLIGHT REPORTS FROM SUB-GROUPS

7.1 Capital Resource Allocation Committee Meeting Minutes – HUTH - January 2024

The HUTH CaMP Committee received and noted the Capital Resource Allocation Committee minutes (HUTH) from January 2024.

7.2 Capital Investment Board Meeting Minutes - NLaG - January 2024

The NLaG CaMP Committee received and noted the Capital Investment Board minutes (NLaG) from January 2024.

8. ANY OTHER URGENT BUSINESS

8.1 Any Other Urgent Business

No other urgent business was raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 Matters to be Referred to other Board Committees

Escalation to other Board Committees was as discussed within the meeting.

9.2 **Matters to be Escalated to the Trust Boards including any proposed changes to the BAFs.**

Matters to be escalated to the Trust Board were as per discussions and agreement within the meeting.

10. DATE AND TIME OF THE NEXT MEETING

Date and Time of the next Capital & Major Projects CiC meeting:

Tuesday, 23 April 2024
9.00am Boardroom, HRI

Mike Robson closed the meeting at 12.05pm and thanked members for their contributions and valid discussions.

Cumulative Record of Attendance at the CaMP CiC 2024/2025

		2024					
Name	**Title**	**Feb**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**
CORE MEMBERS							
Gill Ponder	Chair / Non-Executive Director (NED - NLaG)	Y					
Mike Robson	Chair / Non-Executive Director (NED - HUTH)	Y					
Lee Bond	Group Chief Financial Officer	Y					
Tony Curry	NED (HUTH)	Y					
Simon Parkes	NED (NLaG)	Y					
Shaun Stacey	Group Chief Delivery Officer	Y					
VACANT	Group Chief Clinical Design Officer	N					
Quoracy: *three of five core members (inc.one of two Trust NEDs, two Group Executive Directors or appointed deputies)*							
REQUIRED ATTENDEES							
VACANT	Group Director of Estates	D					
VACANT	Group Director of Transformation	N					
VACANT	Group Chief Digital Information Officer	D					
VACANT	Group Director of Assurance or deputy	D - AH					
Alison Drury	Deputy Director of Finance (HUTH)	Y					
Ivan McConnell	Group Chief of Strategy & Partnerships	Y					
Ian Reekie	Governor Observer (NLaG)	Y					

DESIGNATED DEPUTIES	
Executive Director CiC member	**Designated Deputies**
Lee Bond Group Chief Financial Officer	Deputy Chief Financial Officer – vacant, covered by: Alison Drury, Deputy Director of Finance (HUTH) Brian Shipley, Deputy Director of Finance (NLaG) Steve Evans, Operational Director of Finance (HUTH)
Ivan McConnell Group Chief of Strategy & Partnership	Adam Creeggan, Group Director of Performance
Shaun Stacey Group Chief Delivery Officer	Ashy Shanker – Managing Director - South Bank Neil Rogers – Managing Director - North Bank
Vacant Group Chief Clinical Design Officer	TBC

KEY: ***Y*** *= attended* ***N*** *= did not attend* ***D*** *= nominated deputy attended* *= position vacant*

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on 23 April 2024
9.00am to 12.00noon Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director, NLaG (Chair)
Lee Bond	Group Chief Financial Officer
Tony Curry	Non-Executive Director, HUTH
Simon Parkes	Non-Executive Director, NLaG
Mike Robson	Non-Executive Director, HUTH
Shaun Stacey	Group Chief Delivery Officer

In Attendance:

Alex Best	Interim Group Deputy Director of Capital Services
Linsay Cunningham	Deputy Director of Strategy (rep Group Chief of Strategy)
Alison Hurley	Deputy Director of Assurance
Alastair Pickering	Chief Medical Information Officer (rep Group Chief Digital Officer)
David Sharif	Group Director of Assurance
Lynn Arefi	Personal Assistant (Minutes)

Observer(s):

Julie Beilby	Associate Non-Executive Director, NLaG
Stuart Hall	Non-Executive Director, HUTH
Ian Reekie	Governor Observer (NLaG)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

Gill Ponder welcomed those present to the meeting as the Committee Chair. The following apologies for absence were noted: Ivan McConnell and Andy Haywood. It was also noted that Stuart Hall was not a core Committee member and was attending the meeting as an observer.

1.2 Declarations of Interest

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

1.3 **To approve the minutes of the meeting held on 20 February 2024**

The minutes of the meeting held on 20 February 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

Gill Ponder invited Committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

1.3 - Terms of Reference (ToR) - Closed - on agenda
3.1b - Board Assurance Framework - Closed - picked up within the highlight report
3.3.1 - New Build at Hull Royal Infirmary (HRI) - Closed – short form business case on the agenda
3.4.5 - North East Lincs Community Diagnostic Centre (CDC) Fit Out & Materials (NLaG) - Closed - this contract was on the agenda
4.2 - Draft Capital Plan - Closed - Shaun Stacey advised that various options were being explored and following the previous meeting the waiting list management IT tool and bed management tool schemes had been reviewed. Several Trusts were using the bed management tool and it was noted that confirmation of funding was required from NHS England (NHSE). An update would be provided for the Committees in approximately four months' time. It was agreed to close this action as the Committees would receive the appropriate updates as and when they were due.

1.6 **Terms of Reference – Final**

The Terms of Reference (ToR) were received by the Committees for approval and Gill Ponder sought any comments. Lee Bond noted that 5.2.1 refers to the Group Director of Estates in the attendance section and suggested that as the Group had not appointed to this post it be replaced with the Deputy Director of Estates and Capital, which was currently being covered by Alex Best.

Gill Ponder requested the Group Chief Clinical Design Officer referred to in section 5.1.4 be removed as this post had been removed from the Group Executive structure. Appendix A also to be amended to "NLaG" and not "HUTH" in the NLaG ToR.

Gill Ponder queried the capital limit which the Committees could approve and Lee Bond confirmed this would be in line with the Scheme of Delegation as referred to in the ToR. It was noted that a revised Scheme of Delegation would be presented to the Group Cabinet and then the following Audit Committees for ratification.

The Committees received, noted and approved the Terms of Reference subject to the minor changes noted.

Julie Beilby referred to section 6.7.1 around the publication of papers which should be five clear working days prior to the meeting and queried whether this was normal practice. Gill Ponder confirmed it was and advised that any late papers would be captured in the highlight report in response to a query from Stuart Hall. Simon Parkes agreed that timely circulation of papers was essential, and his understanding was better arrangements had been established but suggested it still required raising at the Non-Executive Director (NED) meeting.

***ACTION**:* Late circulation of papers for Committees-in-Common to be discussed at the next Chair/NEDs meeting.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Gill Ponder reported that no matters had been referred by the Trust Board for consideration by the Committees.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

3.1a It was noted that the HUTH BAF would be referred to in item 10.1 – Complete Board Assurance Framework later in the agenda.

3.1b It was noted that the NLaG BAF would also be referred to in item 10.1.

3.2 Risk Register Report

Gill Ponder noted that there was no written report and asked David Sharif to provide an update. David Sharif noted the Risk Register Report was part of the ongoing Group harmonisation work being undertaken and was work in progress. It was hoped that a refreshed Trust Strategy would be available by June or July which would progress to determine the strategic risks and then align the high-level risks to the appropriate committees. David Sharif noted the good work in progress and confirmed a summary report would be presented to future Committee meetings.

Simon Parkes suggested this should be referred to the Audit Committees as it affected all committees and it felt very uncomfortable that it had been several months since discussion around the Risk Register had taken place. As a NED and Joint Chair of the Audit, Risk and Governance (ARG) Committees-in-Common (CiC) he was concerned about the lack of oversight this presented and suggested that a view should be taken on what impact that may have on the overall scheme of assurance. Gill Ponder concurred. It was noted that as the next AR&G CiC meeting was not until July an interim response would be provided. The review requested would include consideration of the assurance gap with the Committees not having recent sight of the Risk Register and to what extent any gap was mitigated by other arrangements including the Group Cabinet Risk and Assurance Committees.

David Sharif informed members that high-level risks would be presented to the next meeting and Committees should be relatively assured this was being addressed.

ACTION: Risk Register to be referred to the ARG CiC for a response on any assurance gap found, in advance of the July 2024 meeting.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports or recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendations & Assurances**

There were no external reports, recommendations or assurances to note.

Review The Committees confirmed that the Terms of Reference had been approved and the referral of the Risk Register to the Audit, Risk and Governance Committees-in-Common was noted.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Group Capital Finance Report (NLaG and HUTH) Month 12**

Lee Bond referred to the Group Capital Finance report and advised the figures were subject to audit. The report provided the final capital spend for the financial year 2023/24, for both Trusts. Year-end Group capital spend totalled £108 million which was in line with the resource approved throughout the year. A slight variance across the organisations was referred to which was in order to manage the overall resource. Key points to note were the transfer of £3.8 million from NLaG to HUTH, repayable in 2024/25. The £4 million Public Dividend Capital (PDC) related to the underspend on the Community Diagnostic Centres (CDC) at NLaG and had been deferred to 2024-25, which meant the Capital Departmental Expenditure Limit (CDEL) in 2023-24 had been maximised, mitigating the risks into 2024-25.

Lee Bond drew the Committee's attention to the major capital spends for HUTH and NLaG in year and noted that the CDC North Bank scheme for £12 million for NLaG was not referenced within the report as this had been paid direct to the Council. Lee Bond added that the Trust had maximised the allocation with no significant underspend which was a positive.

Simon Parkes queried the basis of re-allocation of money across the Trusts. Lee Bond confirmed that the money was held at an Integrated Care Board (ICB) level and each Trust applied to under-spend or over-spend as required, it was noted that this caused no account issues.

In response to a query from Tony Curry, Lee Bond confirmed that there was an underspend with Electronic Patient Records (EPR) and funds had been brokered to the Centre, which would be received back and although this was being

managed it was not an easy task. It was agreed to circulate a schedule which would show the balances and spend to date. Simon Parkes took the opportunity to thank Lee Bond and his team for the work undertaken on the control total.

ACTION: Lee Bond to circulate the Electronic Patient Records (EPR) spend schedule.

Simon Parkes queried the arrangements for accountability of the money the Council were spending and how assurance would be received. Lee Bond advised that he had met with the Capital Lead from the Council and the Section 151 Officer as it had been felt that the Estates Capital team had been kept a little at "arm's length". It had now been agreed that the Group's Capital team and the Council's team will work openly and transparently going forward and be jointly managed. Lee Bond confirmed that some risks would still be retained but close working would continue with the Council and the contractors. Simon Parkes noted that warranties could be problematic if there were sub-contractor failure which could pose an area of risk.

Review Gill Ponder thanked everyone for their input and noted the Committees were assured that the Group Capital programme had been delivered for 2023/24 and that the Capital Departmental Expenditure Limit (CDEL) had been achieved, but noted that £4.0m of Public Dividend Capital (PDC) relating to the underspends on the Community Diagnostic Centres (CDCs) had been deferred to 2024/25 and that £3.8m had been transferred from NLaG to HUTH, which would be repaid in 2024/25. Areas of risk identified on the Council and the risk arrangements and warranty oversight would be captured in the Trust Board highlight report.

4.1.1 **Draft Capital Programme 2024/25 (NLaG and HUTH)**

Lee Bond presented the Draft Group Capital Programme for 2024-25 and noted little change since the previous meeting. Depreciation for 2023/24 was noted as £40 million with the capital programme being £71 million. This will continue to reduce with the completion of the Acute Assessment Unit (AAU) and the Emergency Department (ED) at DPoW.

The report provided the updated draft Capital Programme for 2024/25, along with expected Integrated Care Service Capital Control Totals. Key points to note were the previously reported shortfall to complete the CDCs at NLAG was resolved due to the £4 million Public Dividend Capital (PDC) funding from 2023-24 being carried over to 2024/25. The remaining allocations in the Capital Programme were to address the backlog maintenance issues, aged equipment replacement and the IT infrastructure, along with allocations associated with the Electronic Patient Record (EPR) Business Case, which would be revised due to affordability issues. A risk was noted that the EPR funding could not be spent in 2024/25 and a request had been submitted to defer it until 2025/26 to allow time for a contract to be awarded and further funding to be secured.

A discussion took place around the risks of insufficient capital being available to complete all planned schemes in year due to a lack of contingency reserves and a potential risk arising from the validity of warranties where CDC funds had been transferred to Hull City Council, who would then place contracts with Sub-Contractors.

Mike Robson queried when the Capital Programme would be signed off and Lee Bond confirmed it formed part of the Annual Planning process which had been presented in draft to the Trust Boards-in-Common.

Lee Bond responded to a query from Mike Robson and advised that there had not been much inclusion in the report on the "Net Zero 30" at the end of the last financial year but additional allocations had now been received to address lighting improvements etc., and there was a boiler replacement planned for SGH (with designs planned in 2024/25 rather than implementation). It was also noted that every new building was "net zero".

Alastair Pickering informed members that grant funding would be applied for in-year which did not require a Group contribution and would support the move to net zero in all approaches.

Review Gill Ponder summarised that the report was endorsed by the Committees for Trust Boards-in-Common approval which would be captured in the highlight report.

4.2 **Review & Evaluation of New Business Cases, Investments & Dis-investments within Delegated Limits and/or Endorsement for Trust Board Approval**

4.2.1 **New Build at Hull Royal Infirmary (HRI) HUTH**

Lee Bond introduced the business case noting that this was a nationally prescribed short-form business case based on value. As part of background to the business case, Lee Bond advised that HUTH's estates strategy was to progressively empty the tower block from the top down with a view to securing funding for additional wards, then the tower block would be utilised solely for administration and office space. Due to bed pressure, the 13th floor of the tower block was developed into a Discharge to Assess facility which left the Trust with no permanent solution for administrative staff accommodation which remained an issue.

The business case outlined the proposal to create a new three storey modular build on the HRI site, adjacent to the Women & Children's hospital to address several current capacity issues. It was proposed that this new modular block would accommodate the following services:

- Paediatric day surgery admissions, second stage recovery/discharge, play area and consultant rooms to facilitate the move of Paediatric Day Surgery into the Women's & Children's Hospital (W&CH)
- The establishment of a Well Being Centre on the HRI site
- Office accommodation for the Emergency Department (ED) consultants and the Trauma & Research Network Team (TARN) who were displaced due to IRT 4 scheme
- The establishment of a Command/Control Centre for Operational/Bed Management, including accommodation for the Discharge Team, Transport Team and Social services teams.

The costs of the new development were included within the Trust's capital programme (£4.2 million) although some associated works were required to the adjacent W&CH building to ensure that the patient pathway remains safe, with appropriate first and second stage recovery. If the current planning application was supported, it would enable a speedy major development and the £300,000 revenue costs would predominantly increase due to domestic and utility charges.

Simon Parkes queried the ground assessment as there appeared to be little contingency and no "optimism" bias included and also asked whether conversations were being held with the PFI provider. Lee Bond confirmed confidence in the costs and advised there were no current issues or concerns with the ground as the Allam Suite had recently been built on the adjacent land with no issues, although less confidence was noted with the costs within the PFI building. A discussion about the links between the buildings ensued.

Tony Curry noted the extent of office accommodation and queried whether the Group Cabinet had agreed this as a high priority. Lee Bond confirmed that this would be presented to Group Cabinet shortly. Shaun Stacey confirmed full support of the paper and its priority from an operational perspective as it contributed to elective service improvements and addressed the need for a robust Command Centre.

In response to a query from Simon Parkes about the extent of the control centre costs reflected in the business case, Lee Bond advised that the national Business Continuity Management Strategy (BCMS) programme had been paused and this operating system would be added to the facility once the programme pause was lifted. The business case did include funding for screens etc., but the main operating system would be funded through BCMS.

Julie Beilby referred to office accommodation versus clinical accommodation and asked if alternatives for office accommodation had been investigated. Lee Bond advised this had been considered previously but no alternative options had been available.

Review Gill Ponder noted that the HUTH Committee had heard the "case of need", supported the continuation of the planning application with associated costs and agreed the Business Case would require approval by the Group Cabinet, before re-presentation for approval at the June CaMP CiC meeting.

4.3 **Review & Evaluation of Existing Business Cases**

There were no existing business cases for the Committees to note.

4.4 **Post Capital Project Evaluation**

There were none for the Committees to note.

4.5 **Capital Contract Approvals**

4.5.1 **North East Lincs CDC Fit Out & Materials – NLaG**

Lee Bond took the paper as read and confirmed the paper sought approval to appoint Morgan Sindall Construction and Infrastructure Ltd to undertake the internal fit out construction works to the CDC 'Spoke' in Grimsby Town Centre within the Freshney Place Shopping Centre, which was currently owned by North East Lincolnshire Council. This scheme was an integral part of the Integrated Care Services (ICS) programme of community diagnostic service developments. The CDC spoke was being constructed within the space of five existing shop units and would provide imaging (X-Ray, Ultrasound and DEXA), physiological measurement and pathology.

Alex Best outlined that the Shared Business Services (SBS) Framework was utilised to source a Principal Contractor for the works on a two stage 'open book' basis. Morgan Sindall was selected through the SBS Procurement Process and appointed to undertake the Enabling Works package. This included site establishment (hoardings), soft strip and the demolition works needed to clear the existing shop units and dividing walls thereby enabling the five units to be combined into one facility. Morgan Sindall had now priced the construction and fit-out elements of the project, which were scheduled to commence on 29 April 2024 with construction work for the CDC due for completion by 30 September 2024 and a clinical start date of 13 October 2024.

Alex Best noted the current cost plan incorporated actual figures for enabling works. Morgan Sindall tendered figures for the main fit-out works, identified savings and indicated a surplus of available funding over forecast cost which left a contingency of circa £160,000. The NLaG Committee was asked to recommend Board approval be granted to appoint Morgan Sindall to undertake the internal fit-out inclusive of all building, mechanical and electrical construction works for the sum of £6,131,903.20 inclusive of VAT.

Lee Bond advised that the £0.5 million "variations" within the report was a form of contingency in response to a query from Gill Ponder.

The Committee received, noted and endorsed the North East Lincs CDC Fit Out and Materials report to be presented to the next Trust Boards-in-Common for formal approval.

4.5.2 **Castle Hill Day Surgery Unit (DSU) Phase 2 & 3 – HUTH**

It was noted that this report had been to the Trust Boards-in-Common for approval and was presented at this meeting for information only.

Review To include the Committees were assured but noted risks in relation to the Capital Plan. The Capital Programme 2024/25 was endorsed for the Trust Boards-in-Common approval. The New Build at HRI planning application was supported in principle by the HUTH Committee, but required approval from Group Cabinet prior to presentation back to this Committee for formal approval. The North East Lincs CDC Fit out contract was endorsed for Trust Boards-in-common approval.

At 10.40am the Committees undertook a short break.

5. Major Service Change / Transformation

5.1 Humber Acute Services Review (HASR)

Gill Ponder welcomed Linsay Cunningham, Deputy Director of Strategy to the meeting. Linsay Cunningham took the paper as read and provided an overview of key issues and challenges raised through the public HASR consultation. An update on progress towards completing the Decision-Making Business Case (DMBC) was provided which would be presented to the Trust Boards-in-Common for a formal decision. It was noted the consultation had run from 25 September 2023 to 5 January 2024 and received nearly 4,000 responses via the questionnaire with a wide range of views also gathered from seldom heard groups and communities through a comprehensive programme of targeted engagement. Work was ongoing to respond and analyse the public consultation feedback and a detailed report would be provided once available.

Lee Bond referred to the presentation and asked about the potential recommendation to consolidate acute and elective urology services. Linsay Cunningham advised that the rationale was to provide efficiencies, whilst noting acute and elective are in the same place at SGH and the model allows a balance of services.

In response to a query from Lee Bond, Linsay Cunningham confirmed there would be slippage of up to two weeks on the planned review of the Business Case by 1 May 2024 and advised of the close working with the finance team on the figures.

Simon Parkes noted the need to be clear on the recommendation and rationale and queried if there was a clinically sound solution which delivered better value for money, on what basis would another option be taken. Linsay Cunningham advised that the rationale around Urology came from the clinical teams.

Gill Ponder referred to slide 10 and queried the suggestion under emergency surgery, trauma and orthopaedics that the over 65's with fractured neck of femur would be repatriated to SGH for recovery, which may not be patient friendly. Shaun Stacey advised of the importance to keep patients as local as possible with planned repatriation and rehabilitation closer to home.

The Committees were assured about the level of public engagement involved in the review and the progress made to date, and noted the key issues and concerns raised through the consultation, the recommended direction of travel and timeline for the DMBC and next steps.

Gill Ponder thanked Linsay Cunningham for the update on HASR.

5.2 Community Diagnostic Centre (CDC) Programme

Gill Ponder welcomed Jackie Railton, Deputy Director Planning and Performance to the meeting. Jackie Railton took the Committees through an overview of the programme. This included an update on progress of the North and South Bank CDC schemes which were progressing at pace. Scunthorpe and Grimsby were on track to open in October 2024 as planned. In relation to the East Riding Community Hub (CH), the NHSE have challenged the spoke status of this

scheme due to the modalities included, which were agreed by NHSE as part of the original business case, but assumptions have changed. It was noted that the additional modalities/activities would require extra space not currently available at the hub. The planned modular ophthalmology build would not have spare capacity for additional activity and discussions were ongoing with NHSE.

Referring to the East Riding hub, Jackie Railton noted that discussions are underway with the Council regarding the build costs and a potential risk share agreement was in place. The Council and their contractor had submitted revised cost plans and the lack of supporting detail for a potential £3 million cost overrun, which had not been validated by the Estates team, was noted. Discussions were ongoing around the issues with Hull City Council's Section 151 officer to agree a resolution.

Simon Parkes acknowledged that these all need to be in place within 2024 and challenges remain over what will be included in the community hub. He queried who monitored the "value for money" and public accountability elements of the schemes and Jackie Railton advised that value for money would be evident for the Trust once referrals are taken from the GPs into the hub and out of secondary care. This is in line with a value for money assessment which was undertaken as part of the business plan presented to the Trust Board and supported by the Integrated Care Board (ICB) and NHSE. As NHSE had changed the rulings which meant that only one modality could be delivered, some accountability would sit with NHSE.

Jackie Railton referred members to the Grimsby CDC current cost forecast which noted an overrun of approximately £500,000 and advised Estates colleagues were reviewing options to maintain the planned contingency. It was noted that the opening had been delayed from April 2024 to October 2024. The Scunthorpe CDC was progressing at speed with one outstanding issue around the Council ownership of the adjacent sports hall which was required for the location of the mobile pad. This risk was currently being managed between teams.

More care pathways were being identified for the south bank services including breathlessness and heart failure and opportunities around gastroenterology, urology and gynaecology. Demand for point of care testing had been lower than anticipated which may impact activity levels and the revenue position which were under review. Jackie Railton advised that plans were in place for staff recruitment and training with the option to utilise the independent sector for support with Sonographer recruitment.

Planned activity for the computed tomography scan (CT) and Magnetic resonance imaging (MRI) demand was lower than planned; this was due to the need for only "low complex" patients and adjustments are being worked through. As this was a system provision across mobile vans and sites these will be utilised elsewhere and therefore would not impact on the overall position.

Tony Curry queried any difficulties in the recruitment of Sonographers and queried why the service was not outsourced. Jackie Railton advised the work needs to be delivered on site and there were very strict rules that must be adhered to. Gill Ponder asked how realistic the recruitment of all trained staff would be in order to open these facilities on time. Lee Bond confirmed that Ivan

McConnell had reported a high confidence level for recruitment except for radiologists.

Gill Ponder thanked Jackie Railton for the update and Jackie Railton left the meeting.

Review The Committees were assured on both the HASR and CDC Programme.

6. Digital

6.1 Digital Plan Delivery – Bi Monthly Update

Alastair Pickering advised the Committees that since the last update three major projects had been delivered or were in progress. The patient administration system (PAS) migration to a single Lorenzo system had been a significant piece of work that had impacted significantly on the south bank and affected the north bank during the cross-over period. This was a successful technical migration, but there had been a significant number of post implementation challenges in practice. The programme was due to enter a stabilisation stage prior to an optimisation stage, but currently south bank staff are not ready for the system to be optimised at present. A project team was available to support this work and it was noted that some areas are already working extremely well.

An issue with resource availability of the Information Teams on the south bank was noted which had been impacted by the work on the data warehouse.

Successful Implementation of the Badgernet Maternity system across HUTH had been undertaken and a slight training issue had been addressed. As there were three different maternity systems on the south bank, the implementation would undergo a “reset” to address identified issues which included data cleansing, training data reporting and working with the service areas. Alastair Pickering advised that a new Project Management group supported this work and a progress update would be presented to the Trust Boards-in-Common and the Group Cabinet.

Moving on to the Electronic Patient Record (EPR), Alastair Pickering referred to the business case and procurement process and advised that Andy Hayward, Chief Information Officer had requested the Trust Boards-in-Common to support a delay until June/July 2024. It was noted that York, Scarborough and Harrogate are procuring their own EPR system with a decision due in May. Potential cost savings on the Group’s business case were being investigated with the national team.

Tony Curry acknowledged the challenges in informatics and queried any plans for artificial intelligence (AI) and end user tools to address some of the challenges. Then moving to EPR, Tony Curry requested an update on timescales and Alastair Pickering confirmed the current contract was with Lorenzo until 2028 with an option to extend to 2030.

Julie Beilby asked if there was a “shared ambition” for an EPR between York, Scarborough and Harrogate Trusts to move to a single supplier. Alastair Pickering confirmed that there was commitment to a single system procurement.

Simon Parkes queried whether the Information team and other staff challenges had impacted progress on normal management reporting and whether there was a robust process for prioritising such elements. Alastair Pickering confirmed that the Information team as part of the PAS project did prioritise effectively, but had found it difficult to keep abreast of the pace of the implementation.

Simon Parkes expressed concern around the inability to receive assurance on the data gaps and Shaun Stacey confirmed there were daily challenges which were managed as well as possible. Sufficient operational quality controls were utilised in patient services to mitigate 'losing someone' on the pathway.

Gill Ponder suggested the Committees sought additional assurance on the lack of timely and appropriate reporting functionality following the data migration to Lorenzo. A report was requested to be presented to the May 2024 Performance, Estates and Finance (PEF) CiC meeting to note where the gaps were and the mitigations and timescales identified to address them. It had been noted that the patient safety risk had been mitigated by the operational teams, but this required several manual work-arounds. Shaun Stacey noted that additional staff had supported the LORENZO roll-out on the south bank to address some critical challenges, although the technical migration and training went very well and lessons had been learned. Shaun Stacey referred to the importance of keeping the Trust Boards-in-Common sighted on this.

ACTION - Ivan McConnell to present a report to the May 2024 Performance, *Estates and Finance (PEF) CiC meeting to provide assurance on timely and* accurate reporting following the migration of data to Lorenzo, including where any data gaps were and the mitigations and timescales identified to address them.

Review The Committees gained assurance from the digital plan delivery update and would highlight the 'go live' date for the NLaG Badgernet was being re-planned to the Trust Boards-in-Common. Concerns regarding the level of resource within the digital team were to be escalated. The data and reporting gaps identified were also to be escalated following the Lorenzo data migration which were leading to manual workarounds, although any patient safety risk was mitigated by the operational teams, the Committees sought assurance of where the gaps were and the timescales for resolution (referred to the May PEF CiC).

7. Highlight Reports from Sub-Groups

7.1 Capital Resource Allocation Committee Minutes February 2024 - HUTH

The minutes taken at the Capital Allocation Committee in February 2024 were noted.

7.2 Capital Investment Board Minutes February 2024 - NLaG

The minutes taken at the Capital Investment Board in February 2024 were noted.

Referring to items 7.1 and 7.2, Lee Bond advised that he was producing a draft ToR for a new Group Cabinet Capital Committee which would be presented to Group Cabinet, this would be an amalgamation of the two Capital meetings. Once approved the ToR would be presented to this Committee.

8. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 Matters to be Referred to other Board Committees

It was agreed to refer the following matters to other Board Committees as noted:

- Audit, Risk and Governance – Risk Register
- Performance, Estates and Finance – Data reporting gaps following Lorenzo implementation

9.2 Matters for Escalation to the Trust Boards

In addition to the items highlighted above at each agenda section review for inclusion in the Committees' highlight report, it was agreed that the following matters required approval by the Trust Board(s):

- Approved Terms of Reference
- Endorsed Draft Capital Programme
- Endorsed North East Lincs CDC

10. Items for Information

10.1 Complete Board Assurance Framework (BAF) – for Reference (HUTH & NLaG)

David Sharif took the paper as read and noted that work was underway to refresh the BAF across the Group. The report included a progress update regarding the harmonisation and rationalisation of the BAFs for HUTH and NLAG together with the 2023/24 Quarter 4 Digital risk rating, the re-scoped 2024/25 Group Digital risks and updated controls, assurances and gaps in controls. The Committees were asked to note the report.

Tony Curry queried the assurance rating on the IT failure and queried how robust the facilities at NLaG were which was not reflected in the rating. Alastair Pickering confirmed that the rating of 15 was the initial proposed rating but was open for discussion. Gill Ponder suggested it be presented to the Risk Management Committee and the CaMP CiC would receive the BAF in its further iteration with the risk score following debate and justification.

11. DATE AND TIME OF THE NEXT MEETING

11.1 Date and Time of the next CiC meeting:

Tuesday, 25 June 2024, 9.00am, Boardroom, Hull Royal Infirmary.

The Committee Chair closed the meeting at 12.00 noon.

Cumulative Record of Attendance at the Capital & Major Projects Committees-in-Common 2024/2025

		2024				
Name	**Title**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**
CORE MEMBERS						
Gill Ponder	Chair / Non-Executive Director (NED - NLaG)	Y				
Mike Robson	Chair / NED (HUTH)	Y				
Lee Bond	Group Chief Financial Officer	Y				
Tony Curry	NED (HUTH)	Y				
Simon Parkes	NED (NLaG)	Y				
Shaun Stacey	Group Chief Delivery Officer	Y				
Quoracy: *three of five core members (inc.one of two Trust NEDs, two Group Executive Directors or appointed deputies)*						
REQUIRED ATTENDEES						
VACANT	Group Director of Estates	D				
VACANT	Group Director of Transformation	V				
Andy Hayward	Group Chief Digital Information Officer	D				
Alison Drury	Deputy Director of Finance (HUTH)	Y				
Ivan McConnell	Group Chief of Strategy & Partnerships	Y				
Ian Reekie	Governor Observer (NLaG)	Y				
David Sharif	Group Director of Assurance or deputy	Y				

DESIGNATED DEPUTIES	
Executive Director CiC member	**Designated Deputies**
Lee Bond Group Chief Financial Officer	Deputy Chief Financial Officer – vacant, covered by: Alison Drury, Deputy Director of Finance (HUTH) Brian Shipley, Deputy Director of Finance (NLaG) Steve Evans, Operational Director of Finance (HUTH)
David Sharif Group Director of Assurance	Alison Hurley, (NLaG) Rebecca Thompson, Deputy Director of Assurance (HUTH)
Ivan McConnell Group Chief of Strategy & Partnership	Adam Creeggan, Group Director of Performance
Shaun Stacey Group Chief Delivery Officer	Ashy Shanker – Managing Director - South Bank Neil Rogers – Managing Director - North Bank

***KEY**: **Y** = attended **N** = did not attend **D** = nominated deputy attended **V** = position vacant*

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)206

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	As Above
Title of Report	Documents Signed Under Seal
Executive Summary	The report below provides details of documents signed under Seal since the date of the last report provided in August 2024. The report includes documents sealed by Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust and Hull University Teaching Hospital (HUTH) NHS Trust
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Not directly
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Use of Trust Seal – October 2024

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal at NLaG has been used on the following occasions:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
286	Lease relating to Elizabeth Row Student Accommodation at Scunthorpe	Jonathan Lofthouse & Lee Bond	08.08.2024
287	Lease relating to Pharmacy at Scunthorpe	Jonathan Lofthouse & Lee Bond	08.08.2024

There were no items sealed on behalf of HUTH.

Action Required

The Trust Boards-in-Common are asked to note the report.

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)207

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	10 October 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	Trust Boards-in-Common & Committees Meeting Cycle
Executive Summary	The attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2024 and December 2024. The report also includes the schedule for January - December 2025.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format.
Prior Approval Process	None
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE - 2024 - V16

	Quarter 4 (23/24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays - 9.00 am - 5.00 pm)		08.02.24		11.04.24		13.06.24		08.08.24		10.10.24		12.12.24
Board Development (Tuesdays - 9.00 am - 5.00 pm)	02.01.24		05.03.24		14.05.24		02.07.24				05.11.24	
Committees in Common												
Performance, Estates & Finance (Wednesdays - 9.00 am - 12.30 pm)	24.01.24	28.02.24	27.03.24	24.04.24	29.05.24	26.06.24	24.07.24	28.08.24	25.09.24	30.10.24	27.11.24	18.12.24
Capital & Major Projects (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)
Remuneration (Thursdays - 9.00 am - 11.30 am)	11.01.24			04.04.24	28.05.24 (Tuesday - 11.00 - 12.00)	19.06.24 (Wednesday - 11.00 - 12.30)				03.10.24		
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	
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24			25.04.24		21.06.24 (Friday - 9.00 am - 10.30 am) **HUTH ONLY**	25.07.24	06.08.24 (Tuesday - 9.00 am - 10.30 am) **NLAG ONLY**		01.10.24		
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	10.01.24			03.04.24			04.07.24			09.10.24		
HUTH (9.00 am - 12.00 pm)		21.02.24			30.05.24			22.08.24			13.11.24	
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
Site Review Meetings												
North Site Review					30.05.24	24.06.24	29.07.24	21.08.24	23.09.24	28.10.24	25.11.24	23.12.24
South Site Review					30.05.24	24.06.24	29.07.24	21.08.24	23.09.24	28.10.24	25.11.24	23.12.24
Governors												
Council of Governors (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** 22.08.24	**Annual Members Meeting** 12.09.24	31.10.24		
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			18.12.24
Appointments & Remuneration Committee (Thursdays - 1.30 pm - 3.00 pm)			14.03.24		30.05.2024 (2.30 pm - 4.00 pm)					03.10.24		
NED & CEO Meetings												
NED & CEO Meetings (Thursdays - 2.00 pm - 4.00 pm - with exceptions as stated)	09.01.24 (Tuesday - 10.00 am-12.00 pm)	15.02.24	14.03.24 (10.00 am-12.00 pm)		16.05.24	19.06.24 (Wednesday)	09.07.24 (Tuesday - 10.00 am - 12.00 pm)	15.08.24	10.09.24 (Tuesday - 10.00 am - 12.00 pm)	15.10.24	14.11.24	19.12.24
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
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	
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
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	

MEETING SCHEDULE -2025 - V5

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays -9.00 am - 5.00 pm)		13.02.25 **Boardroom, HRI**		10.04.25 **Boardroom, DPOW**		12.06.25 **Boardroom, HRI**		14.08.25 **Boardroom, DPOW**		09.10.25 **Boardroom, HRI**		11.12.25 **Boardroom, DPOW**
Board Development (Tuesdays -9.00 am - 5.00 pm)			13.03.25 **Boardroom, DPOW**		08.05.25 **Boardroom, HRI**		10.07.25 **Boardroom, DPOW**		11.09.2025 **Boardroom, HRI**		13.11.25 **Boardroom, DPOW**	
Committees in Common												
Performance, Estates & Finance (Tuesdays -9.00 am - 12.30 pm)	Meeting falls in December 2024 due to previous reporting cycle	04.02.25 **Boardroom, DPOW**	04.03.25 **Boardroom, HRI**	01.04.25 **Nightingale, SGH**	06.05.25 **Boardroom, HRI**	03.06.25 **TBC, CHH**	01.07.25 **Boardroom, DPOW**	05.08.25 **Nightingale, SGH**	02.09.25 **Boardroom, HRI**	30.09.25 **(please note falls in September) TBC, CHH**	04.11.25 **Boardroom, DPOW**	02.12.2025 **Nightingale, SGH**
Capital & Major Projects (9.00 am - 12.00 pm)		19.02.25 **Nightingale, SGH**		22.04.25 **Boardroom, HRI**		18.06.25 **Boardroom, DPOW**		20.08.25 **Nightingale, SGH**		22.10.25 **Boardroom, HRI**		16.12.25 **Boardroom, HRI**
Quality & Safety (Thursdays -9.00 am -12.30 pm with exceptions as stated)	30.01.25 **TBC, CHH**	27.02.25 **Nightingale, SGH**	27.03.25 **Boardroom, DPOW**	29.04.25 **Boardroom, HRI** (Tuesday)	29.05.25 **TBC, CHH**	26.06.25 **Nightingale, SGH**	24.07.25 **Boardroom, HRI**	28.08.25 **Boardroom, DPOW**	25.09.25 **TBC, CHH**	30.10.25 **Nightingale, SGH**	27.11.25 **Boardroom, HRI**	18.12.25 **Boardroom, DPOW**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		05.02.25			27.05.25			06.08.25			20.11.25	
Workforce, Education & Culture (Wednesdays -9.00 am - 12.30 pm)	29.01.25 **Boardroom, DPOW**	26.02.25 **Boardroom, HRI**	26.03.25 **Nightingale, SGH**	30.04.25 **TBC, CHH**	28.05.25 **Boardroom, DPOW**	25.06.25 **Boardroom, HRI**	23.07.25 **Nightingale, SGH**	27.08.25 **TBC, CHH**	24.09.25 **Boardroom, DPOW**	29.10.25 **Boardroom, HRI**	26.11.25 **Nightingale, SGH**	17.12.25 **TBC, CHH**
Audit, Risk & Governance Committee (Thursdays -9.00 am -12.30 pm with exceptions as stated)	23.01.25 **Boardroom, HRI**			24.04.25 **Boardrom, HRI**		20.06.25 HUTH & NLaG **Annual Accounts** Friday - 9.00 am - 12.00 pm **Boardroom, HRI**	31.07.25 **Boardroom, DPOW**				12.11.25 **Boardroom, DPOW**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	22.01.25			02.04.25			09.07.25			01.10.25		
HUTH (9.00 am - 12.00 pm)		06.02.25			07.05.25			07.08.25			06.11.25	
Executive Team Meetings												
Executive Team (Tuesdays -2.00 pm - 5.00 pm)	07.01.25 14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25	01.04.25 08.04.25 15.04.25 22.04.25 29.04.25	13.05.25 20.05.25 27.05.25	03.06.25 10.06.25 17.06.25 24.06.25	08.07.25 15.07.25 22.07.25 29.07.25	05.08.25 12.08.25 19.08.25 26.08.25	09.09.25 16.09.25 23.09.25 30.09.25	07.10.25 14.10.25 21.10.25 28.10.25	11.11.25 18.11.25 25.11.25	02.12.25 09.12.25 16.12.25 23.12.25
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	09.01.25	25.02.25 (9.00 am - 10.30 am) **NED & Governor only Meeting**		16.04.25			17.07.25		04.09.25 (1.30 pm - 5.00 pm) **AMM & Highlight Reports**		05.11.25	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays -5.30 pm - 7.00 pm)			11.03.25			03.06.25				07.10.25		02.12.25
Appointments & Remuneration Committee (Thursdays -3.00 pm - 4.30 pm)		20.02.25			29.05.25				25.09.25			
NED & CEO Meetings												
NED & CEO Meetings (Tuesdays -10.00 am - 12.00 pm)	14.01.25	18.02.25	18.03.25	15.04.25	13.05.25	17.06.25	15.07.25	19.08.25	16.09.25	14.10.25	18.11.25	09.12.25
Union Meetings												
JNCC - NLAG (Mondays -2.30 pm - 4.30 pm)	20.01.25	17.02.25	17.03.25	21.04.25	19.05.25	16.06.25	21.07.25	18.08.25	15.09.25	20.10.25	17.11.25	15.12.25
JNCC - HUTH (Thursdays -10.45 am - 12.45 pm)	02.01.25		06.03.25		01.05.25		03.07.25		04.09.25		06.11.25	
Consultant Meetings												
JLNC - NLAG (Tuesdays -12.30 pm - 2.00 pm)	21.01.25	18.02.25	18.03.25	15.04.25	20.05.25	17.06.25	15.07.25	19.08.25	16.09.25	21.10.25	18.11.25	16.12.25
LNC - HUTH (Wednesdays -10.00 am - 1.00 pm)	15.01.25		19.03.25		21.05.25		16.07.25		17.09.25		19.11.25	

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)205

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**10 October 2024**
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships Officer
Contact Officer / Author	Adam Creeggan, Group Director of Performance
Title of Report	**Integrated Performance Report – NLaG and HUTH**
Executive Summary	**This report provides details of performance achieved against key national performance, quality and governance indicators defined in the NHSE Single Oversight Framework (SOF)**
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	**Presented to the Performance, Estates and Finance Committees-in-Common Sept 2024 and Quality and Safety Committees-in-Common August 2024**
Financial Implication(s) (if applicable)	**The report covers a number of metrics that relate to financial performance inclusive of Elective Recovery Fund activity versus published plan**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Integrated Performance Report

MONTH 5: August 2024 Performance

July 2024 for Cancer data
Produced September 2024

Table of Contents

1. Executive Summary

This report provides an overview of the Group's performance across a range of metrics with specific detail in relation to each individual Trust.

Domain	HUTH Performance	NLAG Performance	Commentary
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	**August 2024** **0** **0** **35** **2,410**	**August 2024** **0** **0** **31** **794**	• Achieved the national requirement for zero >78w waits at end of June. • Continued progress in reducing >65w volumes at NLAG. • Increase in number of 65w waits for HUTH, mainly in Plastic Surgery due to reduced clinical workforce. • Risk of delivering zero >65w waits at end of September with a current worst case forecast of 50 cases at month end. Further mitigation of this forecast is expected.
Diagnostic 6w Performance	**August 2024** **25.6%**	**August 2024** **18.4%**	• Both Trusts have shown a drop in performance in August set against previous month on month improvement. o HUTH deterioration in Echocardiography and Flexible Sigmoidoscopy o NLAG deterioration in Audiology, Echocardiography, Neurophysiology and NOUS
Cancer 62 day Performance (all sources)	**July 2024** **49.7%**	**July 2024** **54.8%**	• Both Trusts in Tier 1 for Cancer delivery; working with NE&Y Regional Office on recovery assurance • 62-day performance impacted by radiotherapy and oncology capacity and prostatectomy surgical capacity, compound in July 2024 by HUTH OPA delays in patient pathway • 28-day Faster Diagnosis Standard (FDS) sustainability plans developed via the Cancer Delivery Group - Operational planning target to achieve FDS (combined) performance of 80% by March 2025 at Trust level. Q1 delivery against the national standard of 77% - HUTH achieved Q1, NLAG performance improving. July 2024 performance deteriorated at HUTH (breaches being reviewed) but continues to improve at NLAG • +63 day backlog reviews implemented fortnightly across the group; NLAG at trajectory & improving with HUTH static
ED: 4 hour standard (Type 1 & 3) 78% by March 2025	**August 2024** **64.4%** **Trust compliance** **74.1% (plan 75.4%)** **Acute Footprint compliance (incl. Bransholme & ERCH)**	**August 2024** **71.4%** **Trust compliance** **73.5% (plan 74.3%)** **Acute Footprint compliance (incl. Goole UTC)**	• Overall 4 hour performance is showing improvement at HUTH. National compliance ranking has marginally improved at 126 of 142 providers reporting in August. • NLaG compliance was also broadly unchanged on the previous month and benchmarks in the interquartile range of national ranking at 103 of 142. • Short-and medium-term recovery plans co-produced at Place level. Final assurance and acceptance of plans underway at system level. • 6 week reset patient flow campaign underway to engage and motivate staff across the pathway, and improve quality and patient experience.

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Jul 24	0	2,051			32
RTT 65 Week Breach	Jul 24	-	18			71
RTT 78 Week Breach	Jul 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Jul 24	18.0	61.2			60
RTT 95th Percentile Non-Admitted Waiting Time	Jul 24	18.0	51.6			59
RTT Admitted Treatment Within 18 Weeks	Jul 24	90.0%	57.5%			55
RTT Average (Median) Admitted Waiting Time	Jul 24	9.0	12.3			64
RTT Average (Median) Non-Admitted Waiting Time	Jul 24	5.0	6.4			86
RTT Average Wait for Incomplete	Jul 24	7.00	13.97			50
RTT Incomplete 18 Week Standard	Jul 24	92.00%	58.6%			46
RTT Incomplete 92nd Percentile	Jul 24	-	42.9			48
RTT Incomplete Pathways With a DTA	Jul 24	25.0%	16.2%			40
RTT Non-Admitted Treatment Within 18 Weeks	Jul 24	95.0%	72.1%			71
RTT Total Clock Starts	Jul 24	-	20,953			90
RTT Total Clock Stops	Jul 24	-	19,797			92
RTT Total Incompletes	Jul 24	-	77,622			17

NLAG

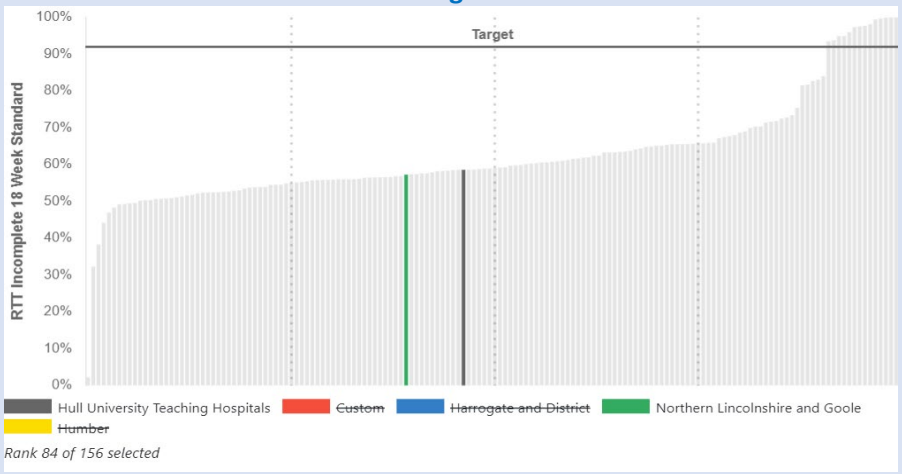
Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Jul 24	0	645			63
RTT 65 Week Breach	Jul 24	-	40			65
RTT 78 Week Breach	Jul 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Jul 24	18.0	59.2			68
RTT 95th Percentile Non-Admitted Waiting Time	Jul 24	18.0	51.3			60
RTT Admitted Treatment Within 18 Weeks	Jul 24	90.0%	56.9%			52
RTT Average (Median) Admitted Waiting Time	Jul 24	9.0	12.6			61
RTT Average (Median) Non-Admitted Waiting Time	Jul 24	5.0	12.0			23
RTT Average Wait for Incomplete	Jul 24	7.00	14.83			36
RTT Incomplete 18 Week Standard	Jul 24	92.00%	57.3%			39
RTT Incomplete 92nd Percentile	Jul 24	-	40.5			63
RTT Incomplete Pathways With a DTA	Jul 24	25.0%	14.0%			55
RTT Non-Admitted Treatment Within 18 Weeks	Jul 24	95.0%	61.4%			31
RTT Total Clock Starts	Jul 24	-	9,833			51
RTT Total Clock Stops	Jul 24	-	9,290			57
RTT Total Incompletes	Jul 24	-	46,079			41

3. Pathway Benchmarking & Trend – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

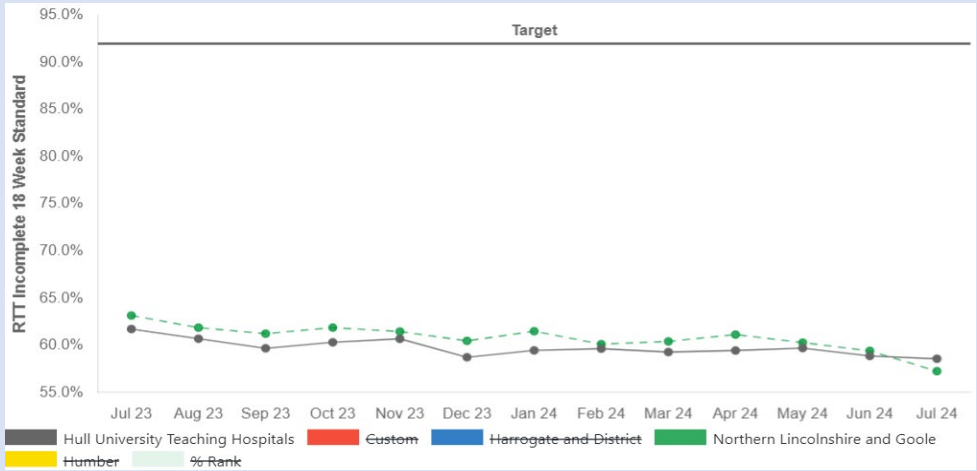
RTT – Incomplete Standard

Ranking Chart



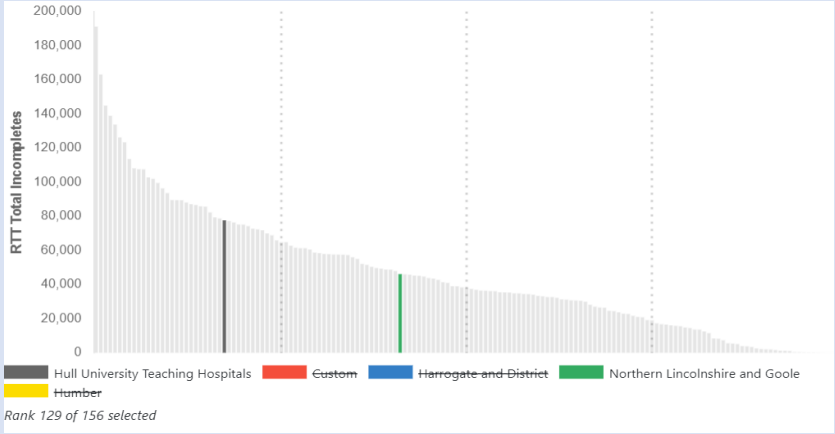
Rank 84 of 156 selected

Trend Chart



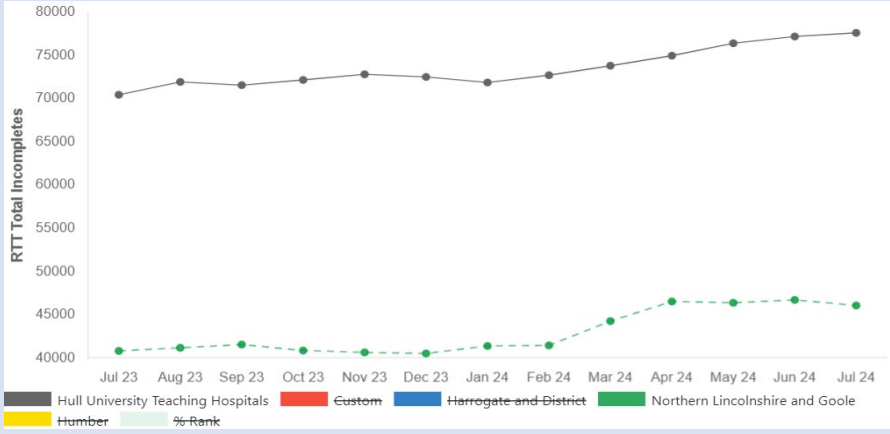
RTT – Total Waiting List Volume

Ranking Chart



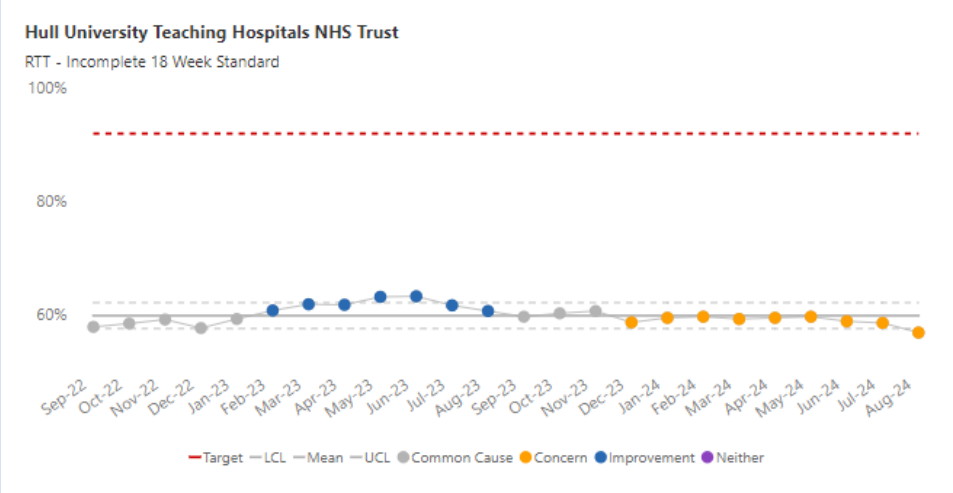
Rank 129 of 156 selected

Trend Chart



3. Referral to Treatment - HUTH

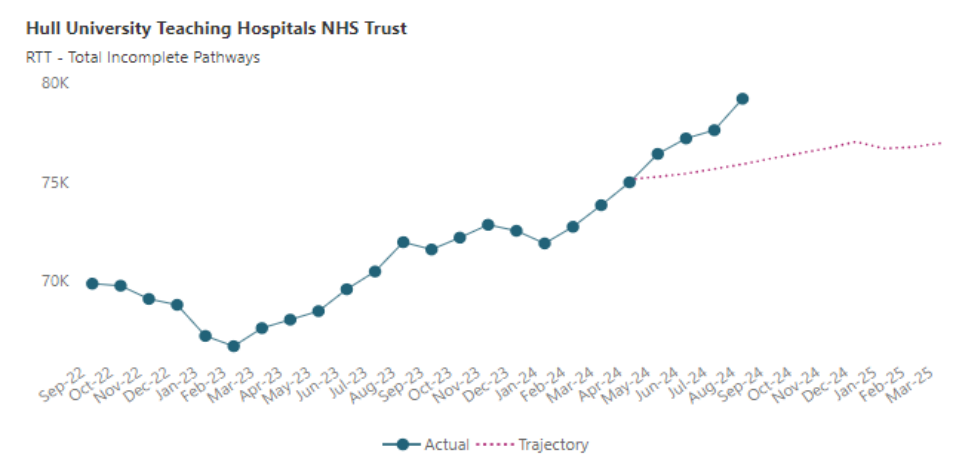
Compliance



Key Themes

- August performance of 56.9% is a deteriorating position and evidences the growth in the long waits.
- August total waiting list volume is at 79,216 above the trajectory of 75,895.
- PTL is showing linear growth with an increase of 7,334 cases (+10.2%) evident since January 2024.
- Increasing waiting list volume underpinned by 6.3% growth in referral rate.
- Currently 58% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Ophthalmology, Dermatology, Cardiology and Neurology
- 22% of patients waiting over 52 weeks.
- Average wait for incomplete pathway is 14 weeks against a standard of 7 but remains broadly stable i.e. not increases despite the increase in PTL size.

Critical Enabler



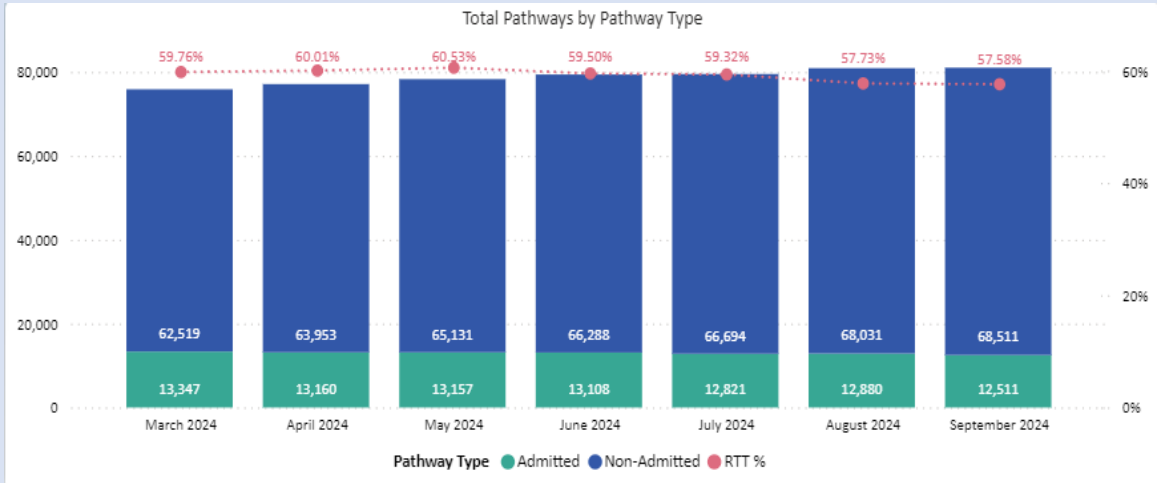
Actions

Critical actions being progressed through RTT Delivery Group:

- Waiting list volume is the key focus to bring back under trajectory
- Ensure all patients who will be at 65 weeks by the end of December have a first seen appointment by end of September 2024.
- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Care Groups reviews to decrease waits for first outpatient activity >40 weeks.
- Reallocate follow up outpatient activity without a procedure.
- Remedial admin action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume.

4. Deep Dive RTT Insights - HUTH 1

Compliance



Key Themes

- +6.8% growth in RTT waiting list volume month on month since March 2024 baseline (and the expected planning trajectory to maintain PTL list size to March 2025)
- Decrease in RTT Incomplete Performance by 2.5% meaning that more patients are waiting over 18 weeks.
- Increase in non-admitted waiting list by 6k since March 2024 reflected by 6.3% growth in referrals, with increases in Cancer pathway referrals notable (+9.8%)
- Increase in average time to first contact from 44 weeks to 75 weeks (some will be skewed with data discrepancies and non-RTT applicable pathways)

Critical Enabler

Referrals Scorecard (right click metric name to drill through to detailed summary)

Measure	Chosen Period	Comparison Period	Variance (#)	Variance (%)	
Referrals	230,385	216,807	13,578	6.3%	▲
Routine GP Referrals	67,638	65,386	2,252	3.4%	▲
Urgent GP Referrals	21,070	21,152	-82	-0.4%	▼
2WW GP Referrals	29,577	26,928	2,649	9.8%	▲
Consultant Referrals	57,955	51,573	6,382	12.4%	▲
ED Referrals	21,830	21,143	687	3.2%	▲
Other Referrals	32,315	30,625	1,690	5.5%	▲
Advice & Guidance Referrals	47,628	39,001	8,627	22.1%	▲
Electronic Referrals	113,023	104,886	8,137	7.8%	▲
Electronic Referrals %	49.1%	48.4%	0.7%	1.4%	▲
Average Referral to First Contact	44	75	-31	-41.2%	▼

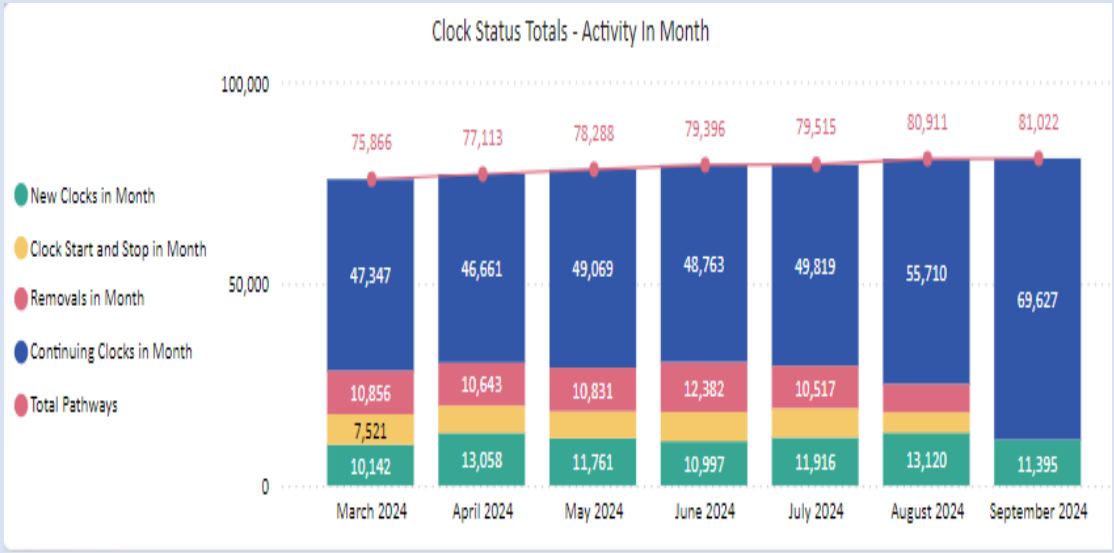
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Insourcing capacity being secured in key specialties to augment sovereign capacity extension.
- Increase outpatient first attendance activity within existing capacity and enhance outpatient procedure rates and recording. Reallocate follow up outpatient activity without a procedure.
- Increased productivity as per financial recovery plan (1 additional case per list).

5. Deep Dive RTT Insights - HUTH 2

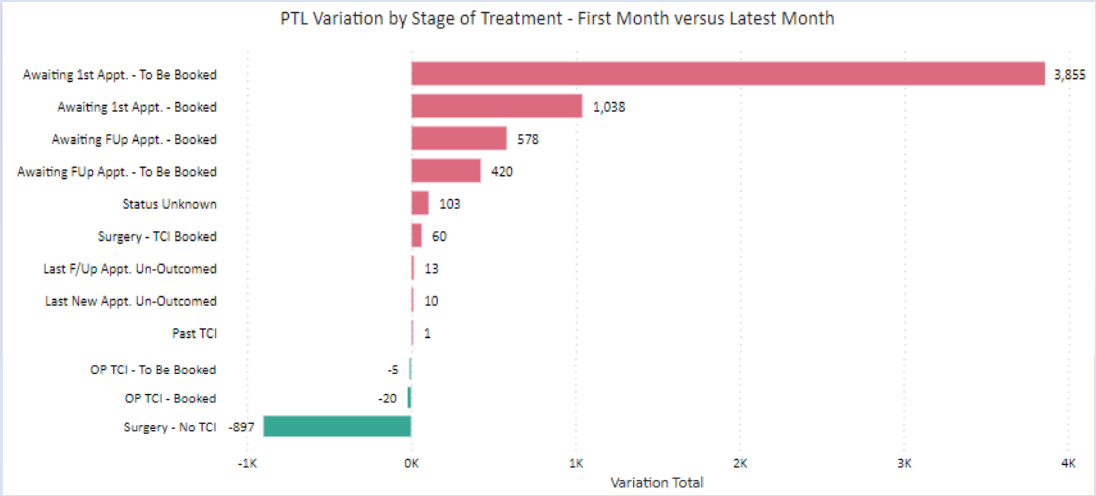
Compliance



Key Themes

- RTT Insights clock stops/starts monthly trend shows
  - Decrease in clock stops in July and August which is a historic trend due to theatre timetable reduction and annual leave
  - Increase in clock starts in August

Critical Enabler



Key Themes

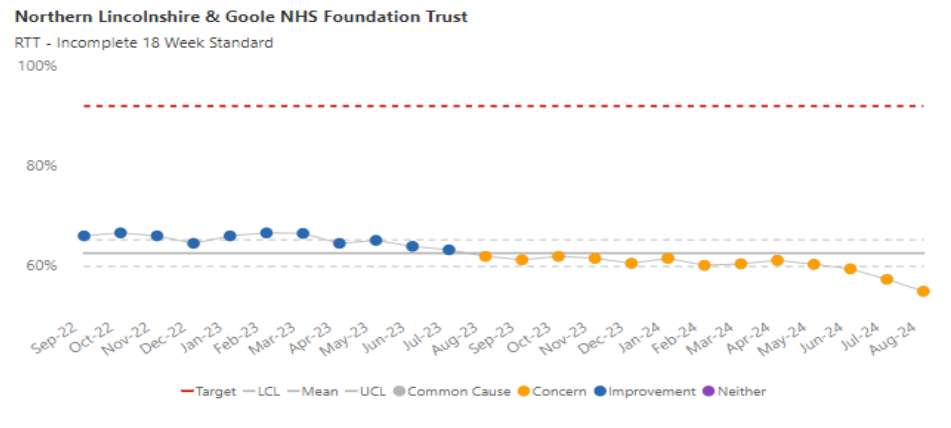
- The chart shows the variation in the PTL by stage of treatment. The issue highlighted is the growth at the front door in patients waiting first outpatient appointment
- The only major reduction in the PTL has been patients have been dated for surgery.

Actions

- Increase in first outpatient capacity is a key critical action that needs to be progressed alongside reduction in unnecessary follow ups and those without a procedure.

6. Referral to Treatment - NLAG

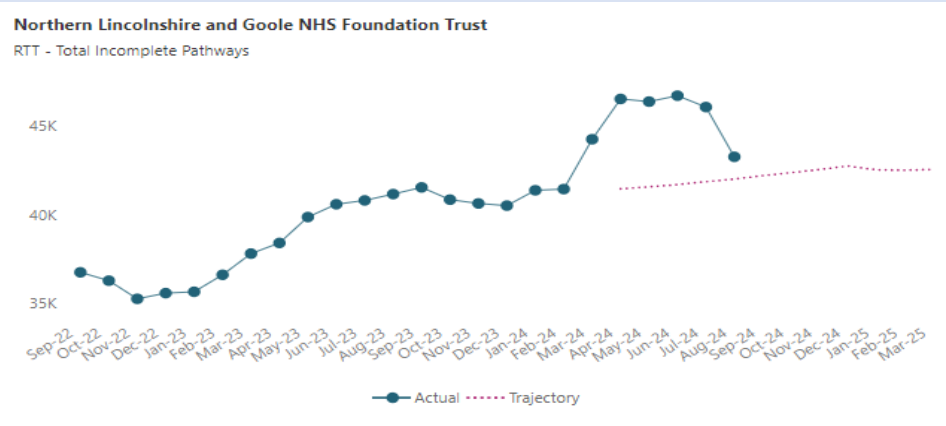
Compliance



Key Themes

- August performance of 54.9% deteriorated 2% on previous months.
- RTT waiting list volume is above trajectory at 43,280. This is a significant on the previous month and evidences the data quality / validation work that has been undertaken since May.
- Detailed review of all outstanding pathway events requiring admin transaction is ongoing.
- New referrals awaiting triage / acceptance not included in RTT count (NLAG historical issue) – work ongoing to resolve but this will increase the list size. Regional engagement to confirm reporting inclusion being concluded.

Critical Enabler



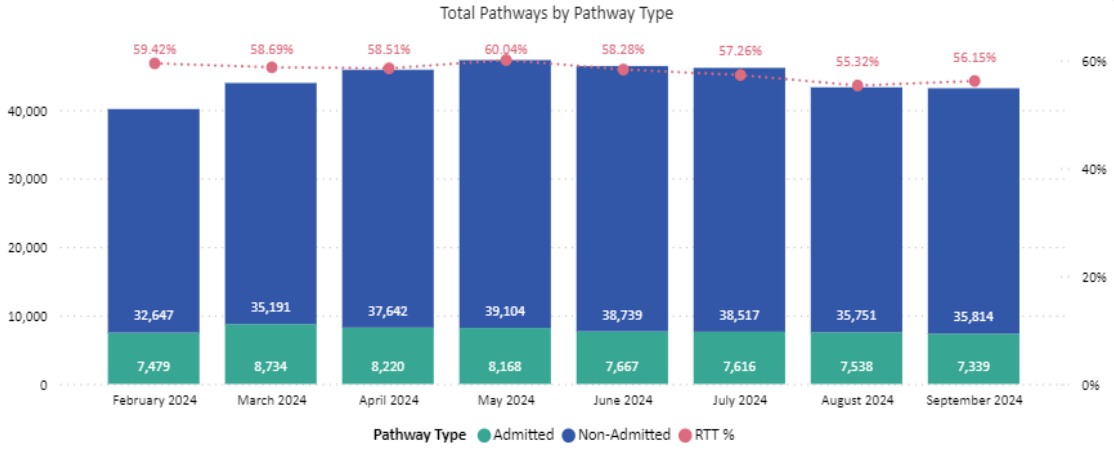
Actions

Critical actions being progressed through RTT Delivery Group

- Waiting list volume is the key focus to bring back under trajectory
- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Care Groups to identify additional activity over and above the 24/25 operational plan to achieve additional Elective Recovery Funds
- Remedial action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume which have stabilised growth. Recruitment to 10 x validators underway and interim admin resourcing sourced via HUTH RTT team, medical records, etc.
- RTT Insights Model now deployed to NLAG which will greatly assist operational teams in management oversight and scrutiny of their PTL and training roll out began at the beginning of August.

7. Deep Dive RTT Insights - NLAG 1

Compliance



Key Themes

- +7.9 growth in RTT waiting list volume from February to August 2024 (pre- and post Lorenzo go-live)
- However, significant improvement since the peak in May driven by the validation work and reduction in data quality errors. Post DQ correction the PTL growth is expected to decrease to ~2%.
- Decrease in RTT Incomplete Performance by 4% meaning that more patients are waiting over 18 weeks.
- No increase overall in Referrals, however, large shift from GP routine referrals to urgent referrals which displaces longer waiting routine patients.

Critical Enabler

Referrals Scorecard (right click metric name to drill through to detailed summary)

Measure	Chosen Period	Comparison Period	Variance (#)	Variance (%)	
Referrals	223,895	225,043	-1,148	-0.5%	▼
Routine GP Referrals	44,413	53,112	-8,699	-16.4%	▼
Urgent GP Referrals	12,791	10,214	2,577	25.2%	▲
2WW GP Referrals	15,628	16,063	-435	-2.7%	▼
Consultant Referrals	34,321	40,027	-5,706	-14.3%	▼
ED Referrals	65,188	70,110	-4,922	-7.0%	▼
Other Referrals	51,554	35,517	16,037	45.2%	▲

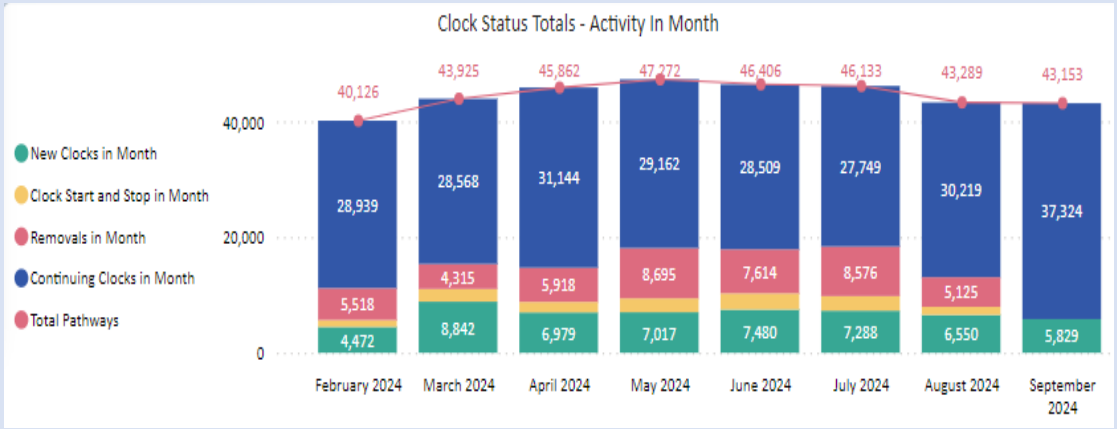
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Insourcing capacity being secured in key specialties to augment sovereign capacity extension.
- Increase outpatient first attendance activity within existing capacity and enhance outpatient procedure rates and recording. Reallocate follow up outpatient activity without a procedure.
- Increased productivity as per financial recovery plan (1 additional case per list).

8. Deep Dive RTT Insights - NLAG 2

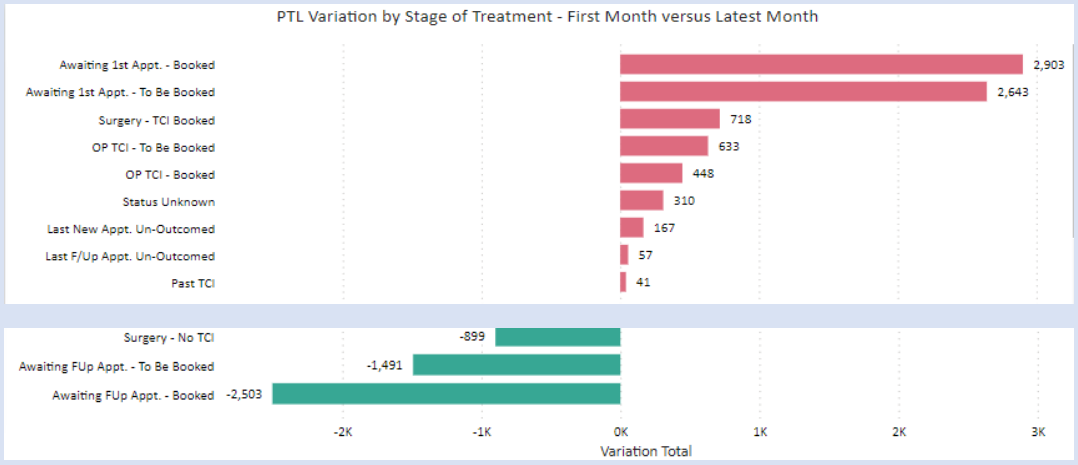
Compliance



Key Themes

- RTT Insights clock stops/starts monthly trend shows
  - Increase in clock stops in May, June and July which evidences the validation work undertaken on the PTL
  - No significant increase in new clock starts over the last 7 months

Critical Enabler



Key Themes

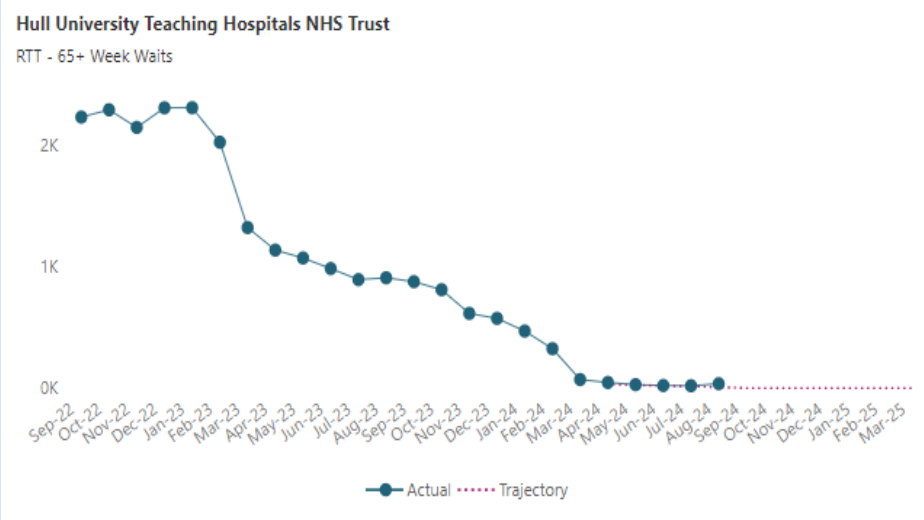
- The chart shows the variation in the PTL by stage of treatment. The issue highlighted is the growth at the front door in patients waiting first outpatient appointment
- Reduction in follow ups booked and unbooked linked to data validation.

Actions

- Increase in first outpatient capacity is a key critical action that needs to be progressed alongside reduction in unnecessary follow ups and those without a procedure.

9. Referral to Treatment – 65w Waits - HUTH

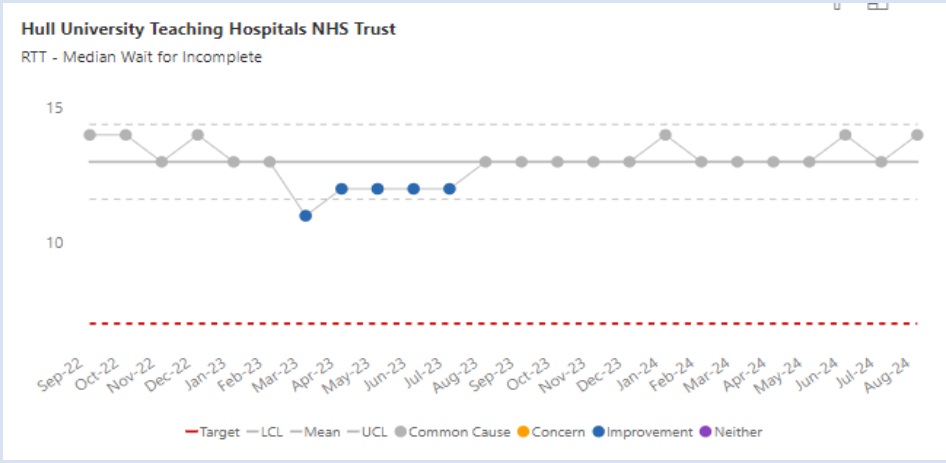
Compliance



Key Themes

- Off plan to deliver elimination of 65 week waits by Sept 2024 but plans in place to mitigate the number reported.
- 35 patients exceeding 65 weeks reported at the end of August which is an increase on the previous month.
- Forecast position for end of September is 35.
- Risks identified:-
  - Paediatric ENT – additional weekend capacity is being delivered.
  - Plastic Surgery – a plan is required for gaps in provision of complex delayed breast reconstruction (DIEP requires 3 session day) is needed to prevent a number of breaches by the end of September.
  - Sub-contract agreed in September with Trent Cliffe to help to mitigate the risk in other cases in Plastic Surgery.
  - Delays in offering admission dates leading to unreasonable offers and then patient choice breaches.

Critical Enabler



Actions

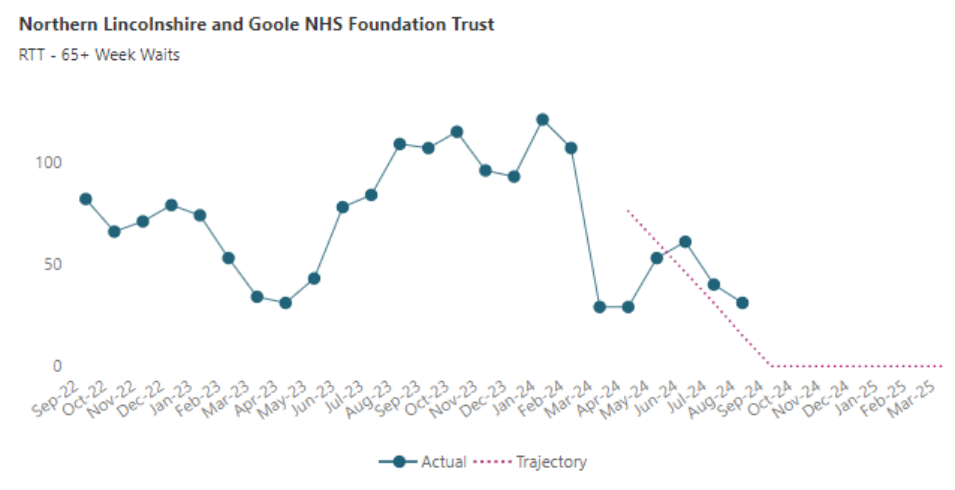
1. Elimination of >78w waits by end of June 2024 - delivered
2. Elimination >65w waits by end of September 2024
3. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Ensure all patients who will be a >65w risk for end of December have a first appointment by end of September 2024
- Continued focus at speciality level of patients dated and/or risks now focussed to eliminate the number of >65-week waits by the end of September 2024
- Delivery of 24/25 operating plan activity extension plans.
- Additional weekend waiting list initiatives to create capacity in Plastic surgery, Breast Surgery and ENT.
- Current growth in 52 week backlog will impact on the March 2025 forecast position against the March 2024 baseline.

10. Referral to Treatment – 65w Waits - NLAG

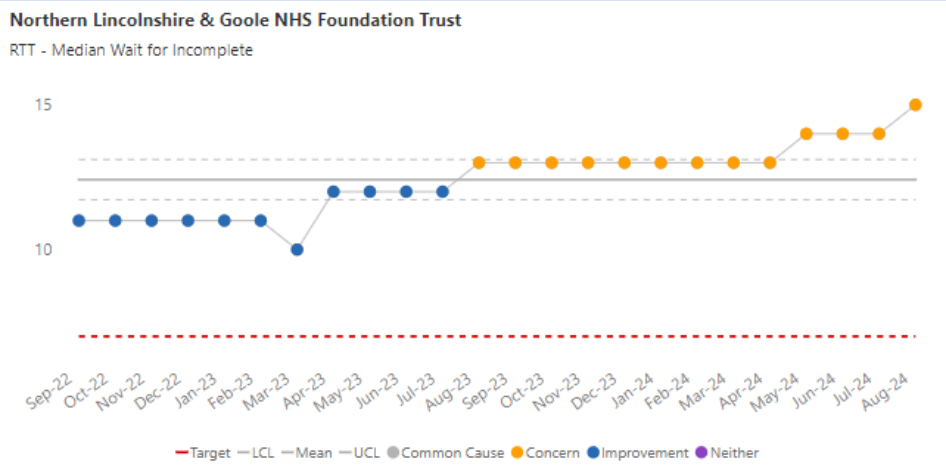
Compliance



Key Themes

- Reduction in 65w waits at the end of August with 31 breaches – main issues:-
  - 7 x Gynaecology
  - 6 x Paediatrics
  - 6 x Community Dentistry
  - 4 x T&O
  - 8 x Other
- Deterioration in median waits from 10 weeks to 14 weeks (national standard 7 weeks) since March 2022 – noting this will reflect the admin backlog currently inflating the PTL
- Forecast for end of September is currently 15 with patient choice being the main contributing factor.

Critical Enabler



Actions

1. Clear >78w waits by end of June 2024
2. Clear >65w waits by end of September 2024
3. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Ensure all patients who will be a >65w risk for end of December have a first appointment by end of September 2024
- Delivery of 24/25 operating plan activity extension plans.
- Ensure patients that will breach >65w by end of September to have a first seen appointment by end of June
- Community Dental capacity and 65w breach risks – mitigated with weekend theatre lists but need sustainable solution
- Earlier planning of offering admission dates to reduce unreasonable offers and then patient choice breaches, alongside revised Group Access Policy.

11. Referral to Treatment – Data Quality - HUTH

Compliance

80,910	3,659	3,747	99.46%	4.52%
Pathways on RTT PTL	Pathways with Metrics	DQ Metrics on RTT PTL	RTT PTL Confidence Level	% Pathways with Metrics on RTT PTL

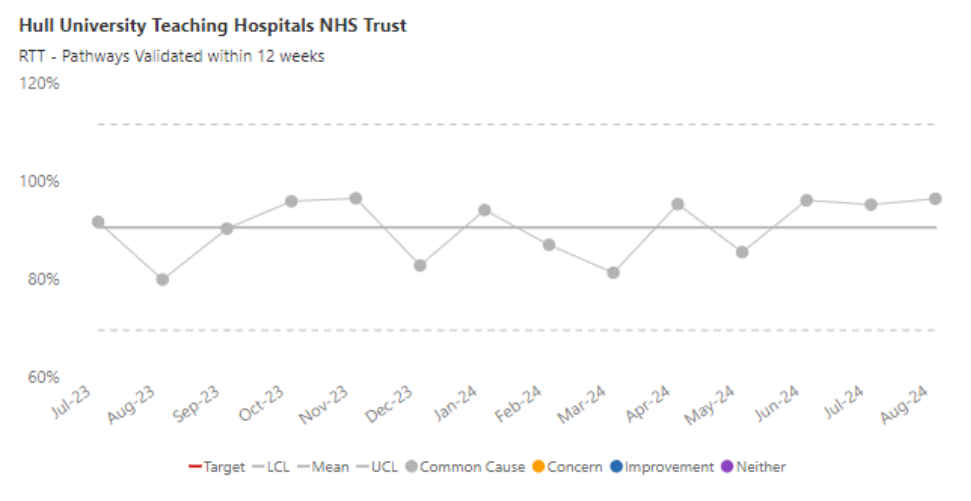
Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.46% confidence level for RTT PTL data quality.

For those pathways validated every 12 weeks performance is 96.5% which remains significantly ahead of the national 90% standard.

Critical Enabler



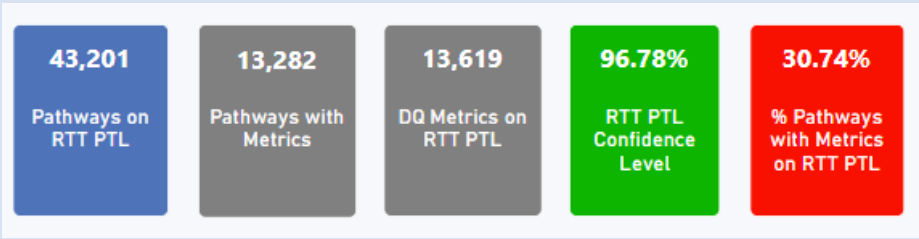
Actions

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment

12. Referral to Treatment – Data Quality - NLAG

Compliance

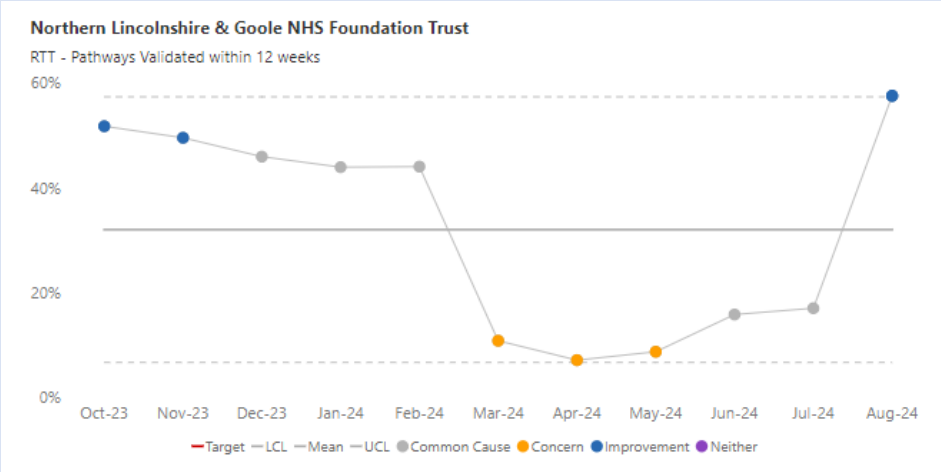


Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a reduction in the confidence rate to 96.78%.
- There has been a dramatic increase in the % of pathways with DQ metrics to 30.7% from 8.8% previously reported due to a change in the information submission which has not been flagged.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks the latest data shows and improvement to 58% compliance against the 90% standard
- This links to the admin delay in transacting pathway events post Lorenzo deployment as outlined in the RTT section of this report.

Critical Enabler

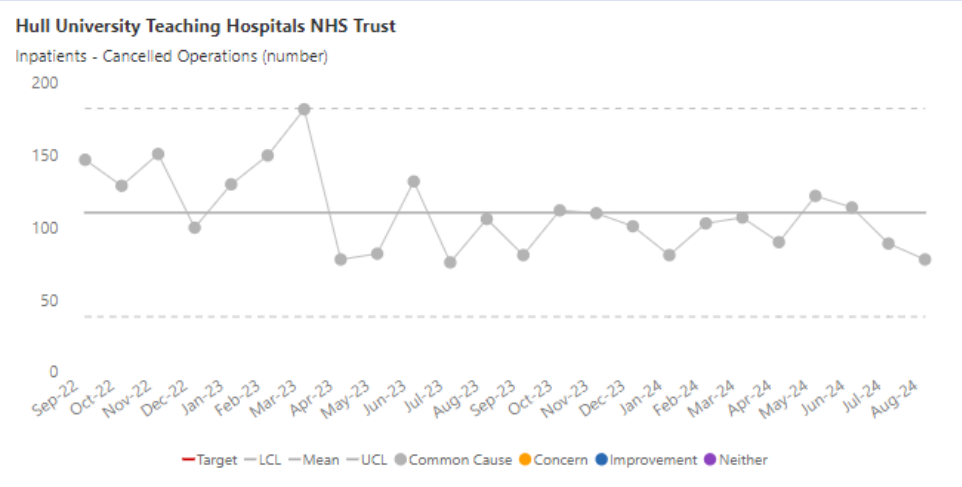


Actions

- Patient Services to reinstate text validation to patients every 12 weeks to confirm patients are still requiring appointments by end of July - completed
- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- 10 additional staff being recruited to support NLAG validation work, 8 of which are now in post.
- Focus on improving up-to-date validation / tracking comments to
- RTT Insights Dashboard training commenced 5th August 2024 to all Care Group Operational teams.

13. Cancelled Operations - HUTH

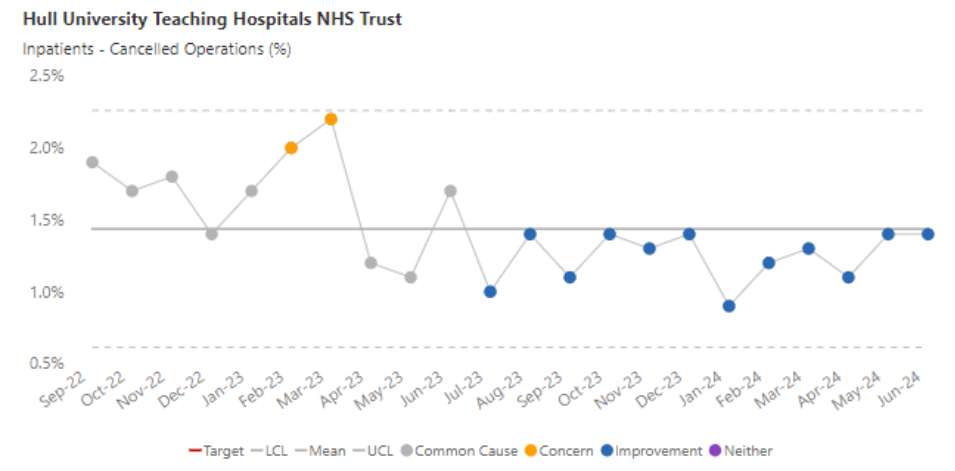
Compliance



Key Themes

- HUTH sits at 1.4% of operations cancelled on the day for non-clinical reasons against a performance tolerance of 0.65% - this is reported quarterly.
- In August there were 78 cancelled operations on the day for non-clinical reasons.
- The largest reasons are –
  - No Bed – 23
  - Theatre list overran – 19
  - No surgeon / anaesthetist - 16
  - Emergency case needing theatre – 14
- The main specialties for cancellations on the day are –
  - Interventional Radiology – 15
  - Vascular Surgery - 10

Critical Enabler

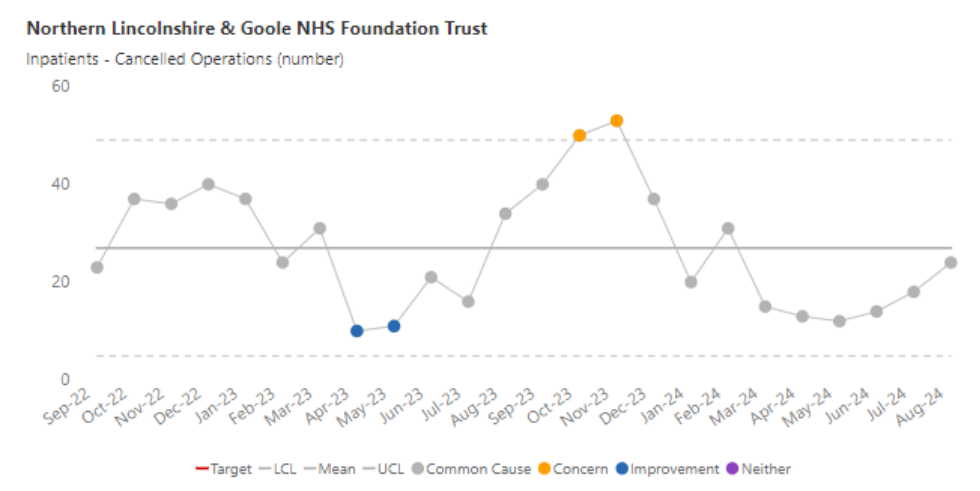


Actions

- Group level Cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28 day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus at operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 day pre-op to commence in Orthopaedics and ENT.
- 85% Capped utilisation report and actions going out to all Care Groups from 17th June.
- Progress GIRFT actions for High Volume Low Complexity activity.

14. Cancelled Operations - NLAG

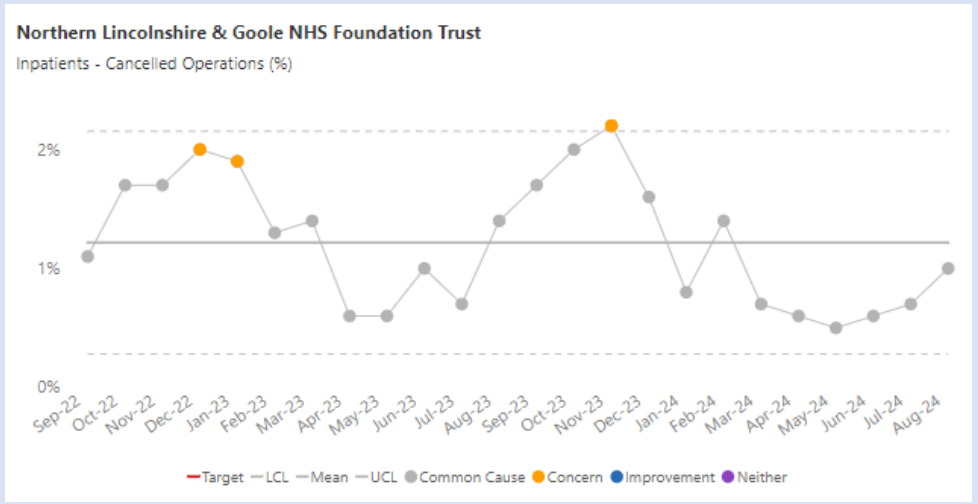
Compliance



Key Themes

- NLAG reports 1% of cancellations to FFCEs - just above the 0.65% standard.
- In August there were 24 elective cancellations on the day for non-clinical reasons
  - 13 due to theatre list over-runs
  - 7 equipment failure
  - 4 Other
- 98% of theatre sessions in August had late starts, however, overall late starts >10 minutes has been reduced.

Critical Enabler

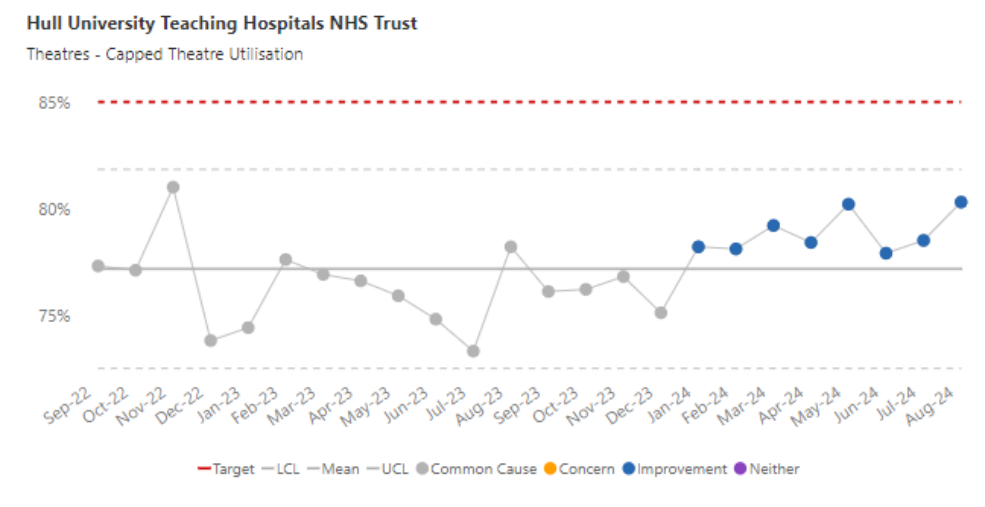


Actions

- Enhanced BIU support to report national data set and eliminate DQ issues.
- Additional daily scrutiny and feed back to specialities regarding capped utilisation and the additional minor patient to be added to all lists not delivering 85% utilisation.
- HUB commenced at GDH 10th June 2024, to support LoS and GIRFT standards improvement.
- Working with NHSE/GIRFT on improvement recommendations
- Reviewing all opportunities to sweat current assets.
- Cancelled operations Standard Operating Procedure (SOP) has been reissued at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Standing down or lifting sessions SOP completed and deployed.

15. Capped Theatre Utilisation - HUTH

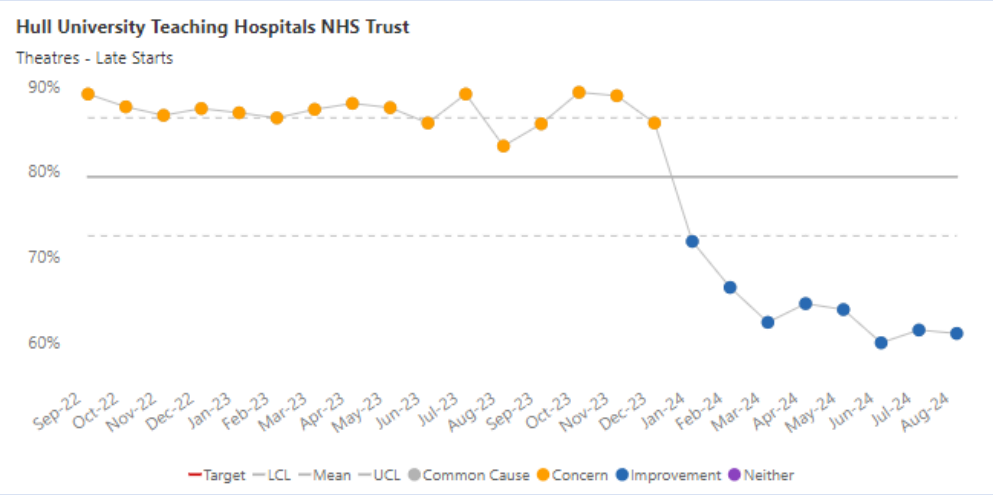
Compliance



Key Themes

- Improvement in capped theatre utilisation with latest Model Hospital data showing performance at 83% placing the Trust in the highest quartile nationally.
- Internal reporting at 80.3% for capped theatre utilisation for August.
- Day Case capped theatre utilisation has improved to 82.5% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- HUTH specifically commended on delivery of capped utilisation improvement by Professor Tim Briggs, Chair of GIRFT and NHSE National Director for Clinical Improvement & Elective Recovery.
- Improvement in late starts down to 61% (methodology 0 minutes = late start)

Critical Enabler

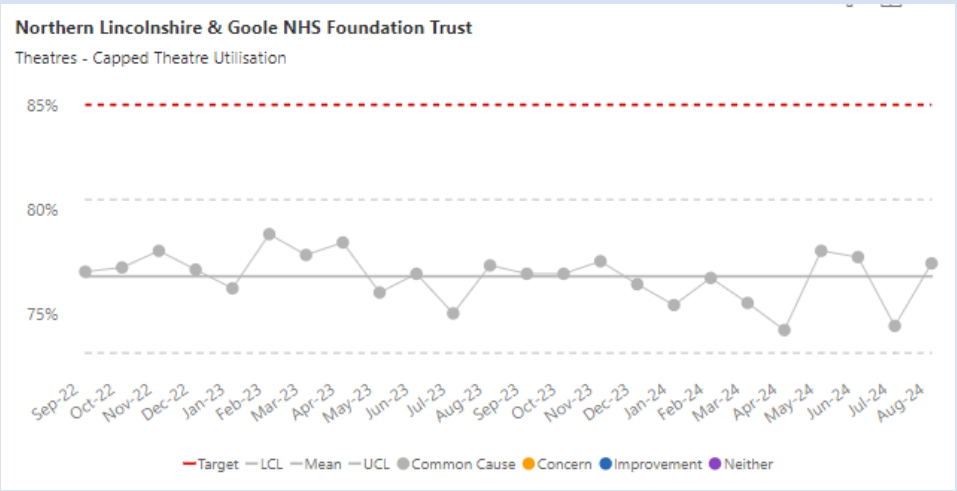


Actions

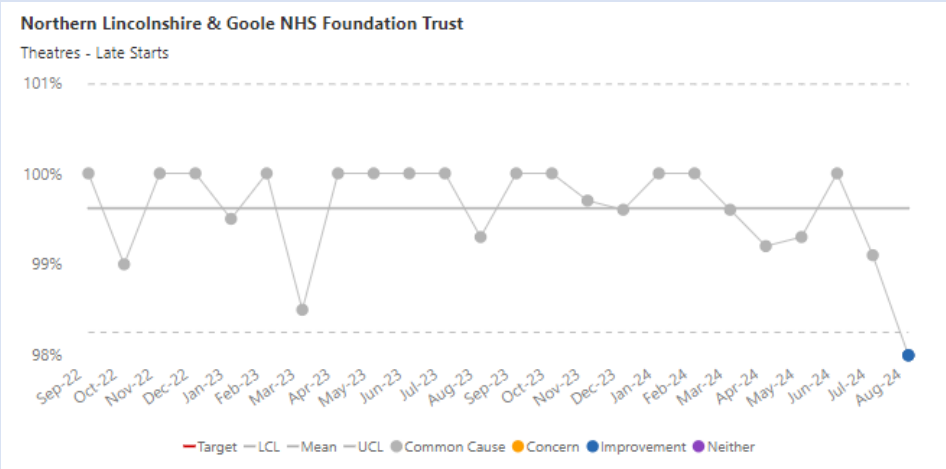
- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Theatres Insights Model being implemented – testing completed and training roll out due to commence end of September.
- Improve recording of day case touch points in ORMIS
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

16. Capped Theatre Utilisation - NLAG

Compliance



Critical Enabler



Actions

- CAP working group established with Theatre and Analytical leads to apply learning from HUTH analysts on improvement work undertaken on data quality issues with the fortnightly submissions to Model Health and the methodologies applied.
- BI reporting being reviewed due to issues with how the theatre sessions are recorded on WebV, currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

17. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Audiology	Jul 24	5.00%	2.3%			75
Barium Enema	Jul 24	5.00%	0.0%			100
Colonoscopy	Jul 24	5.00%	**49.4%**			10
Computed Tomography	Jul 24	5.00%	**9.8%**			28
Cystoscopy	Jul 24	5.00%	**26.4%**			37
DEXA Scan	Jul 24	5.00%	**64.5%**			0
DM01 Waiting <13 Weeks	Jul 24	100.00%	**93.1%**			33
Diagnostic activity levels - Audiology Assessments	Jul 24	-	507			53
Diagnostic activity levels - Barium Enema	Jul 24	-	58			83
Diagnostic activity levels - CT	Jul 24	-	6,204			69
Diagnostic activity levels - Colonoscopy	Jul 24	-	155			28
Diagnostic activity levels - Cystoscopy	Jul 24	-	341			79
Diagnostic activity levels - Dexa Scan	Jul 24	-	586			86
Diagnostic activity levels - Echocardiography	Jul 24	-	739			41
Diagnostic activity levels - Endoscopy	Jul 24	-	931			45
Diagnostic activity levels - Flexi Sigmoidoscopy	Jul 24	-	97			51
Diagnostic activity levels - Gastroscopy	Jul 24	-	338			45
Diagnostic activity levels - Imaging	Jul 24	-	14,916			65
Diagnostic activity levels - Non Obstetric Ultrasound	Jul 24	-	5,038			62
Diagnostic activity levels - Total	Jul 24	-	17,646			62
Diagnostic activity levels - Urodynamics	Jul 24	-	49			71
Diagnostics - 6 Week Standard	Jul 24	5.00%	**24.2%**			32
Diagnostics - 6 Week Standard Reversed	Jul 24	95.00%	**75.8%**			32
Echocardiography	Jul 24	5.00%	**49.9%**			15
Electrophysiology	Jul 24	5.00%	-			-
Gastroscopy	Jul 24	5.00%	**31.6%**			23
Magnetic Resonance Imaging	Jul 24	5.00%	1.4%			77
Neurophysiology	Jul 24	5.00%	**20.8%**			38
Non-obstetric Ultrasound	Jul 24	5.00%	**12.6%**			36
Urodynamics	Jul 24	5.00%	**61.8%**			22

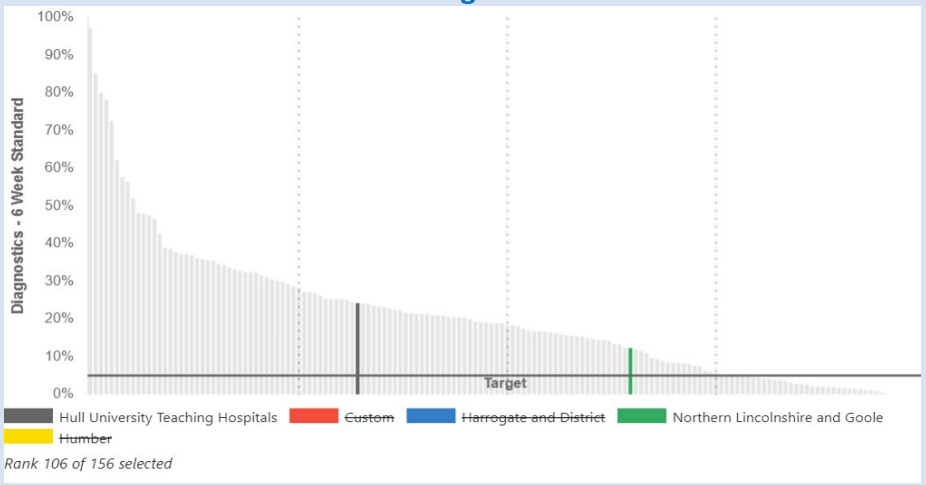
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Audiology	Jul 24	5.00%	**46.9%**			28
Barium Enema	Jul 24	5.00%	0.0%			100
Colonoscopy	Jul 24	5.00%	**11.2%**			53
Computed Tomography	Jul 24	5.00%	**5.4%**			37
Cystoscopy	Jul 24	5.00%	**15.8%**			52
DEXA Scan	Jul 24	5.00%	0.7%			54
DM01 Waiting <13 Weeks	Jul 24	100.00%	**98.0%**			59
Diagnostic activity levels - Audiology Assessments	Jul 24	-	0			17
Diagnostic activity levels - Barium Enema	Jul 24	-	147			98
Diagnostic activity levels - CT	Jul 24	-	11,459			96
Diagnostic activity levels - Colonoscopy	Jul 24	-	528			73
Diagnostic activity levels - Cystoscopy	Jul 24	-	575			96
Diagnostic activity levels - Dexa Scan	Jul 24	-	254			44
Diagnostic activity levels - Echocardiography	Jul 24	-	983			53
Diagnostic activity levels - Endoscopy	Jul 24	-	2,109			92
Diagnostic activity levels - Flexi Sigmoidoscopy	Jul 24	-	265			95
Diagnostic activity levels - Gastroscopy	Jul 24	-	741			86
Diagnostic activity levels - Imaging	Jul 24	-	20,530			88
Diagnostic activity levels - Non Obstetric Ultrasound	Jul 24	-	3,576			42
Diagnostic activity levels - Total	Jul 24	-	24,068			85
Diagnostic activity levels - Urodynamics	Jul 24	-	143			92
Diagnostics - 6 Week Standard	Jul 24	5.00%	**12.3%**			65
Diagnostics - 6 Week Standard Reversed	Jul 24	95.00%	**87.7%**			65
Echocardiography	Jul 24	5.00%	**19.4%**			46
Gastroscopy	Jul 24	5.00%	**6.7%**			59
Magnetic Resonance Imaging	Jul 24	5.00%	**6.2%**			60
Neurophysiology	Jul 24	5.00%	**34.6%**			32
Non-obstetric Ultrasound	Jul 24	5.00%	3.8%			55
Urodynamics	Jul 24	5.00%	**11.9%**			69

18. 14. Pathway Benchmarking & Trend – Diagnostics

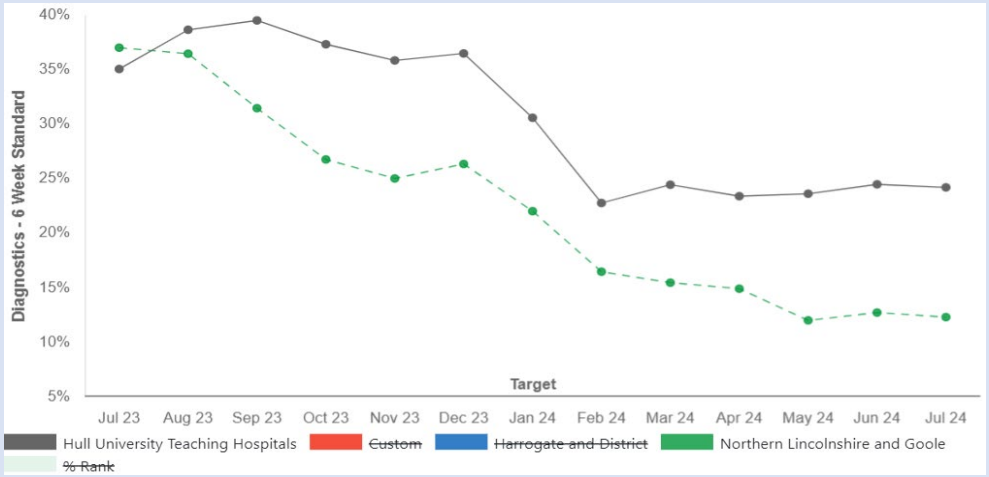
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

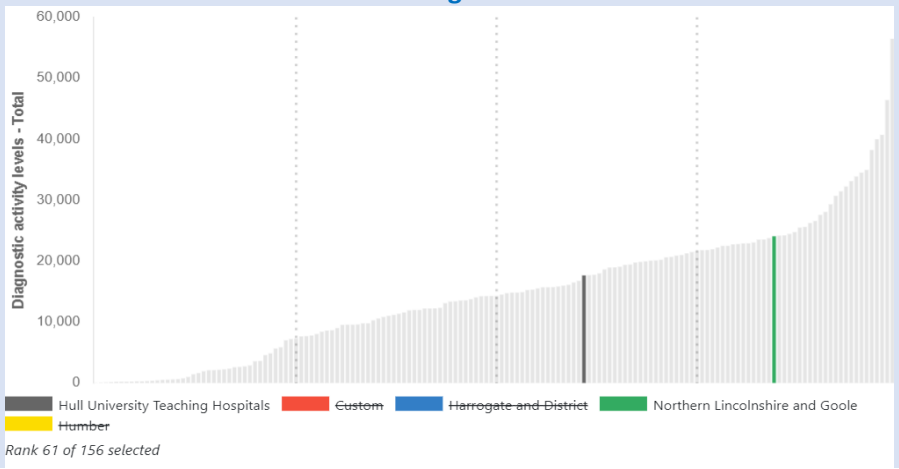


Trend Chart

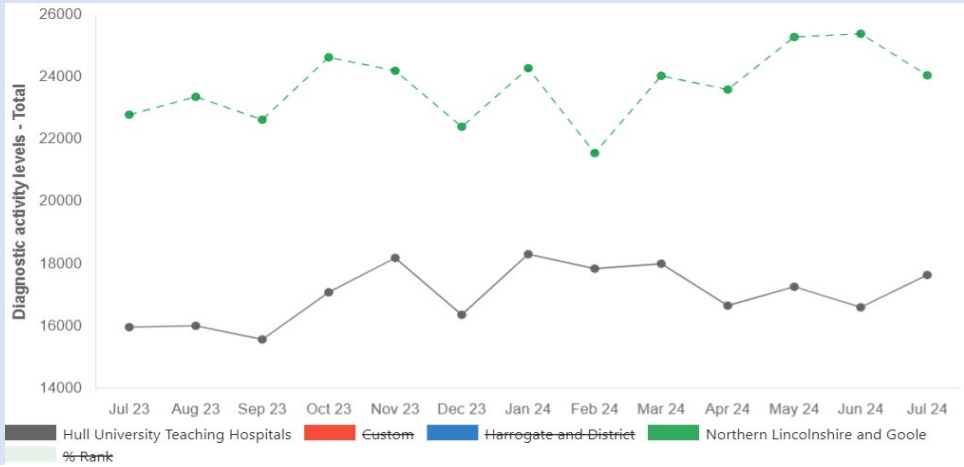


Diagnostics – Activity

Ranking Chart

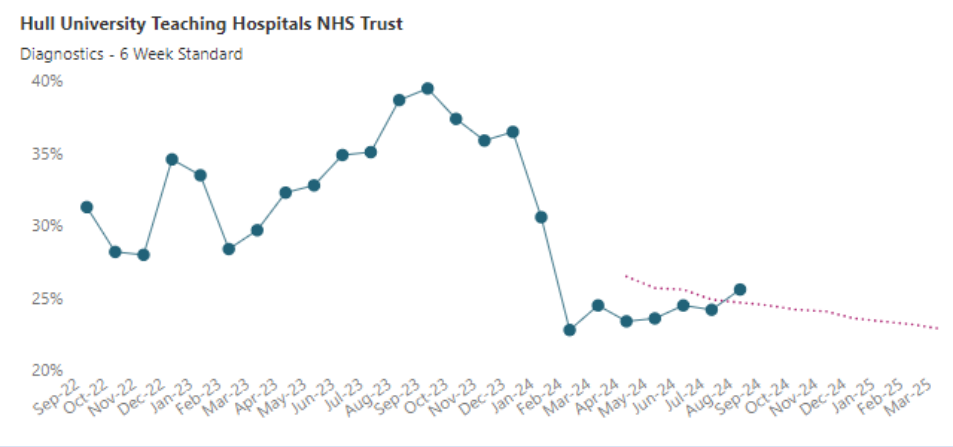


Trend Chart



19. Diagnostic 6 Week Standard - HUTH

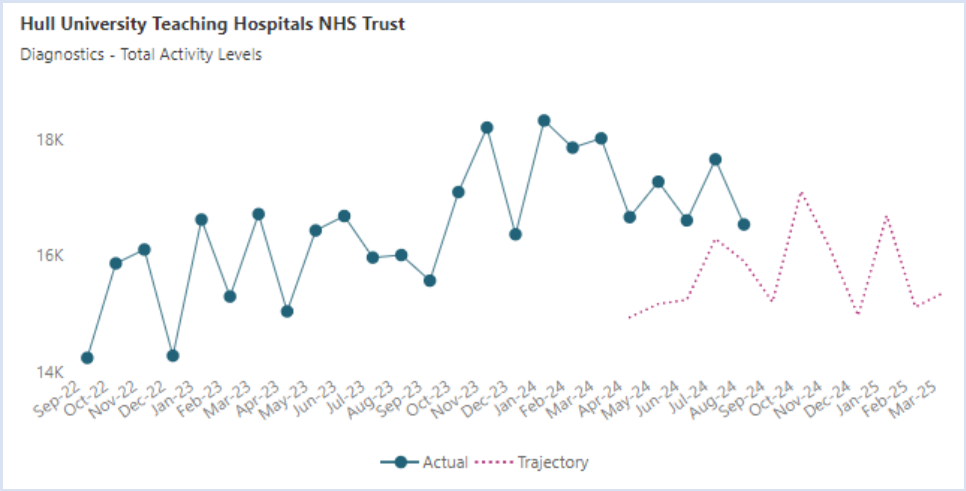
Compliance



Key Themes

- Decline in performance in August to 25.6%, being a deterioration of 1.3%). This places the Trust behind the plan trajectory.
- The most notable decrease in performance in Echocardiography (68.3%) and Flexible Sigmoidoscopy (33.3%) despite little change in waiting list volume in either modality.
- Most modalities at HUTH increased activity levels over 23/24 and into 24/25. Whilst ahead of delivery trajectory, aggregate diagnostic compliance has remained fairly static in recent months.
- Modality level compliance is varied at HUTH versus NLAG, driving a need to equalise waits within the Group.

Critical Enabler

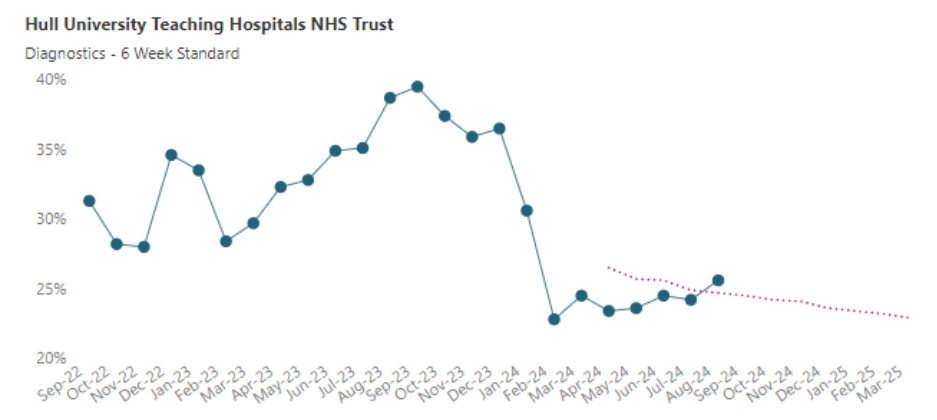


Actions

- Critical actions in place:
  - Services have developed improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
  - Dedicated investment case approved to address DEXA waiting list backlog via increased throughput and testing volume capacity.

20. Diagnostic 6 Week Standard - NLAG

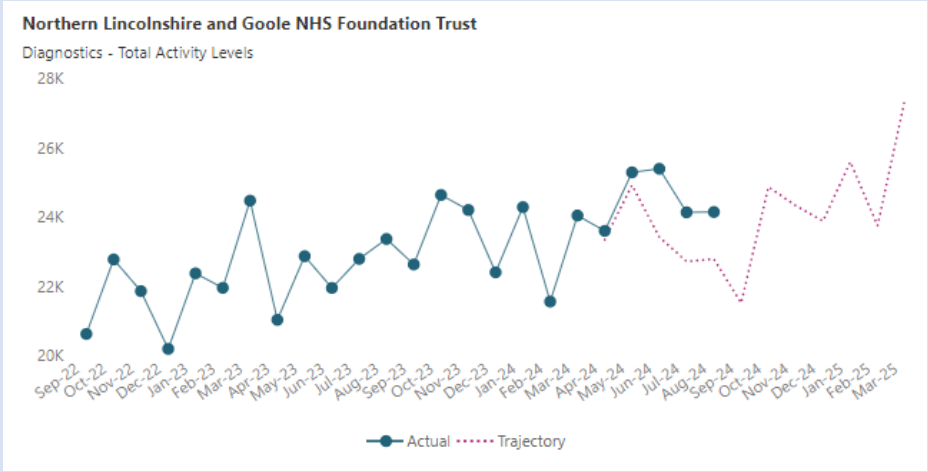
Compliance



Key Themes

- Decrease in performance in August to 18.4% (-6.1%), mainly driven by 4 modalities
  - Audiology, Echocardiography, Neurophysiology and NOUS
  - No signification growth in waiting list in any modality
- Aggregate (all modality) compliance continues to improve through the increased activity levels in imaging.
- Imaging activity recording varies at both Trusts. NLAG reports based on body parts scanned, rather than overall scan volume, which leads to NLAG having higher reported activity levels than HUTH. Both practices technically align to national guidance.

Critical Enabler



Actions

- Operating Plan commitments significantly extend diagnostic activity levels in 24/25.
- Further activity stretch plans have been developed to create additional diagnostic activity levels above the annual plan and utilise mutual aid opportunities across the Group. Where associated investment plans have been approved operational teams are commencing implementation either through use of WLIs, locums, substantive appointments or Independent Sector.
- To mitigate capacity shortfalls relating to staffing in Neurophysiology on the South Bank enhanced workforce arrangements have been deployed to reduce backlog.
- Ultrasound increasing capacity with use of IS. CDC comes on line in November which will also improve the position.

21. Pathway Summary – Benchmark Report – Cancer Waiting Times

Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Jul 24	93.00%	78.9%			41
Cancer 2 Week Wait Breast Symptomatic	Jul 24	93.0%	34.5%			17
Cancer 28 Day Faster Diagnosis	Jul 24	75.0%	73.9%			24
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	Jul 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Brain Tumours	Jul 24	75.0%	80.0%			40
Cancer 28 Day Faster Diagnosis - Breast Cancer	Jul 24	75.0%	87.2%			25
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Jul 24	75.0%	69.2%			6
Cancer 28 Day Faster Diagnosis - Children's Cancer	Jul 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Jul 24	75.0%	51.7%			17
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Jul 24	75.0%	20.0%			9
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Jul 24	75.0%	88.2%			88
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Jul 24	75.0%	39.7%			5
Cancer 28 Day Faster Diagnosis - Lung Cancer	Jul 24	75.0%	79.1%			50
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Jul 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Jul 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Skin Cancer	Jul 24	75.0%	94.7%			79
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Jul 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Jul 24	75.0%	92.2%			95
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Jul 24	75.0%	61.5%			58
Cancer 31 Day All Stages	Jul 24	96.0%	75.0%			0
Cancer 31 Day First Treatment	Jul 24	96.00%	80.9%			2
Cancer 31 Day Subsequent Treatment	Jun 24	96.0%	75.8%			7
Cancer 31 Day Subsequent Treatment - Drugs	Jul 24	96.0%	93.6%			3
Cancer 31 Day Subsequent Treatment - Radiotherapy	Jul 24	96.0%	53.6%			0
Cancer 62 Day All Routes	Jul 24	85.00%	49.7%			4
Cancer 62 Day Consultant Upgrade	Jul 24	85.0%	28.3%			0
Cancer 62 Day Screening	Jul 24	90.0%	42.1%			11
Cancer 62 Day Urgent Suspected	Jul 24	85.00%	54.9%			20
Cancer of bronchus; lung	Aug 24	1.00	1.12			34

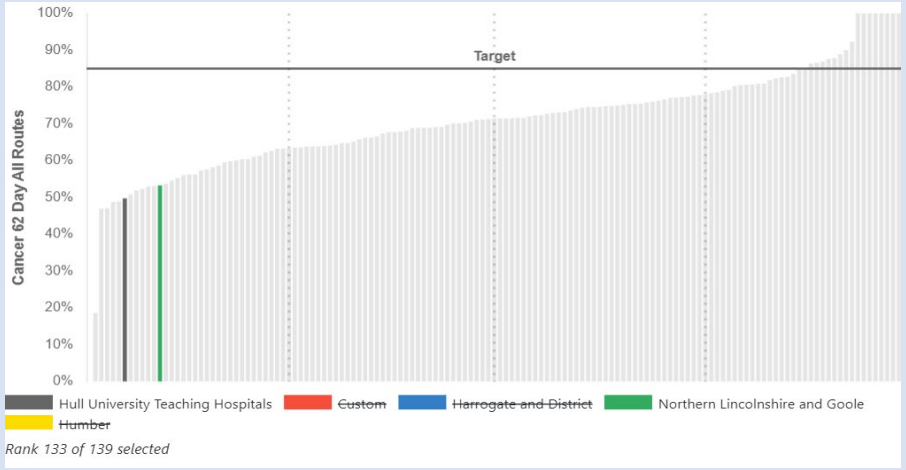
Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Jul 24	93.00%	96.2%			92
Cancer 2 Week Wait Breast Symptomatic	Jul 24	93.0%	93.5%			67
Cancer 28 Day Faster Diagnosis	Jul 24	75.0%	74.8%			29
Cancer 28 Day Faster Diagnosis - Breast Cancer	Jul 24	75.0%	94.9%			63
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Jul 24	75.0%	91.9%			39
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Jul 24	75.0%	55.9%			27
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Jul 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Jul 24	75.0%	63.9%			15
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Jul 24	75.0%	67.5%			55
Cancer 28 Day Faster Diagnosis - Lung Cancer	Jul 24	75.0%	60.6%			11
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Jul 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Jul 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Sarcoma	Jul 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Jul 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Jul 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Jul 24	75.0%	86.0%			71
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Jul 24	75.0%	68.6%			72
Cancer 31 Day All Stages	Jul 24	96.0%	98.7%			81
Cancer 31 Day First Treatment	Jul 24	96.00%	98.7%			81
Cancer 31 Day Subsequent Treatment	Jun 24	96.0%	95.4%			57
Cancer 31 Day Subsequent Treatment - Drugs	Jul 24	96.0%	99.1%			37
Cancer 31 Day Subsequent Treatment - Radiotherapy	Jul 24	96.0%	-			-
Cancer 62 Day All Routes	Jul 24	85.00%	53.3%			9
Cancer 62 Day Consultant Upgrade	Jul 24	85.0%	56.0%			3
Cancer 62 Day Screening	Jul 24	90.0%	50.0%			21
Cancer 62 Day Urgent Suspected	Jul 24	85.00%	53.3%			18
Cancer of bronchus; lung	Aug 24	1.00	1.09			38

22. Pathway Benchmarking & Trending – Cancer Waiting Times

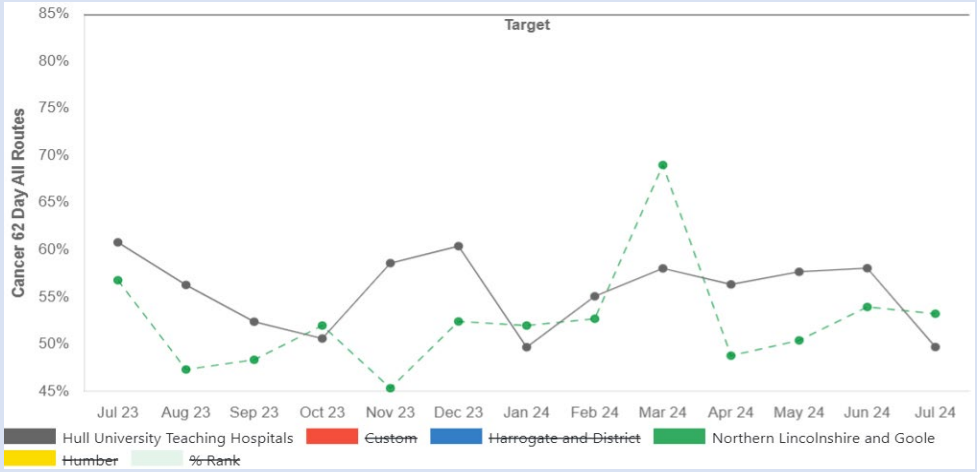
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

62 Day Performance

Ranking Chart

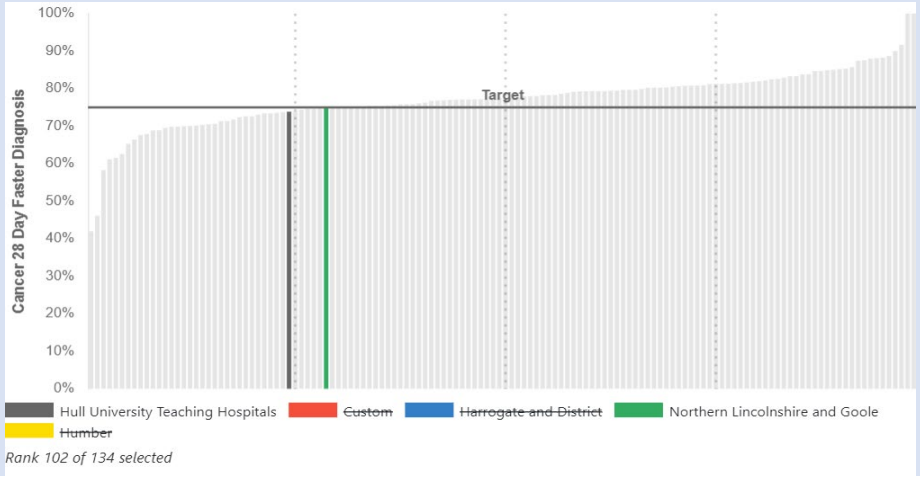


Trending Chart

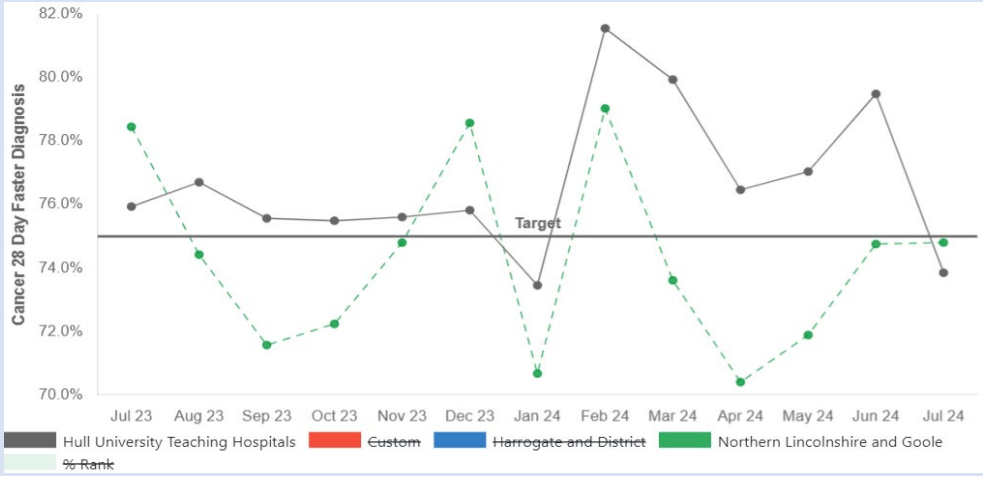


Faster Diagnosis Performance

Ranking Chart

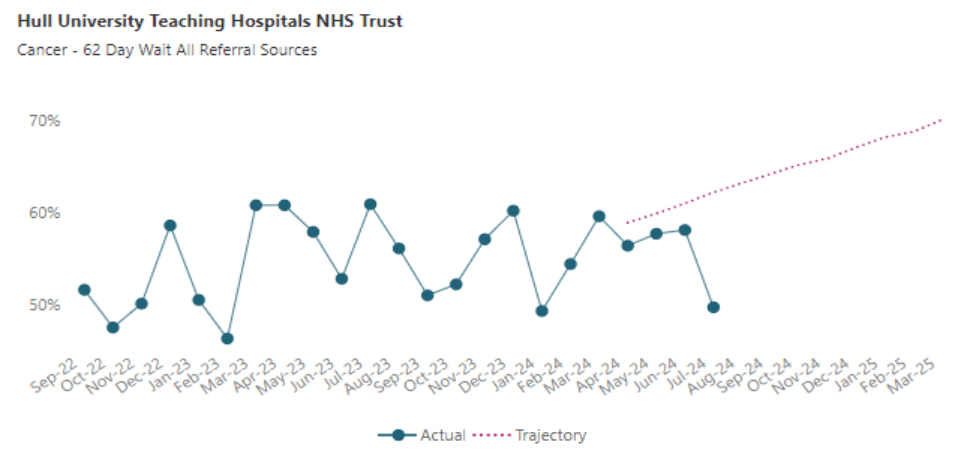


Trending Chart



23. 62 Day Cancer Performance - HUTH

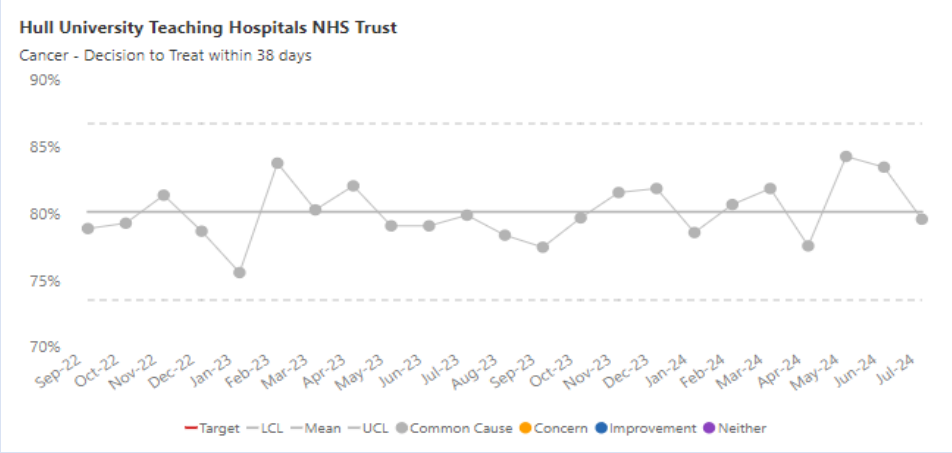
Compliance



Key Themes

- Deterioration in performance for July 2024 at 49.7% (-8%)
- Very high number of treatments in July 2024 – review of all breaches underway by operational and cancer teams
- Breast, H&N & Skin breaches due to capacity for 1st OPA which lengthened patient pathway
- Endoscopy diagnostic delivery affecting LGI 62-Day RTT
- Lung/Thoracic – need to pool patients to avoid differential waiting times
- Radiotherapy recovery plan continues (12 months from November 2023) & mutual aid from Lincoln; referrals and complexity above trajectory
- Histology TATs - SHYPS TAT Improvement Plan; poor delivery vs. national performance escalated to the SHYPS Oversight Committee (Aug 2024)
- PET CT performance issues escalated to System Tier & NHSE meetings
- Late IHTs – Lung, Gynae & Urology: focussed work within the Group
- Oncology capacity (vacancies plus increased demand) – clinical prioritisation in place for Breast & Urology
- Surgical capacity in LGI and Urology (vacancies)
- +7% increase in Cancer Referrals 23/24 vs. 22/23

Critical Enabler

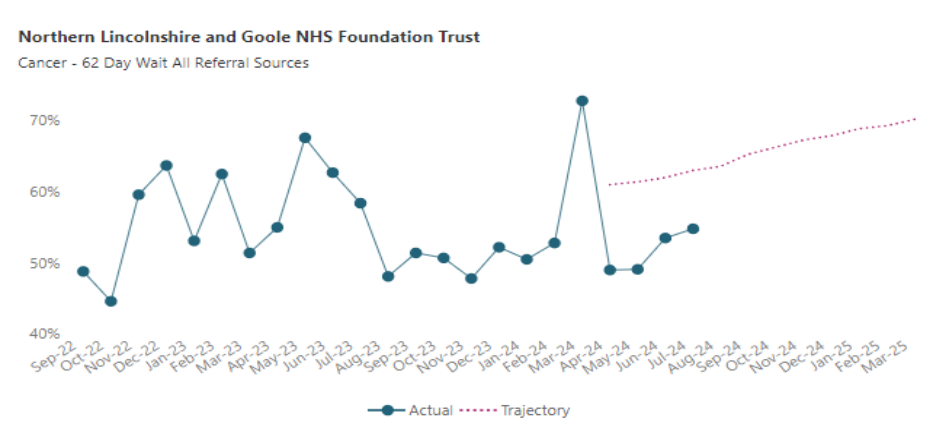


Actions

- Endoscopy recovery plan delivery
- Lung whole pathway review undertaken 28 June 2024 – Group-wide improvement plan to progress/deliver
- Gynaecology improvement group established with action plan
- Plastic Surgery & Dermatology capacity – x2-4 vacant consultant posts; focussed effort to maintain FDS and treatments
- Urology consultant vacancies – impacted by annual leave, significant delays with outpatient and surgical capacity; looking at potential mutual aid options
- HNYCA IPT SOP – embed and review across the Group
- Inter-Group review of the Urology IPTs – urology improvement group extended to cover the Group

24. 62 Day Cancer Performance - NLAG

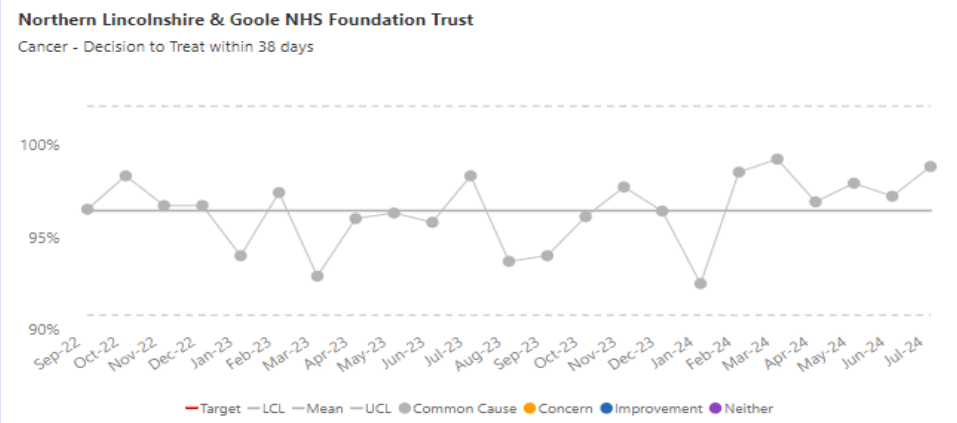
Compliance



Key Themes

- 54.8% performance for July 24, an increase on the previous month – 4th month of improvement
- Lung - capacity for OPAs, diagnostics & oncology appointments (to determine surgical vs. oncology treatment). Lung physician vacancies x 2 – in recruitment, previous difficulties and retention issues
- Urology surgical capacity (vacancy)
- H&N – pathways issues to resolve; multiple diagnostics and histology not marked 31/62
- Gynaecology – OPA and diagnostic capacity issues, plus review of tracking/pathway management underway. Additional tracking support identified; Co-ordinator vacancy filled – start date 27.8.2024
- Histology TATs - % within 10 days and overall TATs being analysed by Path Links
- IPT transfer delays continue, impact assessed at 7-10% due to breach attribution in Lung & Urology pathways; both have front end pathway delays to be addressed.

Critical Enabler

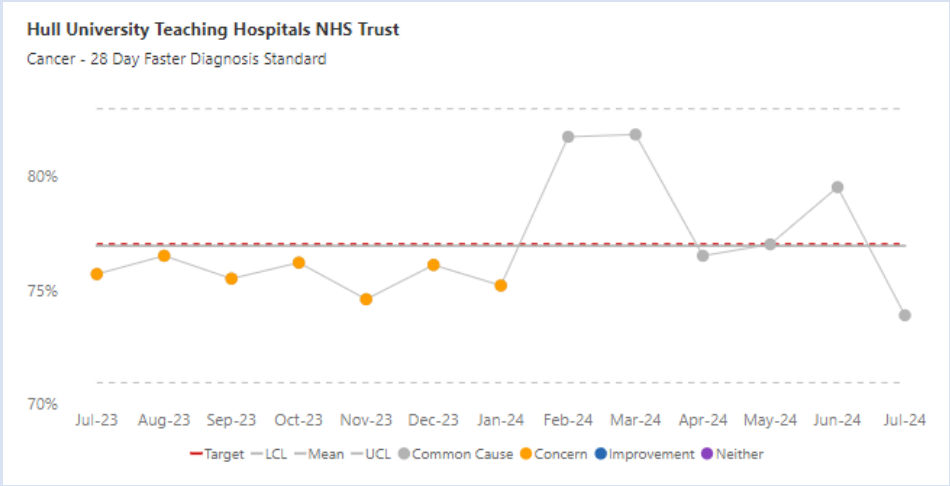


Actions

- Urology – Improvement group established to use/apply learning from HUTH pathway improvement
- Gynae – improvement plan developed at workshop during September 2024 to address delays in benign diagnosis before 28 days, OPA capacity, colposcopy & hysteroscopy capacity needs to match demand.
- Colorectal – review of NSS/STT and LGI pathways being undertaken; identification of non-cancer pathways in USC capacity
- Lung – improvement opportunities identified through workshop which need clinical agreement; vacancies and retention issues for Respiratory Physicians (locums) plus navigational bronchoscopy delays as per HUTH
- HUTH Escalation SOP being applied cross Group
- Focussed work on IHT process improvements with Lung and Urology as priority areas
- Alignment of DQ reports (following Lorenzo implementation at NLAG) across HUTH/NLAG

25. 28 Day Faster Diagnosis Standard - HUTH

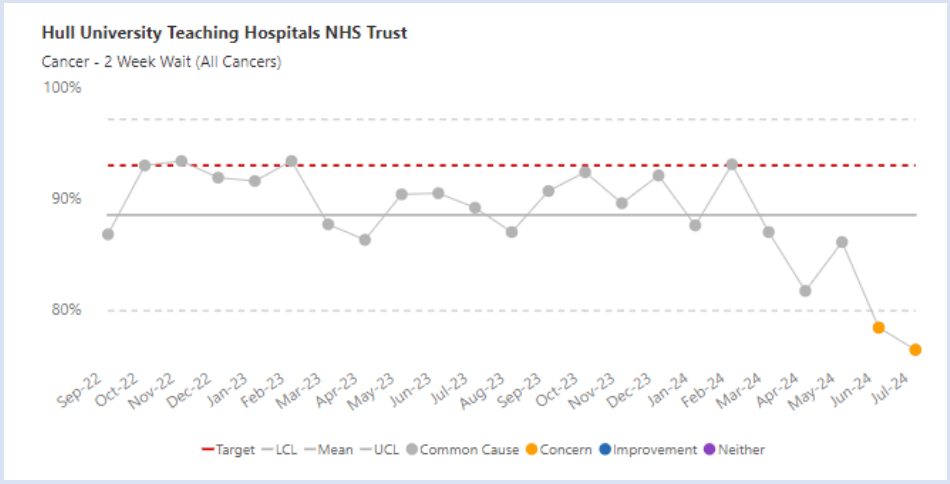
Compliance



Key Themes

- Under-delivered against the standard at 73.9% in July 2024, some improvement for August 2024 (provisional data - not shown)
- 1st OPA capacity issues in Breast, Head & Neck and Skin which affected the delivery significantly
- Brain, Haematology and Lung review of breaches at service level requested
- Bowel Screening – capacity concerns highlighted to the Triumvirate which is negating good improvement in the Urgent Suspected Cancer pathway
- Lung, Breast and Cervical screening breaches also impacting performance

Critical Enabler



Actions

Increased focus on outpatient stage of treatment

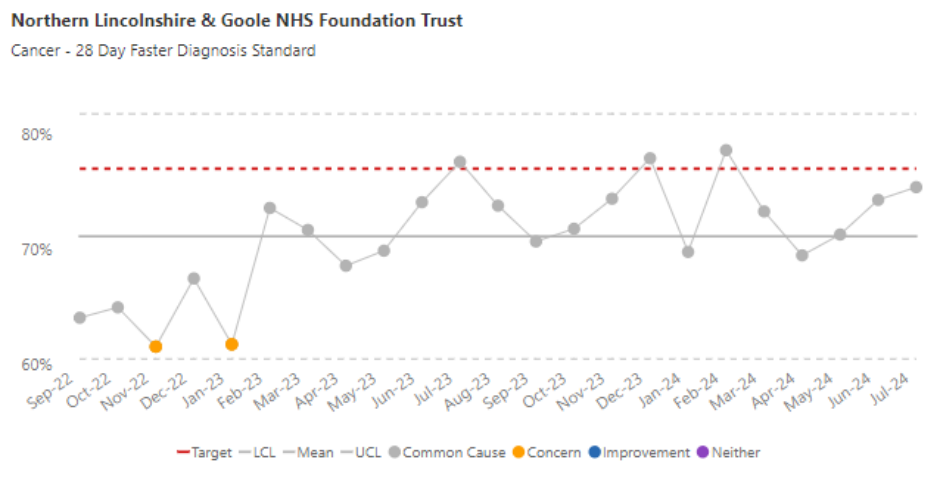
FDS Delivery Improvement plans – to sustain performance at least 80% monthly

- Focussed work for urology, LGI, gynaecology and lung to achieve the standard of 77% for USC cancer referrals
- Endoscopy recovery plan – post investment improvements required

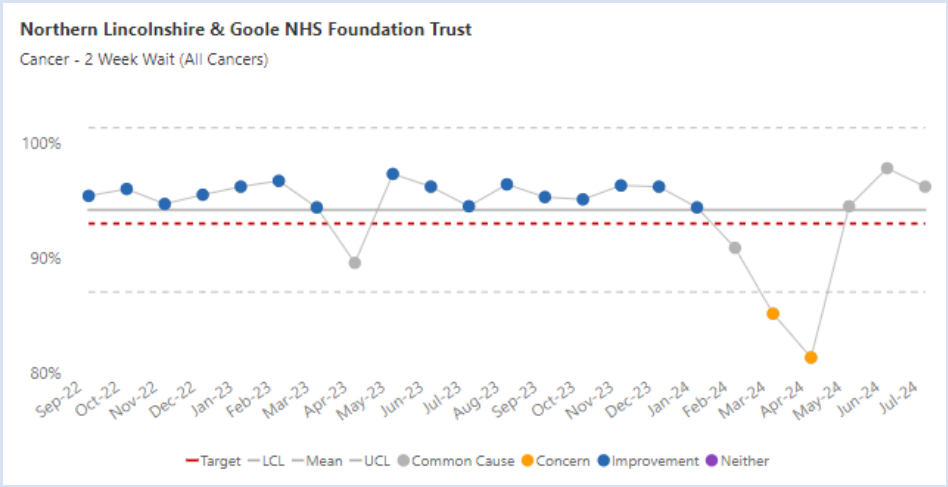
Review of screening pathway breaches to understand improvement requirements

26. 28 Day Faster Diagnosis Standard - NLAG

Compliance



Critical Enabler



Actions

FDS Delivery Improvement plans developed and signed off via the Cancer Delivery Group – priorities:

- Urology, LGI, Lung, H&N and Gynaecology USC referral to patient notified improvements to be delivered
- Bowel, Cervical and Lung screening pathway improvements to be delivered

27. Pathway Summary – Benchmark Report – Unscheduled Care

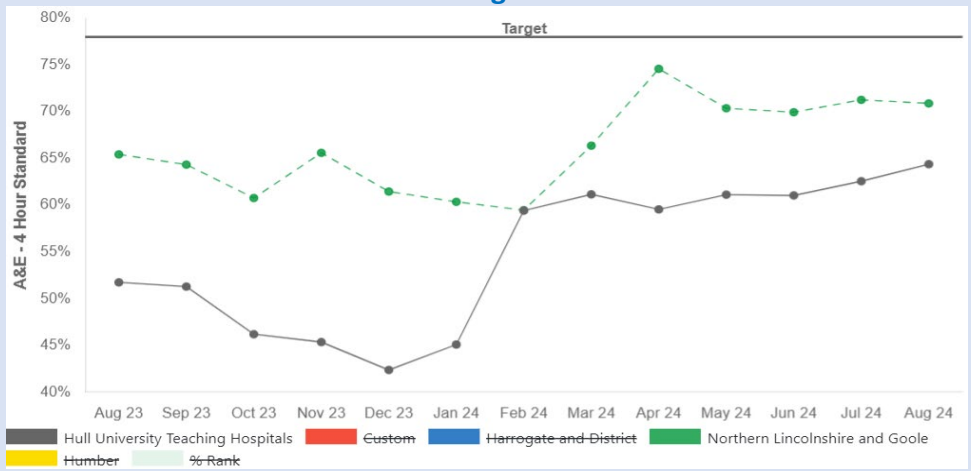
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Aug 24	78.00%	64.4%			11
A&E - 4 Hour Standard (Type 1)	Aug 24	78.0%	49.4%			8
A&E - 4 Hour Standard (Type 2 or 3)	Aug 24	95.0%	96.9%			20
A&E - Conversion Rate	Aug 24	25.0%	26.7%			17
A&E - DTA to Admission >12 Hours	Aug 24	0.0%	6.4%			38
A&E - DTA to Admission >12 Hours#	Aug 24	0.0	221.0			32
A&E - DTA to Admission >4 Hours	Aug 24	10.00%	36.4%			32
A&E - Left Without Being Seen	Jul 24	5.00%	8.3%			7
A&E - Reattendance Rate	Jul 24	5.0%	9.4%			34
A&E - Time to Initial Assessment	Jul 24	15.0	17.0			16
A&E - Time to Treatment	Jul 24	60.0	84.0			32
A&E - Total Time in A&E	Jul 24	160.0	217.0			12
A&E - Total Time in A&E (Admitted)	Jul 24	180.0	-			-
A&E - Total Time in A&E (Non-Admitted)	Jul 24	140.0	228.0			2
A&E Attendances All	Aug 24	-	13,033			52
A&E Attendances Type 1	Aug 24	-	8,912			58
A&E Attendances Type 3	Aug 24	-	4,121			58
Complaints - Emergency	Q4 21/22	-	0.6			46
Emergency Admissions Type 1	Aug 24	-	3,476			36
Emergency Admissions via A&E	Aug 24	-	3,476			35
Friends & Family A&E Score	Apr 24	85%	69.6%			9
Other Emergency Admissions	Aug 24	-	1,974			12
Total Emergency Admissions	Aug 24	-	5,450			23

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Aug 24	78.00%	70.9%			28
A&E - 4 Hour Standard (Type 1)	Aug 24	78.0%	50.6%			11
A&E - 4 Hour Standard (Type 2 or 3)	Aug 24	95.0%	99.2%			55
A&E - Conversion Rate	Aug 24	25.0%	32.9%			4
A&E - DTA to Admission >12 Hours	Aug 24	0.0%	12.9%			24
A&E - DTA to Admission >12 Hours#	Aug 24	0.0	652.0			6
A&E - DTA to Admission >4 Hours	Aug 24	10.00%	28.0%			46
A&E - Left Without Being Seen	Jul 24	5.00%	2.8%			80
A&E - Reattendance Rate	Jul 24	5.0%	10.4%			13
A&E - Time to Initial Assessment	Jul 24	15.0	23.0			7
A&E - Time to Treatment	Jul 24	60.0	54.0			71
A&E - Total Time in A&E	Jul 24	160.0	149.0			75
A&E - Total Time in A&E (Admitted)	Jul 24	180.0	283.0			60
A&E - Total Time in A&E (Non-Admitted)	Jul 24	140.0	133.0			74
A&E Attendances All	Aug 24	-	15,293			41
A&E Attendances Type 1	Aug 24	-	8,901			60
A&E Attendances Type 3	Aug 24	-	6,392			38
Complaints - Emergency	Q4 21/22	-	0.7			36
Emergency Admissions Type 1	Aug 24	-	5,038			11
Emergency Admissions Type 3	Aug 24	-	-			-
Emergency Admissions via A&E	Aug 24	-	5,038			10
Friends & Family A&E Score	Apr 24	85%	83.8%			73
Other Emergency Admissions	Aug 24	-	326			74
Total Emergency Admissions	Aug 24	-	5,364			24

28. Pathway Benchmarking & Trending – Unscheduled Care

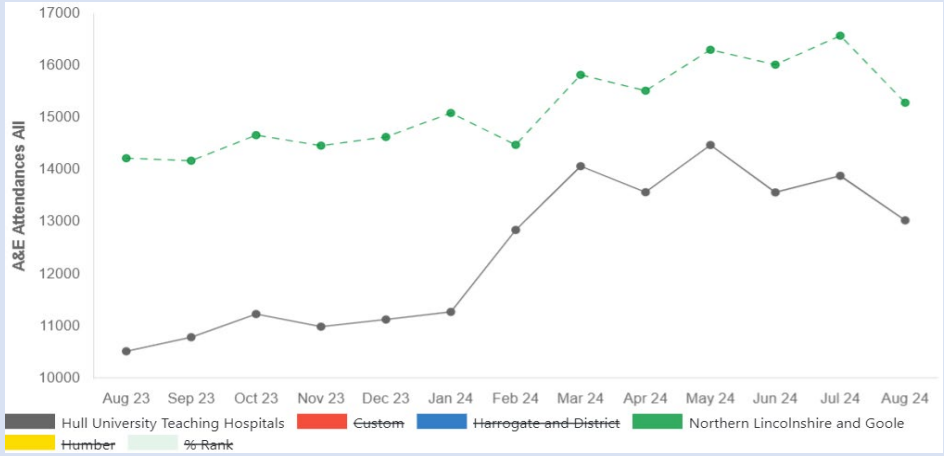
A&E - 4 Hour Performance

Trending Chart



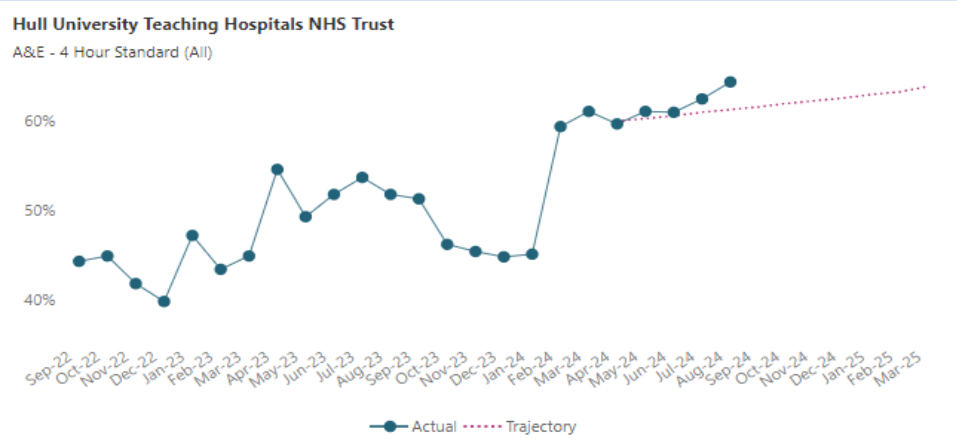
A&E – Attendances

Trending Chart



29. Emergency Care Standards – 4 hour Performance - HUTH

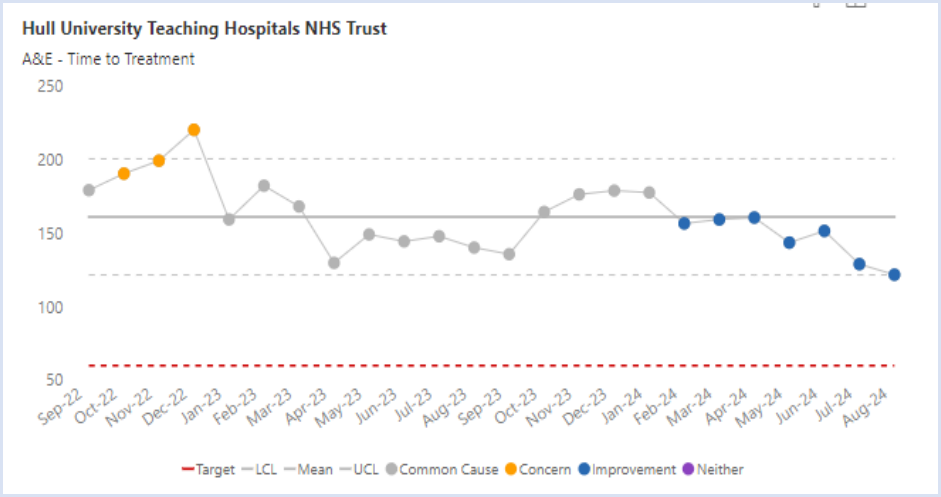
Compliance



Key Themes

- Compliance step change relates to inclusion of HRI UTC in HUTH formal reporting from Feb '23
- A&E 4 Hour standard (all types) above trajectory in August at 64.4%.
- Type 1 performance in August of 49.3% remains significantly ahead of the 24/25 operating plan target of 36.7%.
- Type 3 performance (HRI UTC) has improved from 87.0% in May to 96.6% August against the 95% target. Attendances at UTC remain significantly below planned levels.
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival. The improvement since February reflects a 60 min reduction (a -31.4% improvement) to 121.9mins in August. Significant further reduction is planned to reduce to 60mins.

Critical Enabler



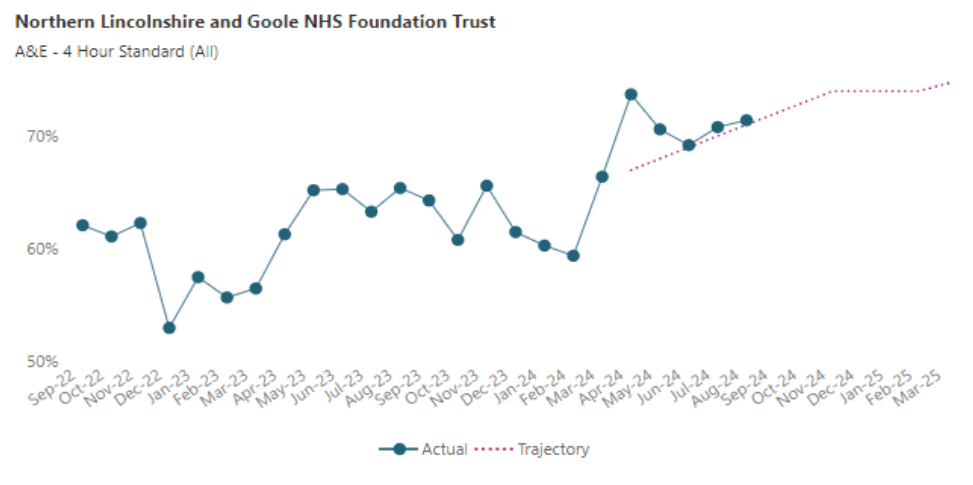
Actions

3 critical objectives identified. Improvement since project initiation in February 2024:

1. Reducing non-admitted breaches:
   Improvement of 30 mins (-14.4%) in total time in department reducing to 257mins in August
2. Time to first clinician:
   60 min reduction (a -31.4% improvement) to 121.9mins in August. Significant further reduction is planned to reduce to 60mins.
3. Improved frailty assessment:
   100.8min reduction (a -17.9% improvement) to 457.2mins in August for total time in department for patients >65 years of age

30. Emergency Care Standards – 4 hour Performance - NLAG

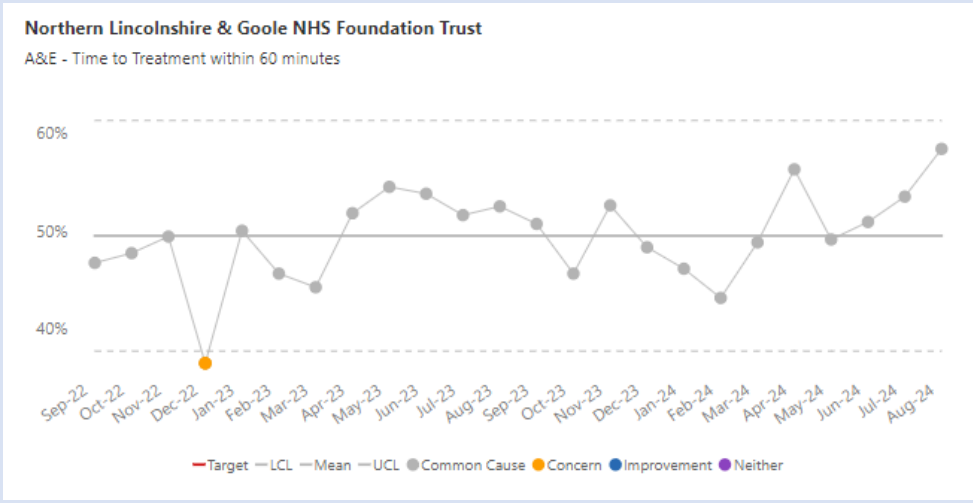
Compliance



Key Themes

- Combined type 1 and 3 performance was 71.4% in August, slightly above the 71% target trajectory.
- Total attendances in July were 15,294, which is significantly higher than planned at 14,953.
- Time to treatment improvement is 26.0mins (-27.9%) to 67.4mins in August

Critical Enabler



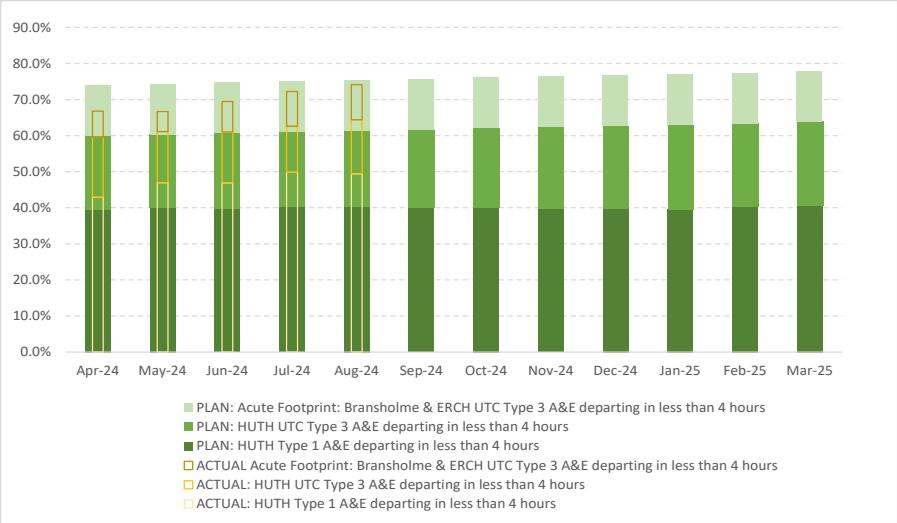
Actions

3 critical objectives identified. Improvement since project initiation in February 2024: Reducing non-admitted breaches.

1. Reducing non-admitted breaches:
   Improvement of 43.3mins (-19.6%) to 177.6mins in August in total time in department
2. Time to first clinician:
   Improvement of 26.0mins (-27.9%) to 67.4mins in August
3. Improved frailty assessment:
   improvement of 94.1mins (-28.2%) to 239.3mins in August for total time in department for patients >65 years of age

31. Acute Footprint Compliance – A&E

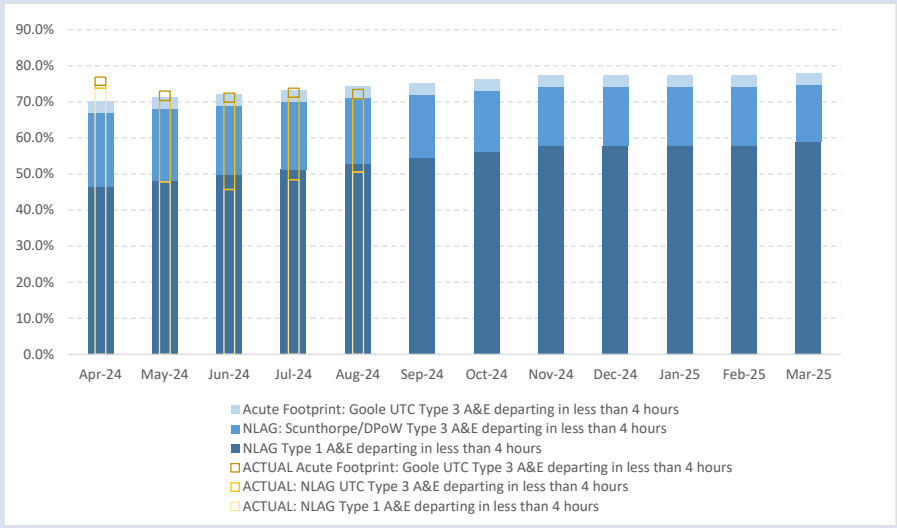
Compliance - HUTH



Key Themes

- As per NEY Region/HNY ICB instruction, 2024/25 trajectories are predicated on 78% delivery as an Acute Footprint by March '25.
- HUTH Type 1 compliance of 49.3% in August significantly exceeded plan (40.2%)
- Type 3 compliance on the HUTH site delivered via the CHCP UTC achieved 96.9% in August.
- While a significant step change in attendances is evident at HUTH this reflects co-located UTC go live. When adjusted for absorption of previously reported CHCP activity growth in attendances is less than 0.5%
- Aggregate Type 3 compliance at Bransholme/ERCH was 92.8% contributing 9.6% to acute footprint compliance versus a plan of 14.1%

Compliance - NLAG

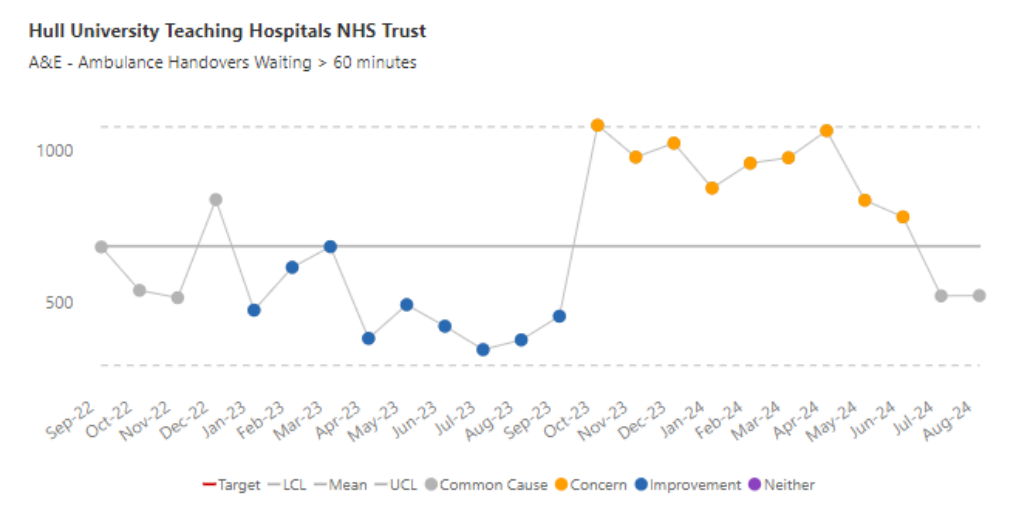


Key Themes

- NLAG Type 1 compliance of 51.4% in August was below the acute footprint plan of 52.9%.
- Type 3 compliance on the Scunthorpe and DPoW sites delivered 99.2% in August. This provided an acute footprint contribution 22.8%, exceeding the plan of 18.7%.
- Goole UTC operated at 99.0% in July contributing 2.5% to the acute footprint compliance versus a plan of 3.3%

32. Ambulance Handovers >60 minutes - HUTH

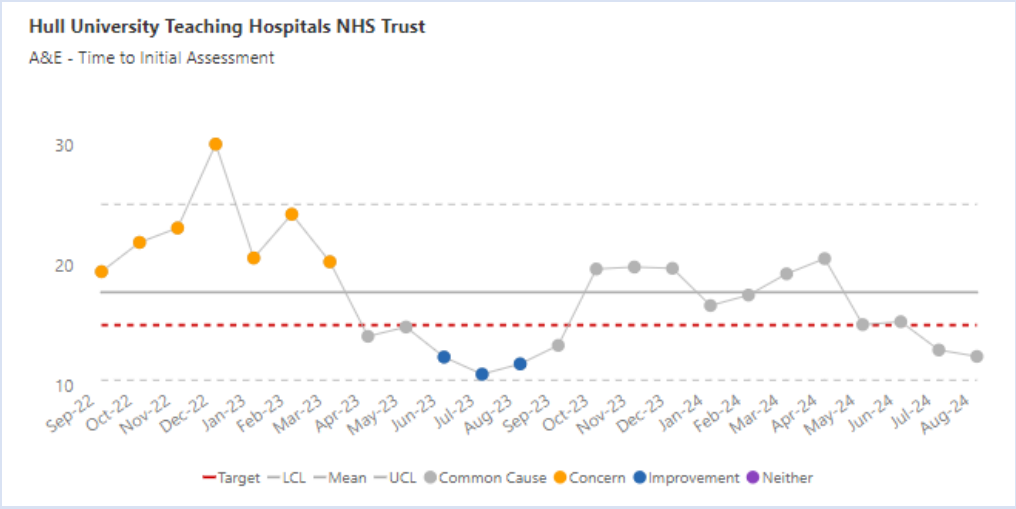
Compliance



Key Themes

- Month on month reduction in the number of ambulance handovers >60 minutes continued in July, following a step change in reported volume by EAMS/YAS in October 2023.
- Root cause of handover delays linked to patient volumes in A&E and compression of available assessment spaces. Focus of A&E improvement actions in previous section of this report relating to 4-hour delivery will significantly lower patient volumes in department, in turn decompressing assessment spaces and minimising handover delays.
- There has been a reduction of >60min delays by -45.6% since Feb 2024

Critical Enabler

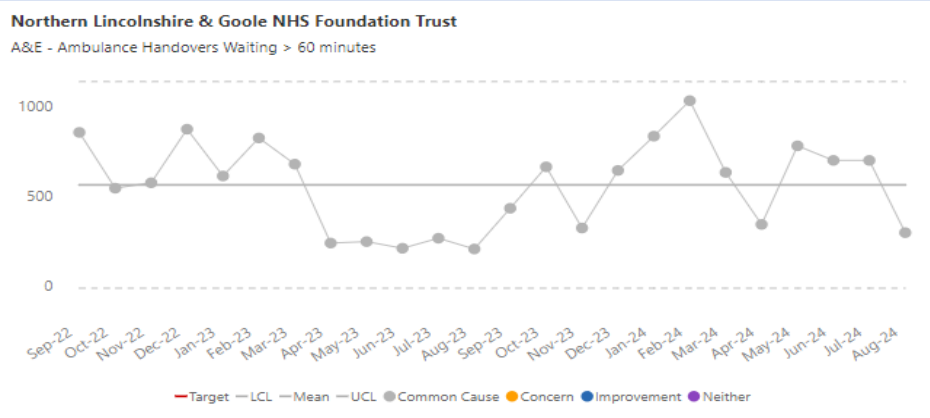


Actions

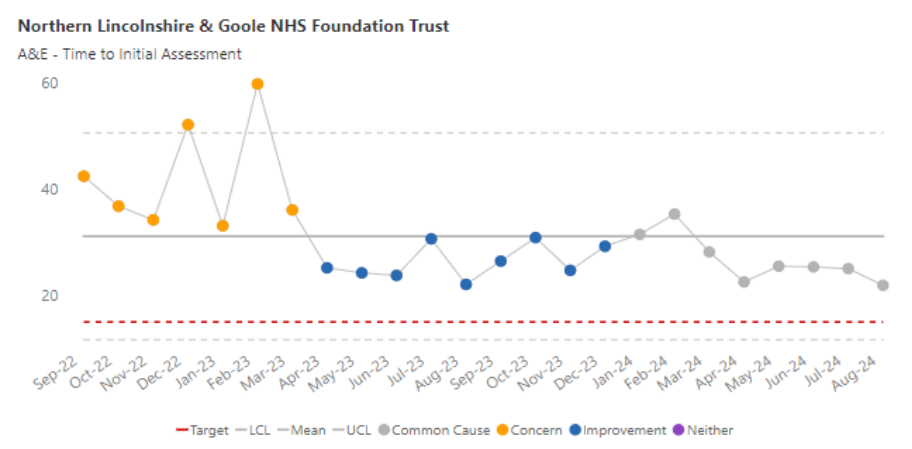
- Time to initial assessment reduced to an average of 12 minutes in August, below the national 15 minutes threshold.
- Triggers and Escalation/SOP for ambulance handovers is being reviewed and adapted linked to national OPEL system, enabling 30-minute Cat 2 responses for YAS.
- Work with YAS to bring forward clinical assessment through proposing changes to current practice.

33. Ambulance Handovers >60 minutes - NLAG

Compliance



Critical Enabler



Actions

- Rapid Assessment and Treatment (RAT) model to be embedded to reduce waiting time to be seen.
- Audit of current practices planned to ensure handover principles are being adhered to. Working toward zero tolerance of >45-minute handover, aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.
- Improvement of flow/ LOS through Discharge rounds in wards will reduce congestion.
- Impact and timelines for recovery programme being finalised with system partners.

34. Deep Dive Occupied Bed Insights - HUTH

Occupied Beds

Key Themes

- Data shows month on month bed occupancy from 2019/20.
- Total bed use exceeds the pre Covid baseline by 200 beds
- The majority of this growth has occurred in the non-elective bed use with occupancy significantly exceeding the pre covid baseline.
- Elective bed use has been restored to pre pandemic levels and marginally exceeds baseline.

Non-Elective Bed Demand per Day

Key Themes

- Growth in non-elective activity relates predominately to Zero LOS reflecting implementation of SDEC
- Activity >1 day remains significantly below the 19/20 baseline
- However, very specific growth in patients with a LOS >7 days is driving higher bed absorption rather that growth in patient volumes (increased acuity or reduction in discharge efficacy
- In conjunction with the occupancy increase detailed above this highlights exceeds beddays/NCTR as the driver of increased bed use – with the latter absorbing 200 beds on average over the past year.

35. Deep Dive Occupied Bed Insights - NLAG

Occupied Beds

Total elective bed days

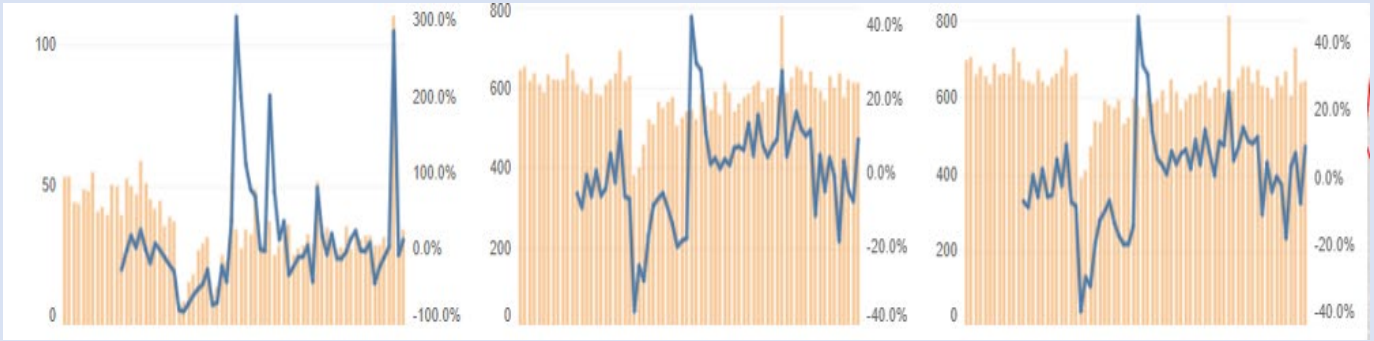
Activity YTD	Net Growth YTD	Growth YTD
13,765	1,959	16.6%

Total non-elective bed days

Activity YTD	Net Growth YTD	Growth YTD
222,261	-2,524	-1.1%

Total bed days

Activity YTD	Net Growth YTD	Growth YTD
236,026	-565	-0.2%



Key Themes

- Having increased in 20/21 & 21/22, the current bed occupancy broadly aligns to the pre covid 19/20 baseline
- Non elective bed use dominates occupancy with circa 95% of all Trust bed use relating to non-elective activity. This contrasts to circa 88% for HUTH.
- Elective bed use remains below pre pandemic levels.

Non-Elective Bed Demand per Day

Total zero LoS non-elective admissions

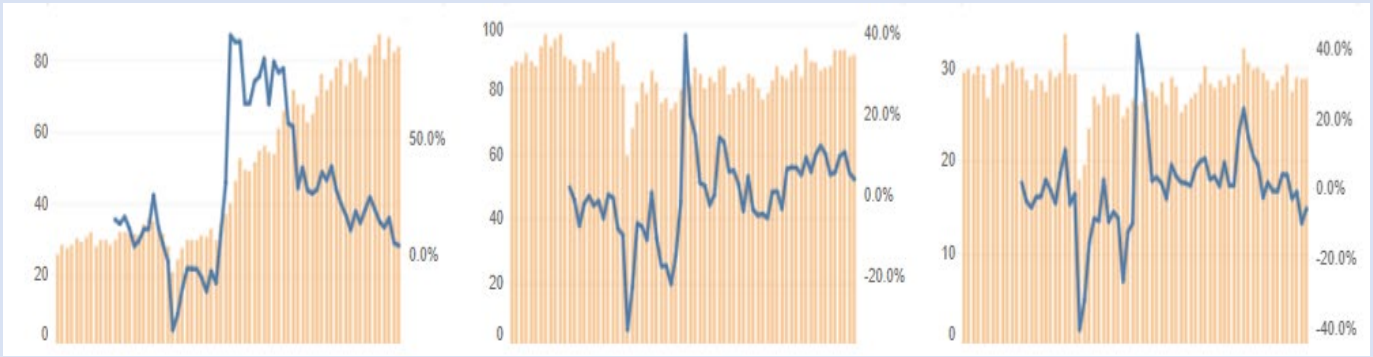
Activity YTD	Net Growth YTD	Growth YTD
29,475	3,758	14.6%

Total >= 1 day LoS non-elective admissions

Activity YTD	Net Growth YTD	Growth YTD
32,567	2,310	7.6%

Total >= 7 day LoS non-elective admissions

Activity YTD	Net Growth YTD	Growth YTD
10,595	5	0.0%



Key Themes

- Growth in non-elective activity relates predominately to Zero LOS reflecting SDEC implementation
- Activity >1 day remains unchanged against the 19/20 baseline
- Activity >7 days remains unchanged against the 19/20 baseline

36. Deep Dive Occupied Bed Insights – LOS and Demographic Variance

LOS by Discharge Volumes

HUTH

Specialty	Discharges	Avg LOS	Day Case Rate	Crude Mortality
Gastroenterology	64,558	0.7	99.2%	0.4%
General Medicine	50,655	3.1	81.0%	3.2%
Medical Oncology	46,072	1.1	96.0%	1.5%
Obstetrics	33,512	1.6	47.1%	0.2%
Clinical Oncology (Previously Radiotherapy)	28,973	1.5	92.6%	1.7%
Clinical Haematology	28,719	1.1	93.0%	1.1%
Colorectal Surgery	26,549	2.3	83.5%	0.8%
Plastic Surgery	25,281	0.3	94.3%	0.0%
Total	**615,971**	**2.4**	**86.0%**	**1.6%**

NLAG

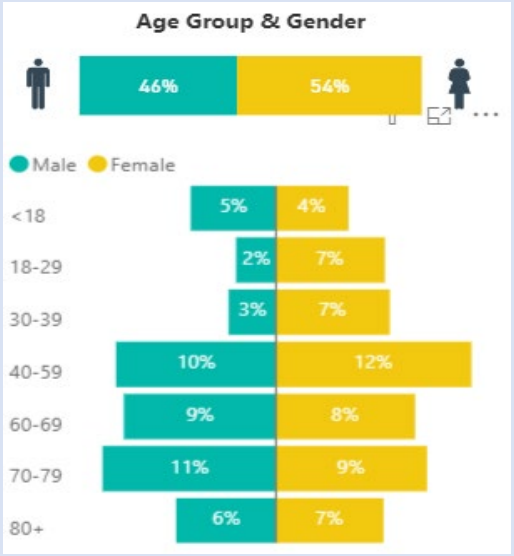
Specialty	Discharges	Avg LOS	Day Case Rate	Crude Mortality
General Medicine	65,721	2.6	86.5%	2.7%
Colorectal Surgery	25,276	0.7	93.0%	0.3%
Ophthalmology	25,041	0.0	99.3%	0.0%
Urology	22,399	0.5	92.4%	0.1%
General Surgery	21,431	1.6	79.4%	0.8%
Gastroenterology	18,877	0.7	98.9%	0.5%
Paediatrics	17,292	0.9	37.6%	0.1%
Medical Oncology	15,829	0.1	99.4%	0.1%
Obstetrics	13,396	1.8	35.4%	
Total	**311,521**	**1.8**	**92.1%**	**1.2%**

Key Themes

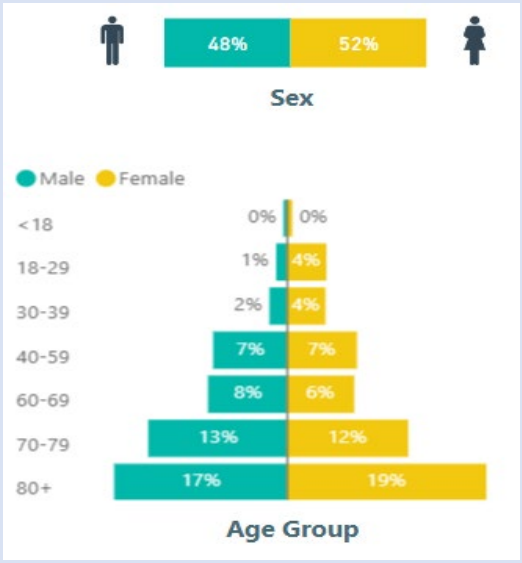
- Analysis of average LOS by discharge volume shows relatively close alignment by specialty.
- Significant variances such as Colorectal reflect case mix variation due the tertiary cancer service run at HUTH.

Demographics

HUTH



NLAG



Key Themes

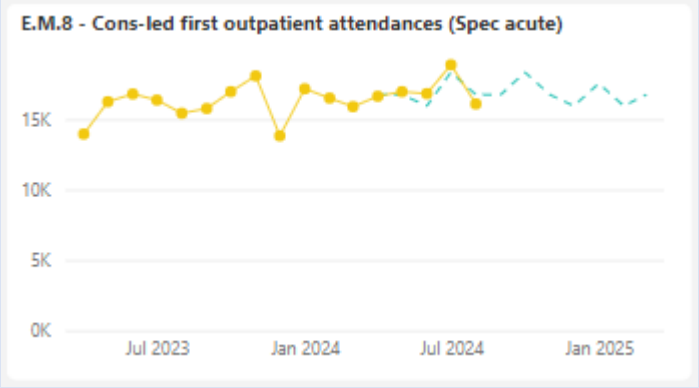
- Analysis of bed absorption by demographic characteristic shows significant variance across the provider Trusts.
- Both Trust show a bias toward female admissions and associated bed absorption.
- Patients >60 years of age absorb 50% of beddays at HUTH in contrast to 81% at NLAG. This significant variance links to tertiary status & variance in available elective beds.
- Importantly, and linking to the high % of non-elective bed absorption at NLAG this highlights the limited options to flex beds in periods of heightened demand. This also impacts Operating affordability due to low comparative income per bed day.

37. Activity

HUTH

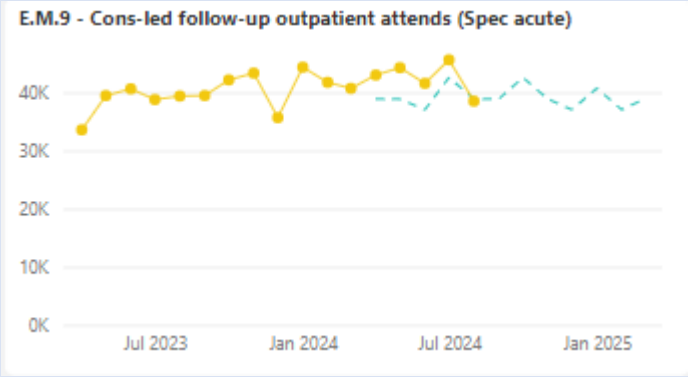
New Outpatient Attendances vs Plan

YTD New consultant-led activity is above plan at +844.



Follow up Outpatient Attendances vs Plan

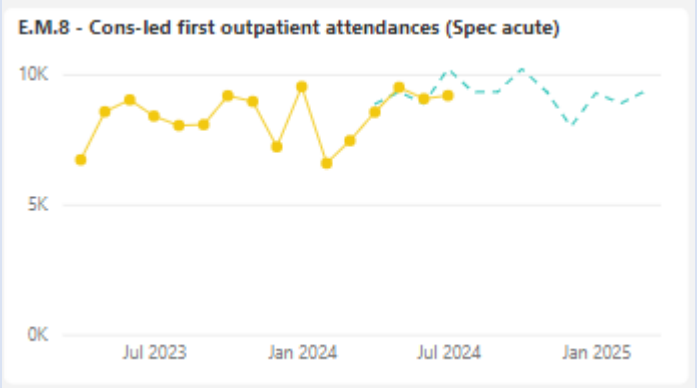
YTD Follow up activity is above plan +16,719.



NLAG (data shown to Month 4)

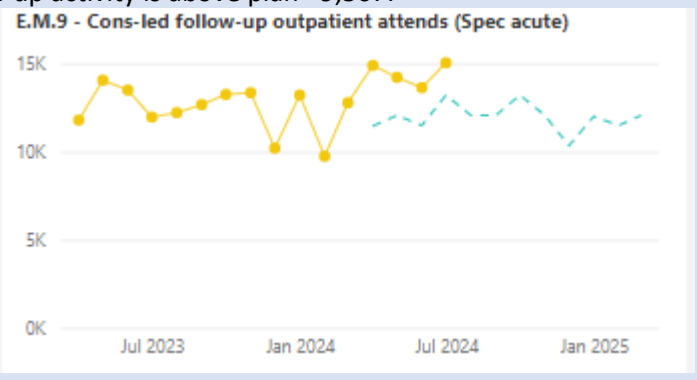
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -976.



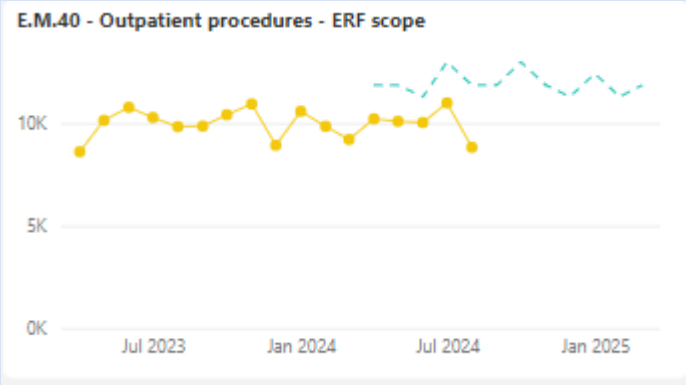
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is above plan +9,567.



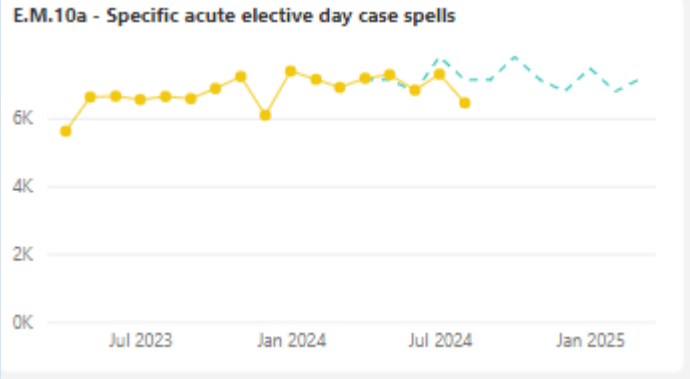
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -9,684. Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



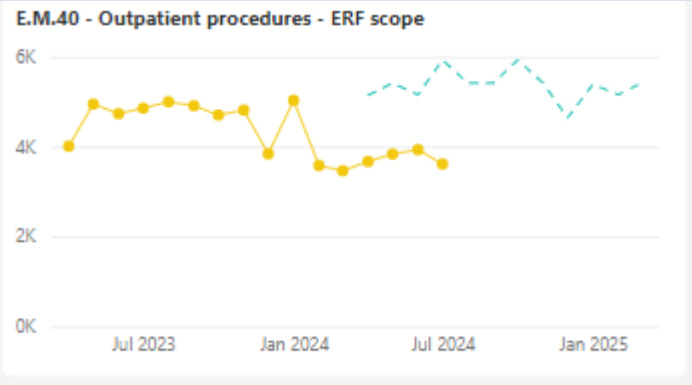
Day Case Admissions vs Plan

YTD Day case elective spells is below plan at -954.



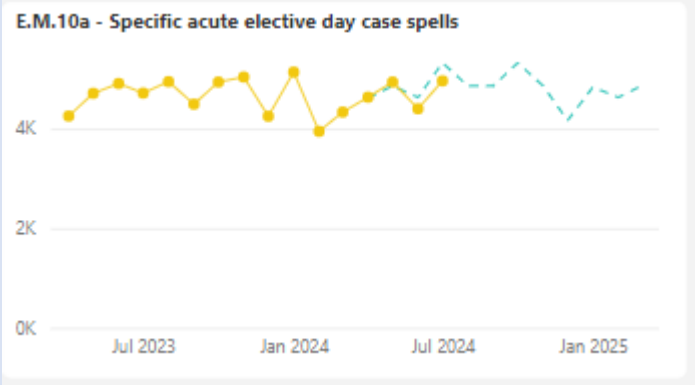
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -6,597. Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



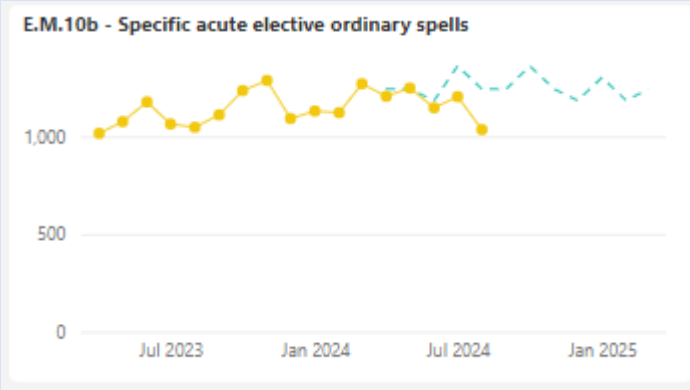
Day Case Admissions vs Plan

YTD Day case elective spells is below plan -497.



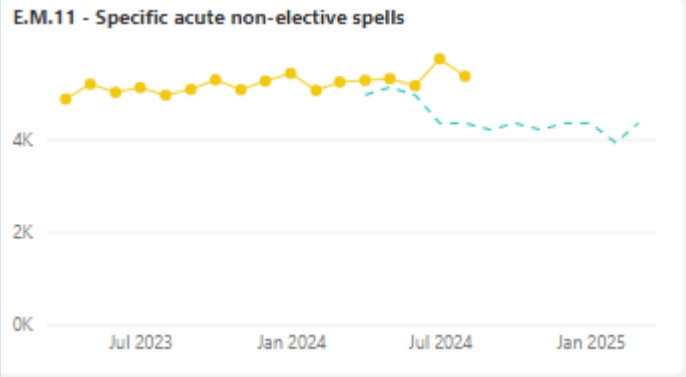
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -434.



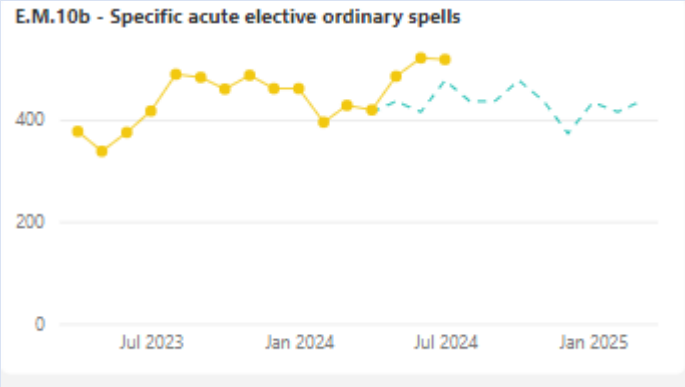
Non-Elective Admissions vs Plan

YTD non-elective spells +3,109 over plan.



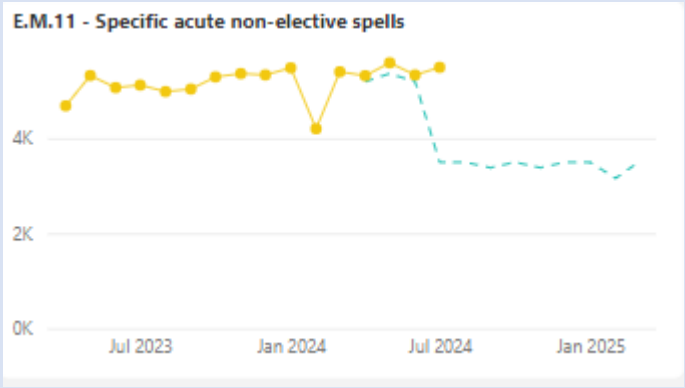
Elective Admissions vs Plan

YTD Inpatient spells is above plan +201, however data is subject to further evaluation of correct operational recording of intended management (Daycase versus zero LOS inpatient). A recent audit has evidenced this to be a recording issue.



Non-Elective Admissions vs Plan

Non-elective spells above plan YTD +2,492.



38. Elective Recovery Fund - HUTH

Hull University Teaching Hospitals	ERF Performance (%)					
	Apr	May	Jun	Jul	Aug	YTD
DAYCASE	109%	112%	111%	100%	98%	106%
ELECTIVE	107%	108%	104%	94%	93%	101%
OP FIRST ATTENDANCE	105%	109%	112%	111%	110%	109%
OP FIRST PROCEDURE	101%	98%	102%	100%	94%	99%
OP F/UP PROCEDURE	148%	147%	151%	142%	141%	146%
Total	**109%**	**111%**	**110%**	**102%**	**101%**	**106%**

The reported ERF position is based on the early month 5 information against the ERF baseline 2019/20 updated for the new tariff.
The Trust has assumed that the baseline will be profiled on working days and therefore this may change when the national information is available.
There have been some changes made to the ERF calculation for 2024/25 and whilst we have tried to replicate the methodology, this may need some amendments when we receive the national reports to ensure consistency.

39. Elective Recovery Fund - NLAG

Northern Lincolnshire & Goole Hospitals	ERF Performance (%)					
	Apr	May	Jun	Jul	Aug	YTD
DAYCASE	115%	116%	115%	114%	119%	116%
ELECTIVE	97%	105%	122%	104%	99%	105%
OP FIRST ATTENDANCE	97%	112%	114%	102%	90%	103%
OP FIRST PROCEDURE	90%	96%	94%	84%	95%	92%
OP F/UP PROCEDURE	68%	66%	76%	65%	69%	69%
Total	**101%**	**108%**	**113%**	**103%**	**102%**	**105%**

Notes

This data is an early pull of data and as such is not fully coded and may omit some clinics/discharges that were cashed up late.

This data is from the new Insource Data Warehouse and contains some known DQ errors.
This data will not fully match to the SUS national position, as this the SUS position is being generated through the old Data Warehouse to avoid the known errors.

Known errors are:
- Length of stay is overstated where a second or subsequent critical care stay exists, this may overstate excess bed-day value.
- Nurse led activity is being treated as Consultant led due to some errors in clinic set up in implementation. A call is being logged to get this addressed.

Quality Performance Metrics

NHS
Humber Health Partnership

July 2024

United By Compassion: Driving For Excellence

Introduction

- The IPR for both HUTH and NLAG is not automated.
- NLAG PowerBI dashboard have gaps and data refresh intervals have varied. Some of the data is unchanged from the last report, which is stated for each indicator.
- The BI team are engaged in a Quality metrics workstream to integrate the metrics onto the new Group Integrated Performance Report, which to date has prioritised performance metrics.
- The team are bringing together metrics from individual trusts to present on a consistent basis, checking commonality of definitions and subsequently present at Group / Trust / Site Management / Care Group management levels.
- Updates for this report:

HUTH

- VTE data inclusion, which is demonstrating improvement but is below performance target.
- FFT charts have been included on an SPC basis.

Highlights and Lowlights

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	HUTH	NLAG
Highlights	• Patient experience data, particularly Inpatient FFT and A&E FFT is demonstrating improvement. Inpatient and daycase FFT performance of 94.3% was achieved in July 2024, approaching 95% target, a significant improvement from 85% across 2022/23. • Pressure ulcer rate data shows a decrease for July to 1.5 per 1000 bed days. • VTE rate July 2024 has improved to 93.57%, whilst not reaching the target there is an ongoing improvement.	• SHMI value is 0.9897 – lowest on record for >7 years. • HSMR rate is 94.3 for the rolling 12 months, below the 100 national average. • FFT rates for Inpatient remain above the national target and has 86th centile performance. • Complaint response rate within the 60 day target is at 88% and achieving the desired target consistently.

Lowlights	• IPC, PHE have not set trajectories for any organisations yet. 2023/24 target trajectories shown until the new targets are set. A number of Infections are above set trajectories C.Difficile/ C.Difficile – over the target trajectory. MSSA BSIs – 14 target cases in July 2024 at process limit.
	• HUTH is identified as having a 'higher than expected' SHMI, with an overall SHMI of 1.1476. This is lower than last month's value of 1.1535. The HHP Mortality Improvement group is targeting areas for improvement, including those diagnosis groups where SHMI is "higher than expected":
	  • Fracture of neck of femur (hip)
	  • Secondary malignancies
	  • Septicaemia
		• Residual issues to resolve the medical beds, trolleys and equipment entrapment or falls reduction Patient Safety Alert. Remains a group wide challenge due to scale and replacement of equipment costs.
		• Data submission issues for HSMR reflect changes from Lorenzo implementation, recovering now. Resolution expected in October 2024. HSMR is 94.3 with other data for the year subject to this resolution work with NHSE.
		• VTE data validation and reporting capture being pursued following change to capture from ePMA, since Lorenzo implementation.
		• IPCC C.difficile rate is higher than historical trajectories.
		• IPCC P.aeruginosa is higher than historical trajectories.

Duty of Candour and Patient Safety Alerts

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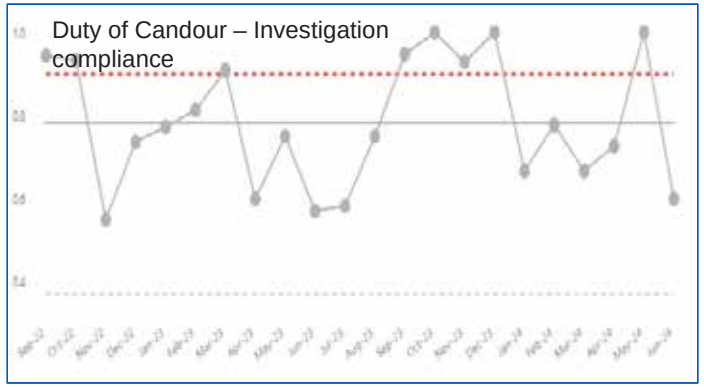
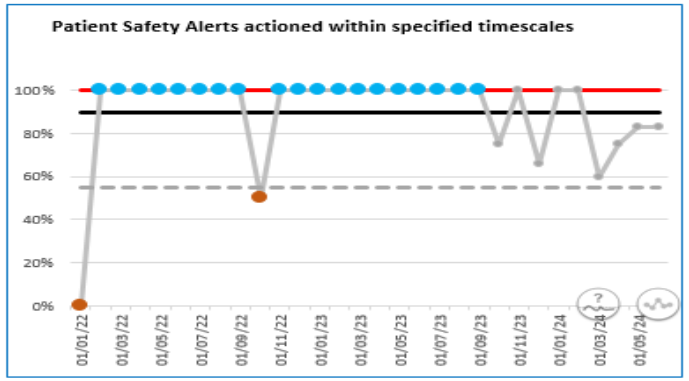
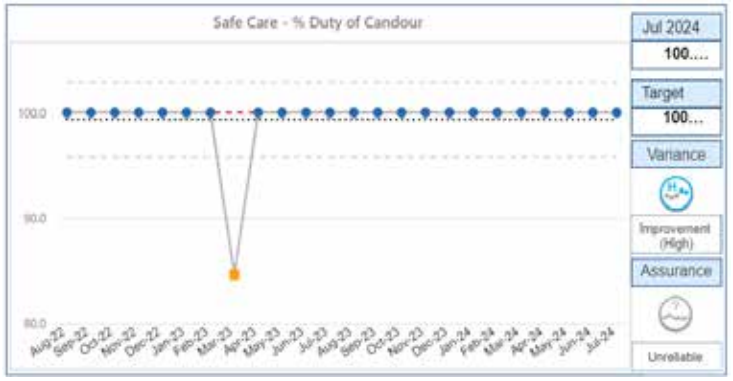
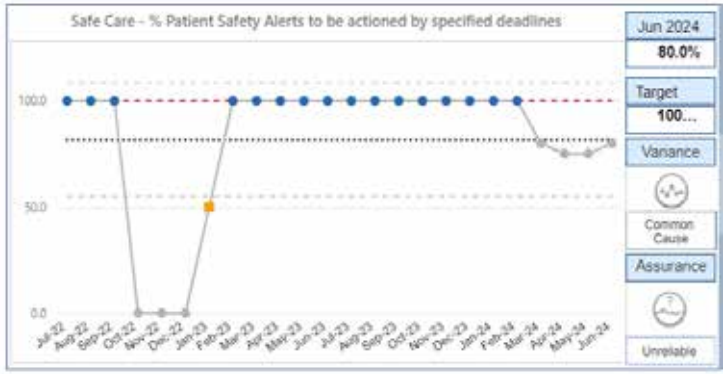
HUTH





NLAG





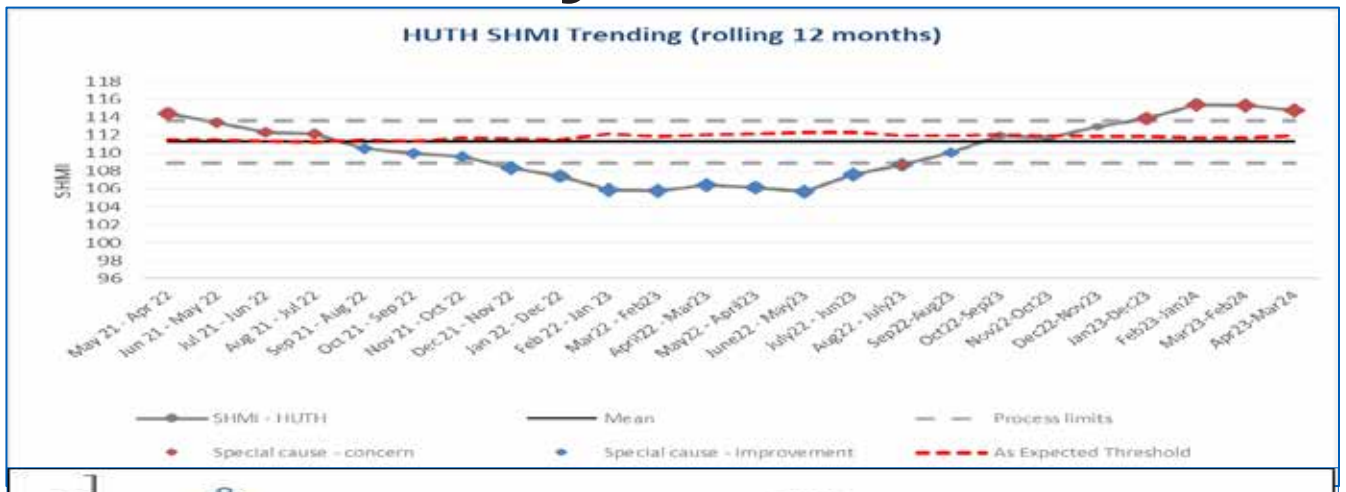
Duty of Candour

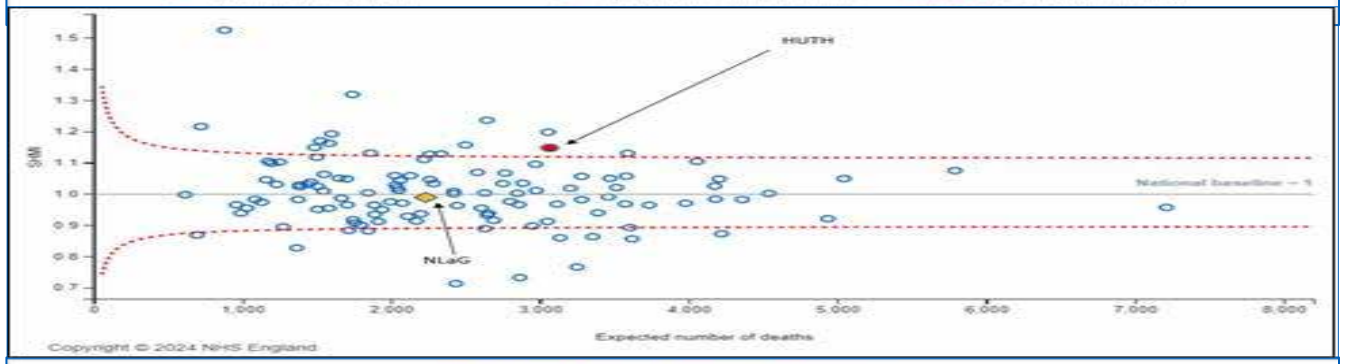
- **NLAG:** 100% for July 2024 for the proportional investigation and PSII/SI casework.
- **HUTH:** Compliance rates against the 10 working day criteria are below the expected standard.
- A detailed review of data underpinning duty of candour compliance has been undertaken in August 2024 which has not been limited to the PSII casework but opened to all moderate and above harm incidents in scope of Regulation 20.
- Alignment of monitoring and reporting processes across the Group is underway, with a number of immediate measures effective from September 2024. Further BI support is required to ensure the KPIs are appropriately capturing written compliance at a care group level.

Patient Safety Alerts

- The one Patient Safety Alert that remains open is in relation to Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts, consistent with an ICB working group overseeing progress with this alert. HUTH/ NLAG meeting 11/8/24, next planned 9/9/24.

Mortality – SHMI





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SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings.

HUTH is identified as having a 'higher than expected' SHMI, with an overall SHMI of 1.1476. This is lower than last month's value of 1.1535. There are 14 other Trusts in the 'higher than expected' range.

NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of 0.9897. This is lower than last month's value of 1.0038 and lowest it has been for a number of years.

The latest SHMI values for each site are:

- Castle Hill – 1.3112; 'higher than expected' (previously 1.3140 and 'higher than expected')
- Hull – 1.1012; 'as expected' (previously 1.1080 and 'as expected')
- Grimsby – 0.9695; 'as expected' (previously 0.9869 and 'as expected')
- Scunthorpe – 1.0142; 'as expected' (previously 1.0258 and 'as expected')
- Goole – insufficient activity for SHMI to be calculated

For the conditions for which a SHMI is calculated by NHS Digital:

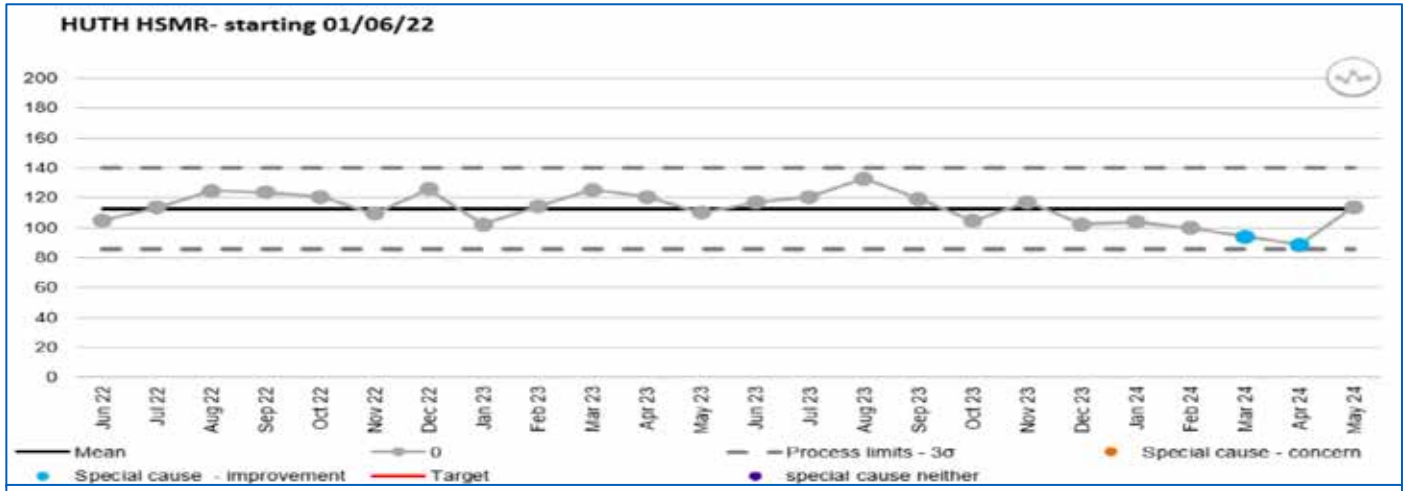
HUTH is identified as having a higher than expected SHMI for:

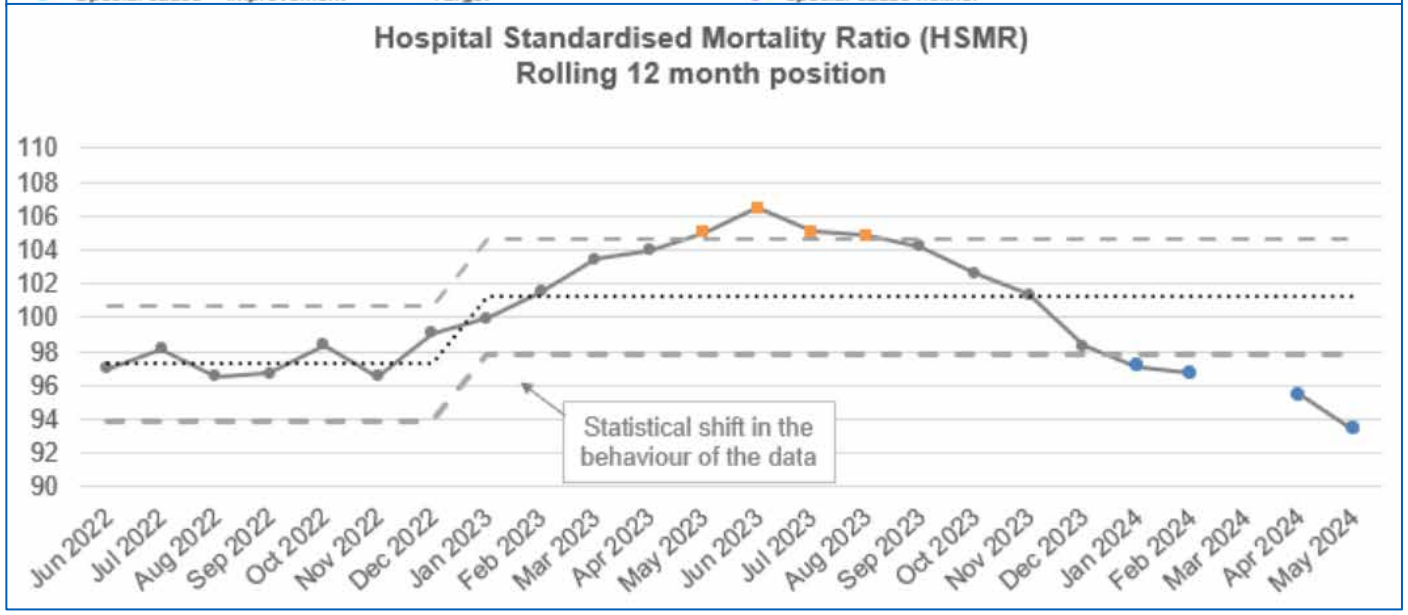
- Fracture of neck of femur (hip) – the latest data published in August 2024 (to March) was SHMI of 1.48, down from 1.7 in November 2023.
- Secondary malignancies – most recently 1.32 to March 2024 which is static.
- Septicaemia – most recently 1.28 to March 2024 which remains static.

NLaG is identified as having a lower than expected SHMI for:

- Acute bronchitis
- All other diagnosis group specific SHMI values are 'as expected' for both trusts.
- No condition-specific SHMI is calculated by NHS Digital for some conditions that might be of interest, including acute cerebrovascular disease, in the data that is published.

Mortality - HSMR





HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

HUTH

- The latest HSMR data available is May 2024, with a 12 month rolling value of 113.97.
- A programme of targeted mortality improvement work is in progress which forms part of the Group's wider quality priority workstreams; Deteriorating Patient, Sepsis, End of Life and Medication Safety.

NLAG

- The latest HSMR data available is May 2024, with a 12-month rolling value of 93.4. There has been successive reduction in the HSMR over the past seven months.
- There is a data gap in March 2024, linked to challenges of change to Lorenzo. Values for this are based on incomplete data submission to NHS Digital and should therefore be interpreted with caution. NHSE and the Information Team expect this to be resolved by October when the dataset is refreshed.

HHP Mortality Improvement Group –The Group mortality meetings are being unified as one meeting from August 2024, workplans and report framework designed. Learning from deaths policy has been developed.

Falls

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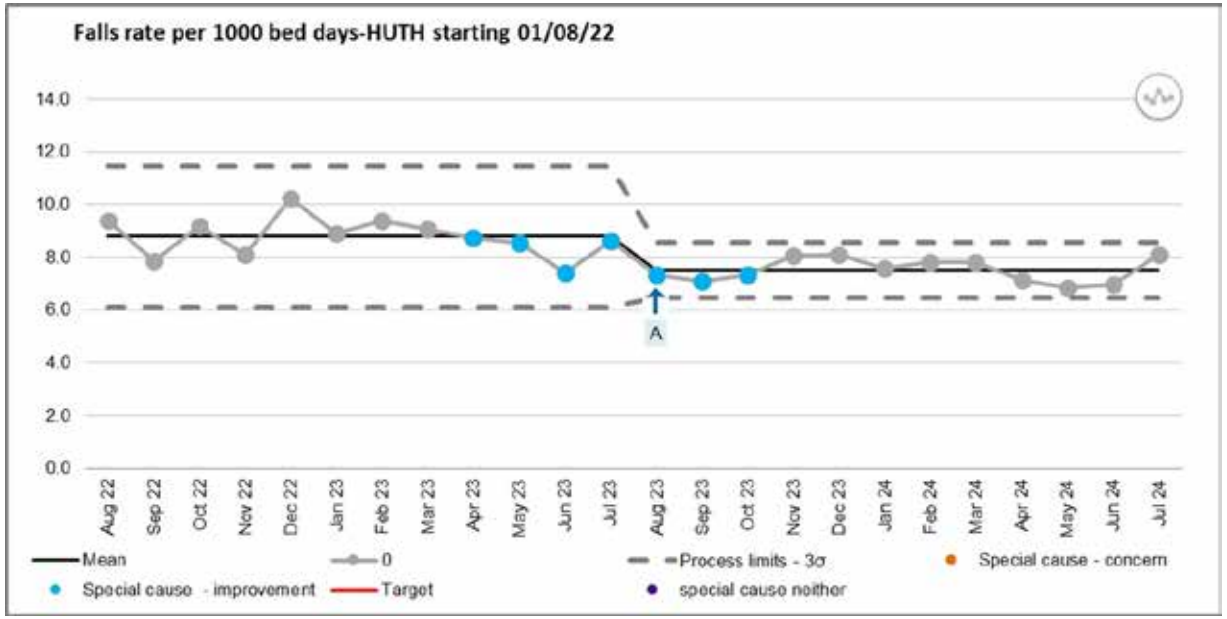
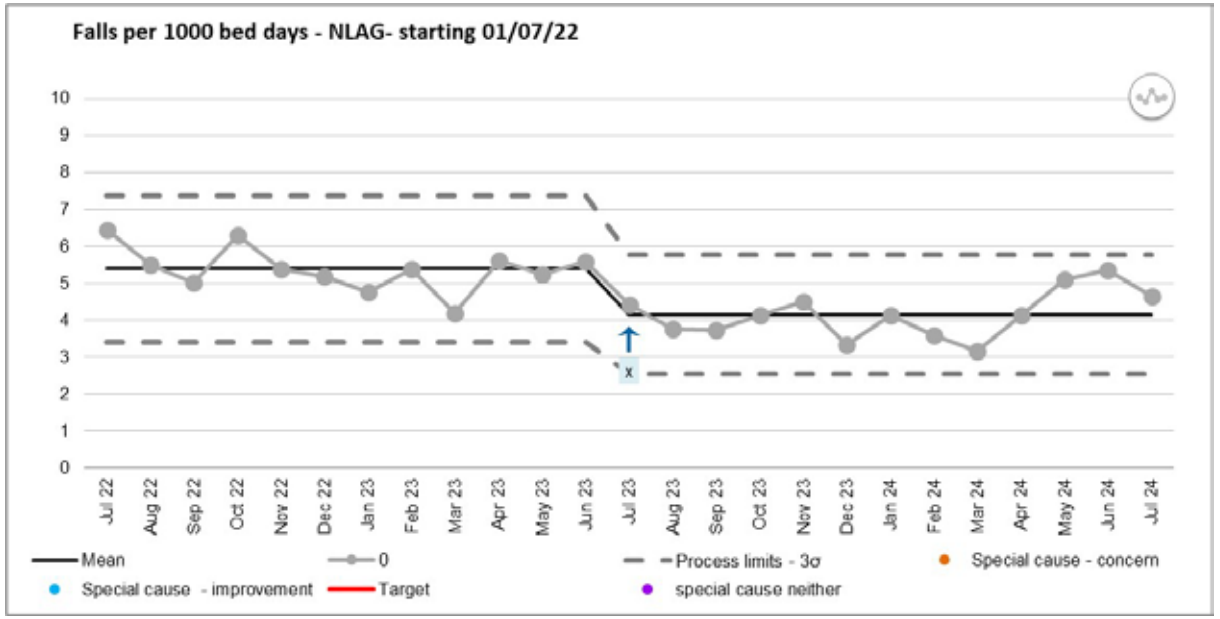
HUTH



NLAG



- HUTH – Falls rate shows a reduction from April 23, with revised control limits from August 2023. The Falls team review patients who have fallen on a daily basis supporting interventions to prevent further falls, use of Swarm huddles in place.
- NLAG Falls rate data shows common cause variation following a reduction in rate evident from July 2023. Repeated fall cases are reviewed by Matrons and Swarm huddles are used to review care provision. A strategic action plan is in place.

Pressure Ulcers

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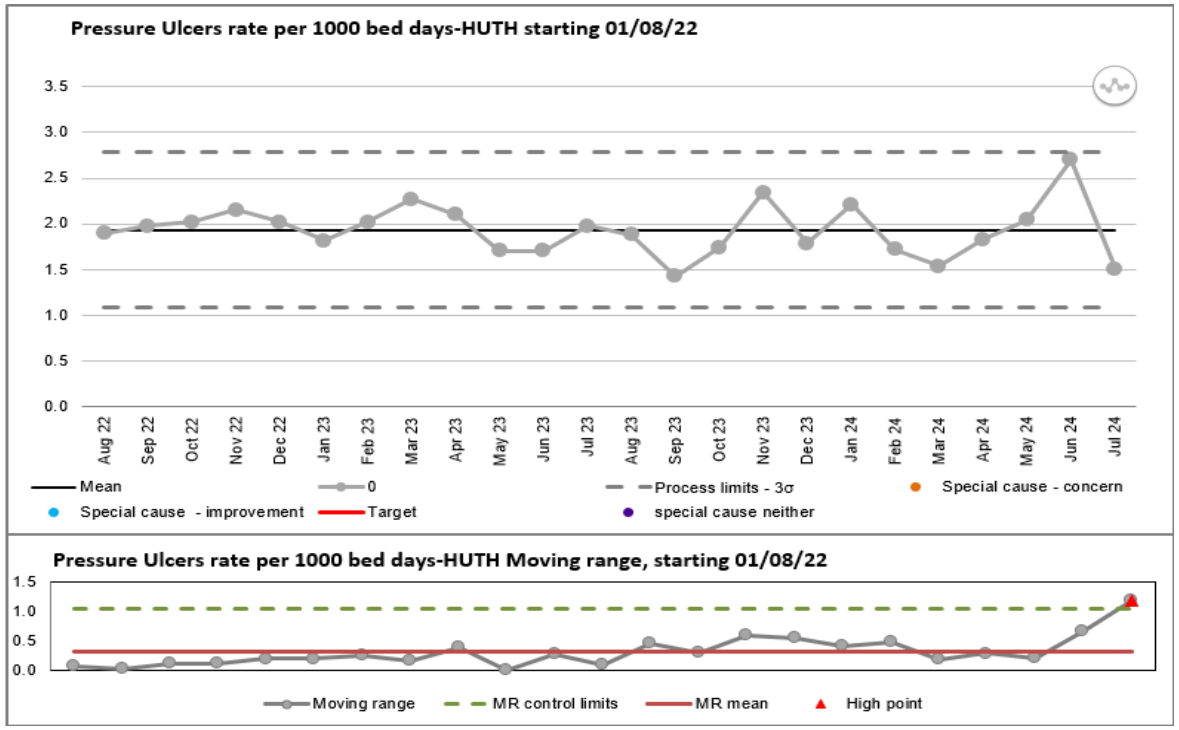
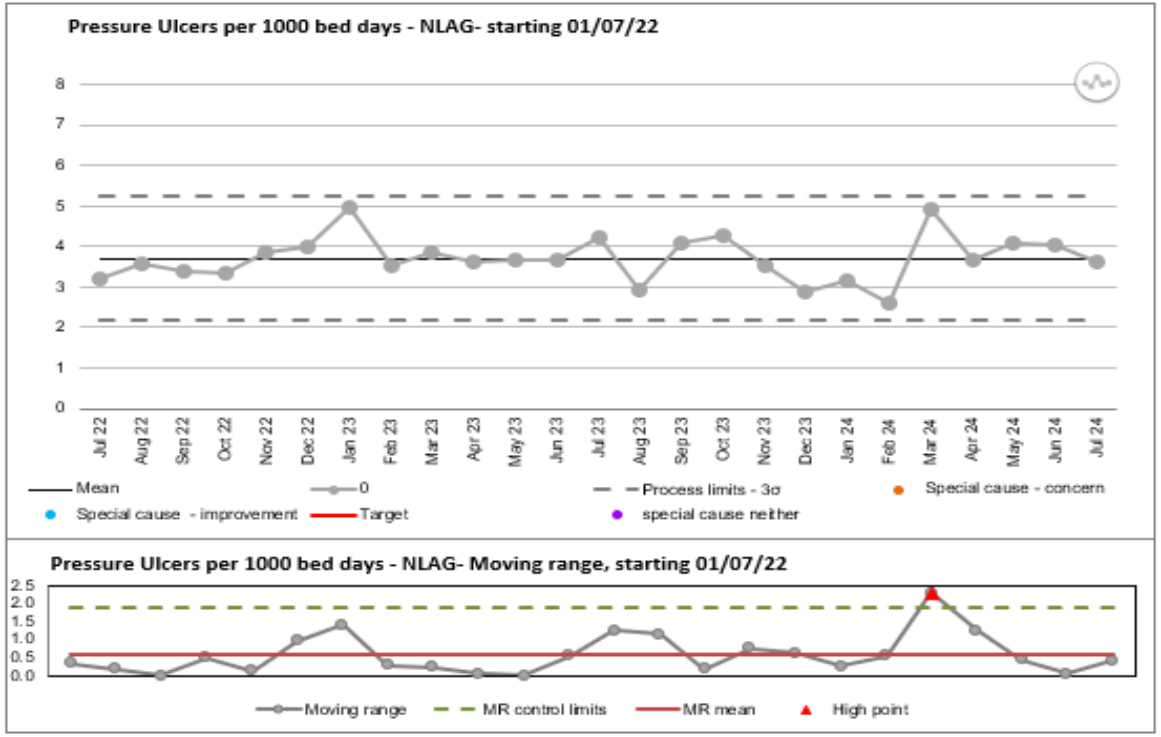
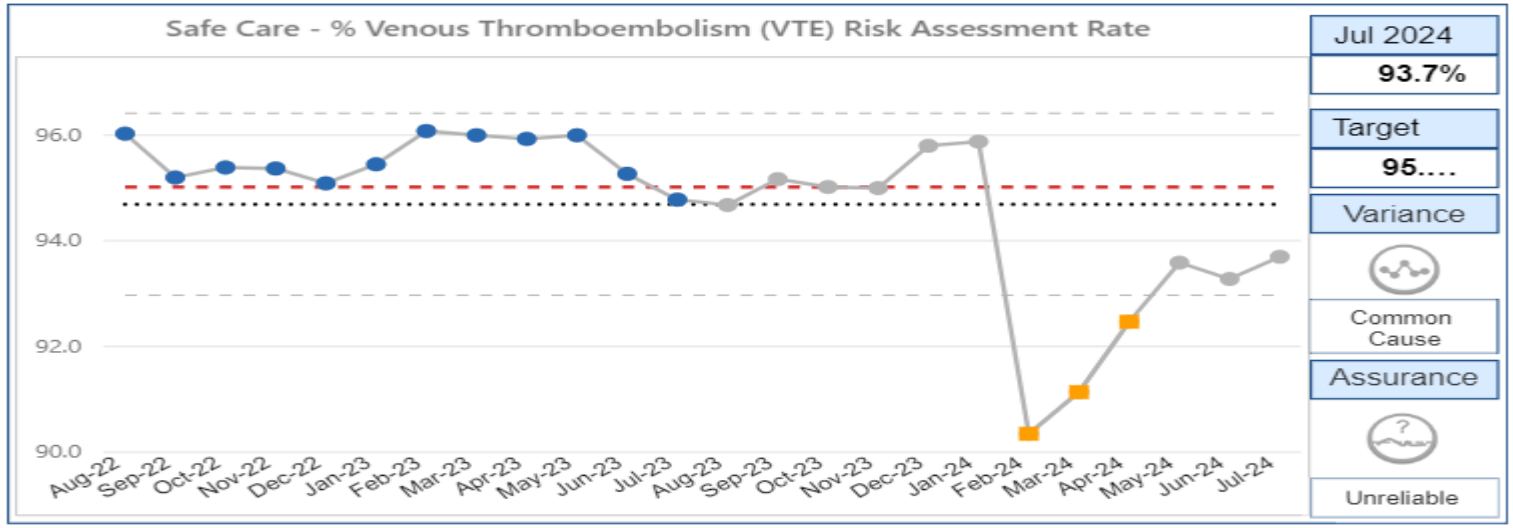




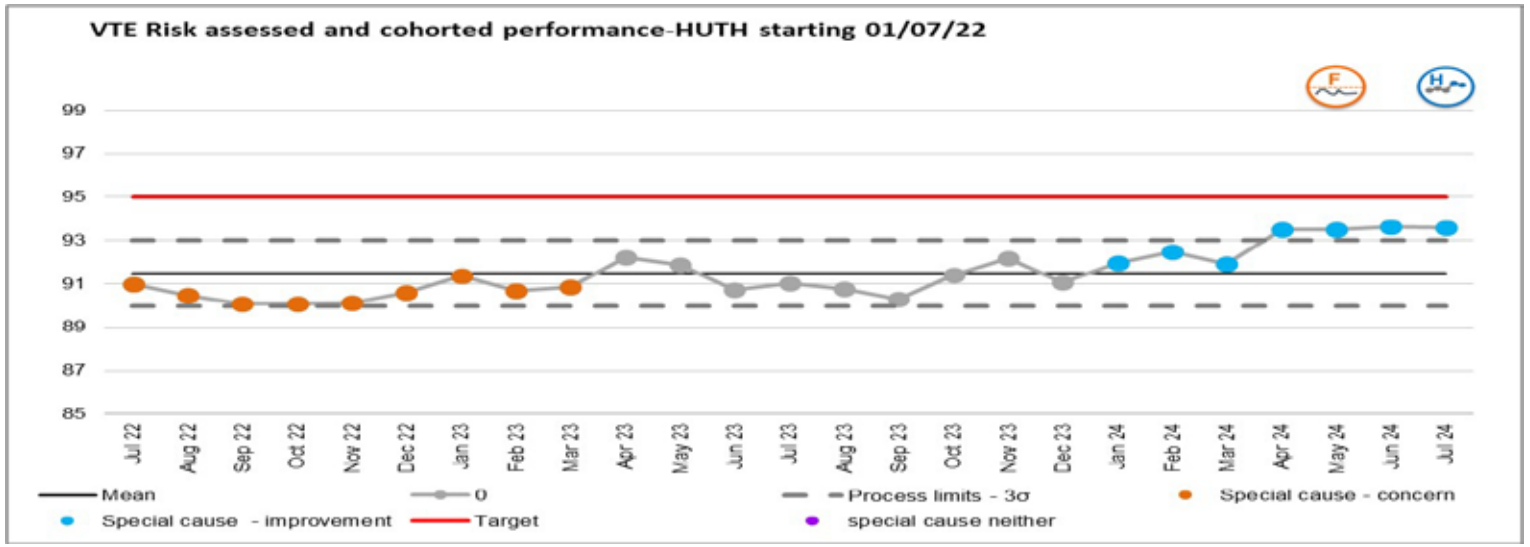
- HUTH – The rate shows a decrease for July to 1.5 per 1000 bed days.
- NLAG – Pressure ulcer rate demonstrates normal variation, with a rate of 3.6 per thousand bed days.

VTE risk assessment rate

NLAG



HUTH



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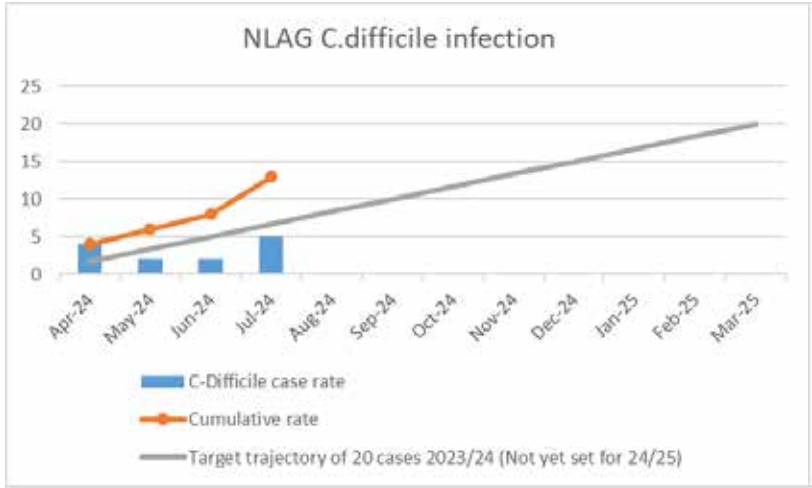
NLAG

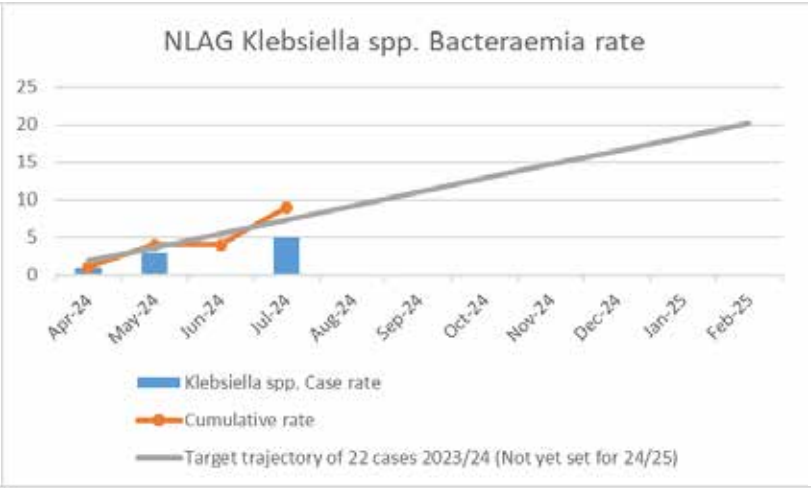
- Following a period of inability to report following the Lorenzo implementation, the data is now available. A reduction in compliance was reported last month. Work is ongoing with the CMIO, the GCMO and Information team to resolve the reporting changes. The ePMA is now the main source of VTE assessment capture rather than WebV and picked up through a coding function. Further validation work is being undertaken to demonstrate the risk assessment rate and cohort groups of patients.

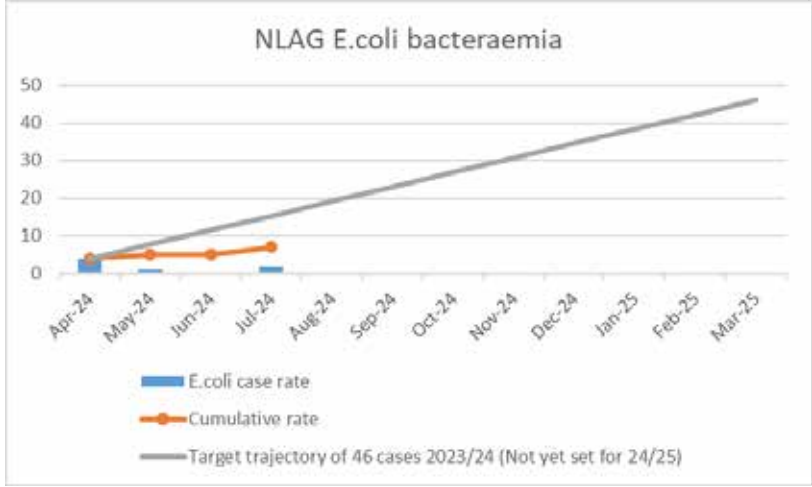
HUTH

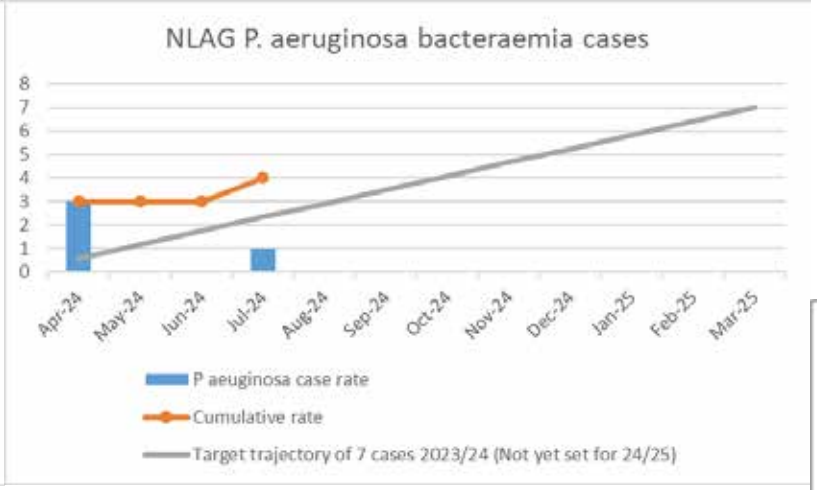
- BI have developed a VTE SPC chart reporting weekly; previously data was captured quarterly.
- VTE support provided by QI team, improvement actions. Pilot wards agreed, working with digital nurse team some areas of non-compliance to target further improvement
- Rate for July 2024 is 93.57%. Although not reaching the target, there is an improvement special cause evident for 7 data points.

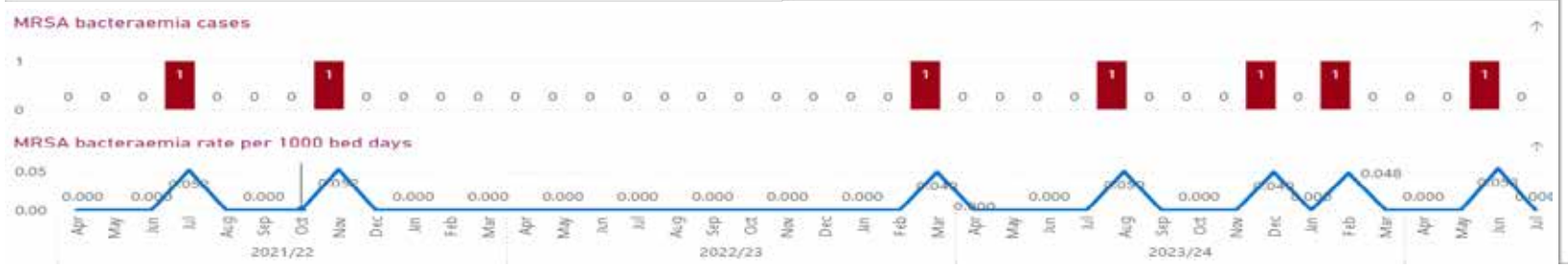
Infection Control - NLAG











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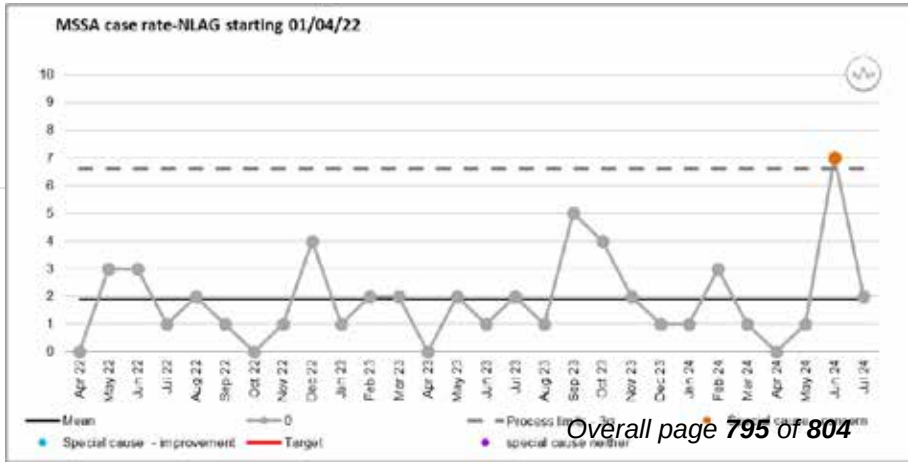
PHE have not set trajectories for any organisations yet. 2023/24 target trajectories are shown until the new targets are set.

NLAG

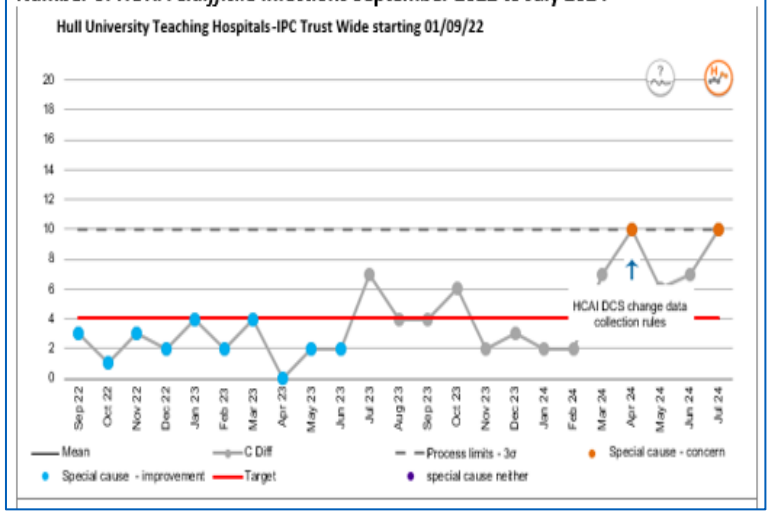
- C.Difficile – over the target trajectory.
- E.Coli – under the target trajectory.
- Klebsiella – over the target trajectory.
- P.Aeruginosa – over the target trajectory
- MRSA bacteriaemia – zero target and 1 case in 2024/25
- MSSA – no target, but an increased rate in June 2024, with 3 cases in the same ward, C1 Glover.



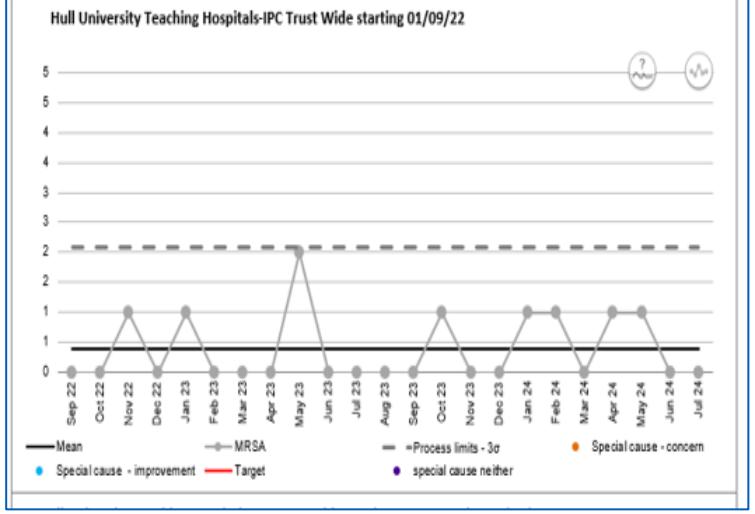
Infection Control - HUTH

Humber Health

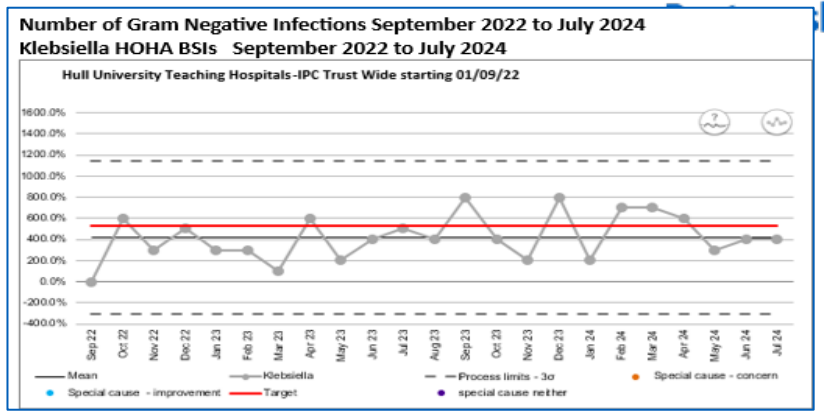
Number of HOHA *C.difficile* Infections September 2022 to July 2024



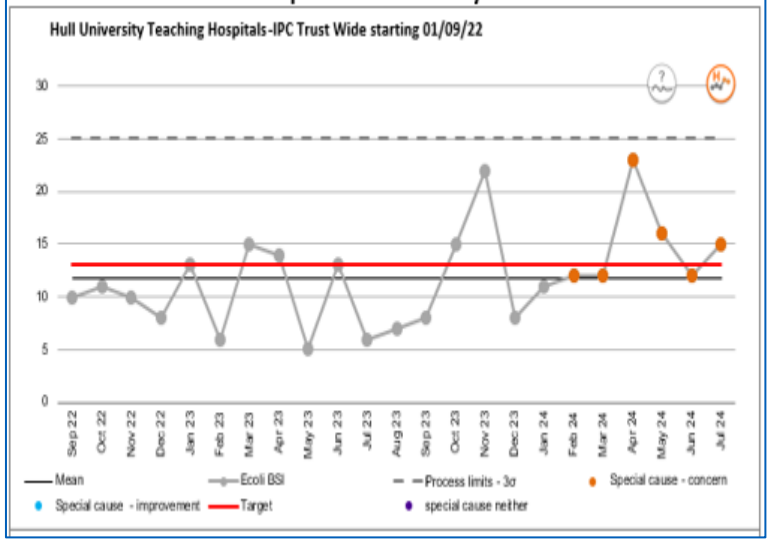
Number of HOHA MRSA BSIs September 2022 to July 2024



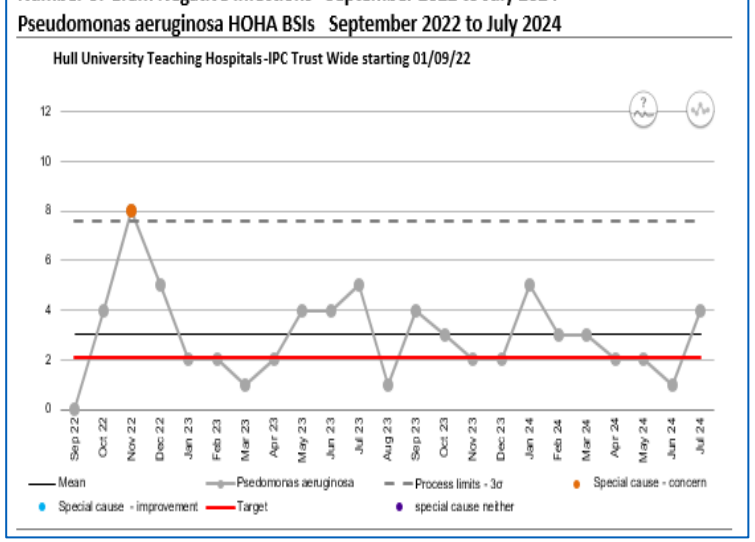
Number of Gram Negative Infections September 2022 to July 2024
Klebsiella HOHA BSIs September 2022 to July 2024



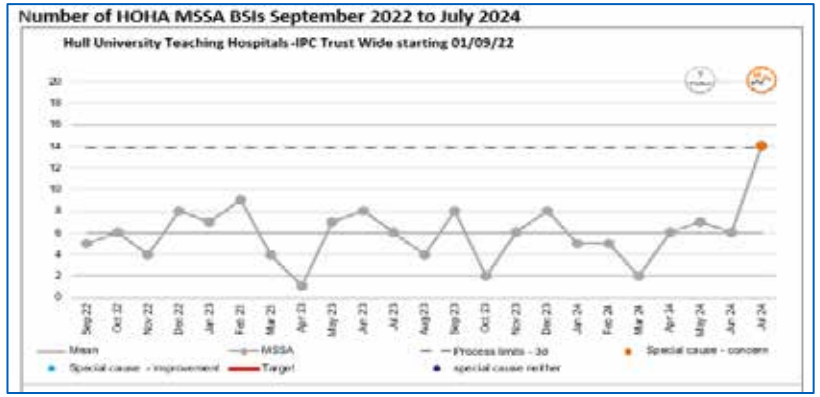
Number of HOHA E.coli BSIs September 2022 to July 2024



Number of Gram Negative Infections September 2022 to July 2024
Pseudomonas aeruginosa HOHA BSIs September 2022 to July 2024



Number of HOHA MSSA BSIs September 2022 to July 2024



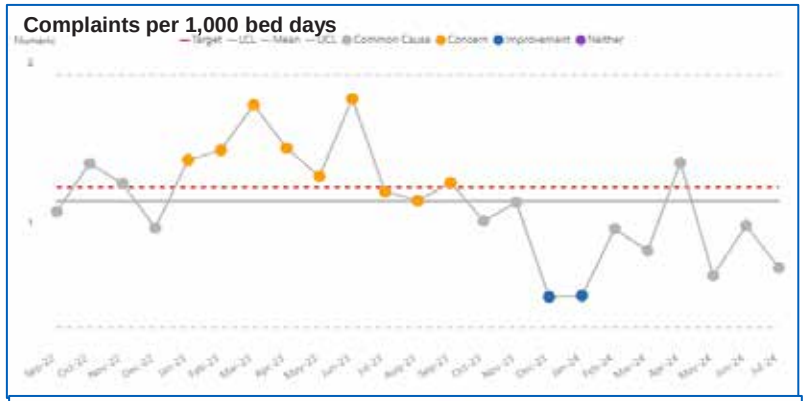
PHE have not set trajectories for any organisations yet. 2023/24 target trajectories shown until the new targets are set.

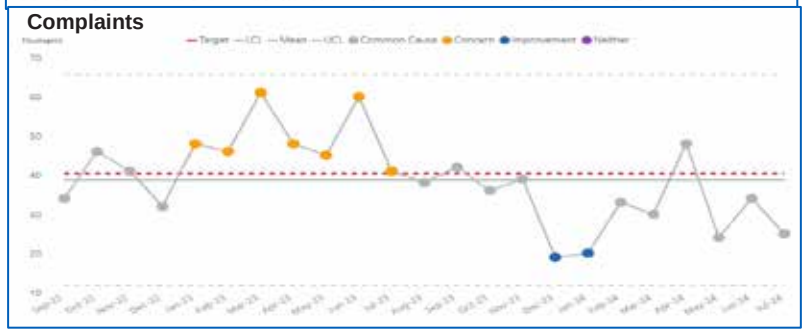
- C.Difficile – over the target trajectory
- E.Coli – over the target trajectory
- MRSA bacteriaemia – zero target 0 cases in July
- Pseudomonas aeruginosa BSIs: Four cases reported during July 2024 this is an increase from the previous month.
- Klebsiella – under the target trajectory
- MSSA BSIs – 14 target cases in July 2024 at process limit

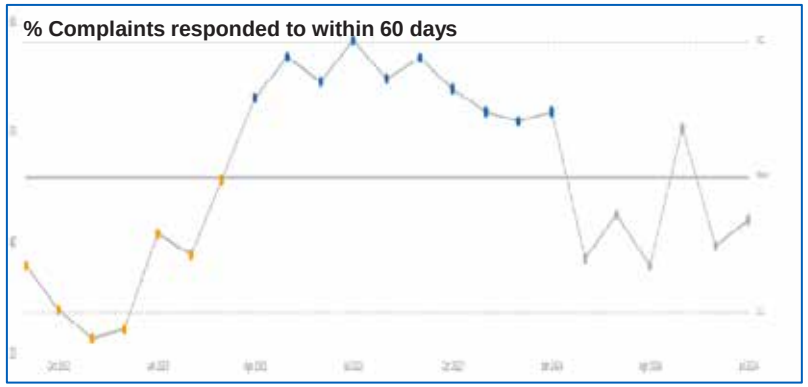
Complaints

Humber Health Partnership

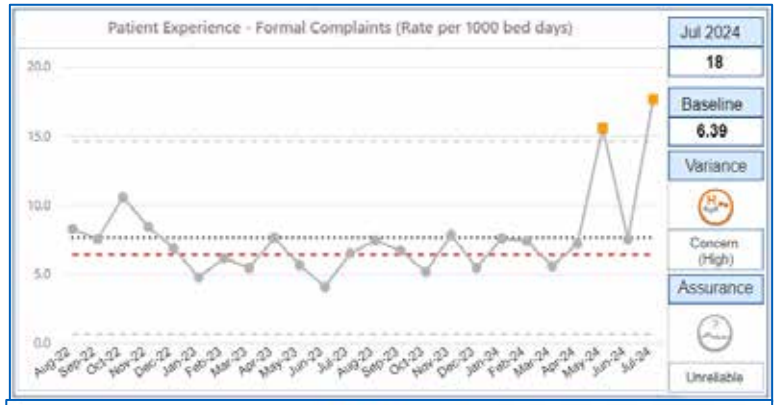
HUTH







NLAG



NLAG - There is an anomaly with the bed days accuracy over the last 3 months. The run rate on complaints is shown for the recent period on the 2nd chart shown to capture actual numbers and demonstrate the data quality issue.

Completion performance remains better than target at 88.4%

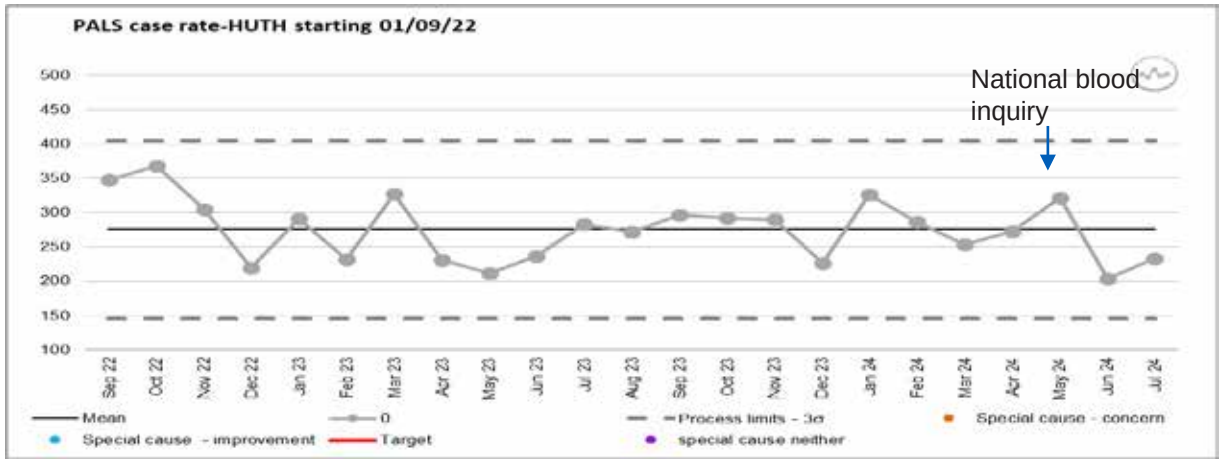
HUTH -The number of complaints received (25) in July 2024 is in line with a reducing trend from the complaints peak experienced in Qtr 1 and Qtr 2 of 2023/24.

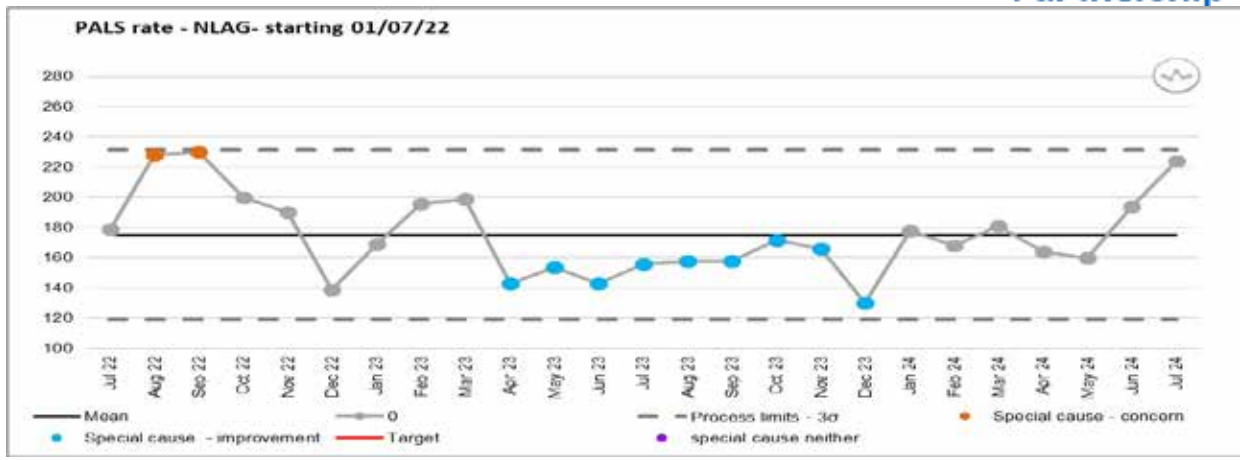
Whilst there is an average of 56 days to close, the Trust has focused on closing long-standing cases which has impacted on the overall performance.

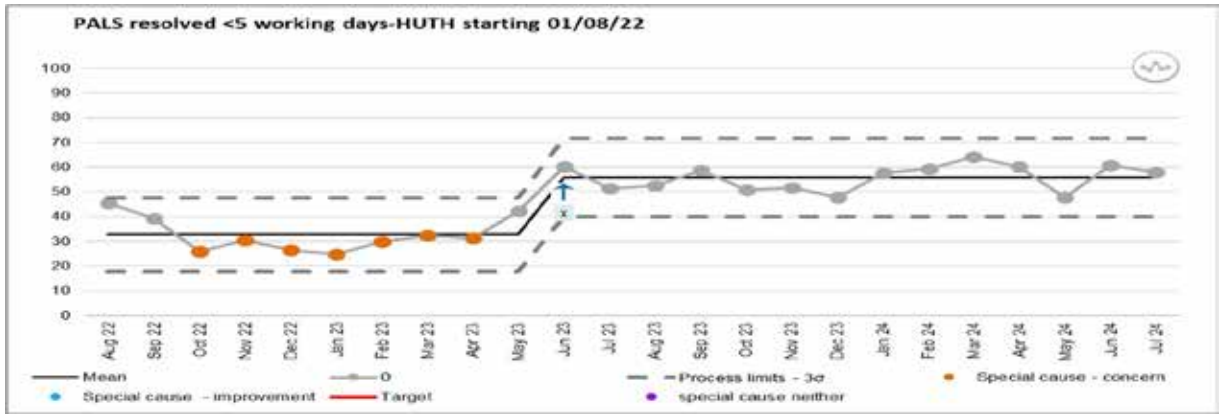
There remained 49 complaints outstanding for greater than 60 days which require input from the care groups to assist in closing and embed performance within 60 days going forward.

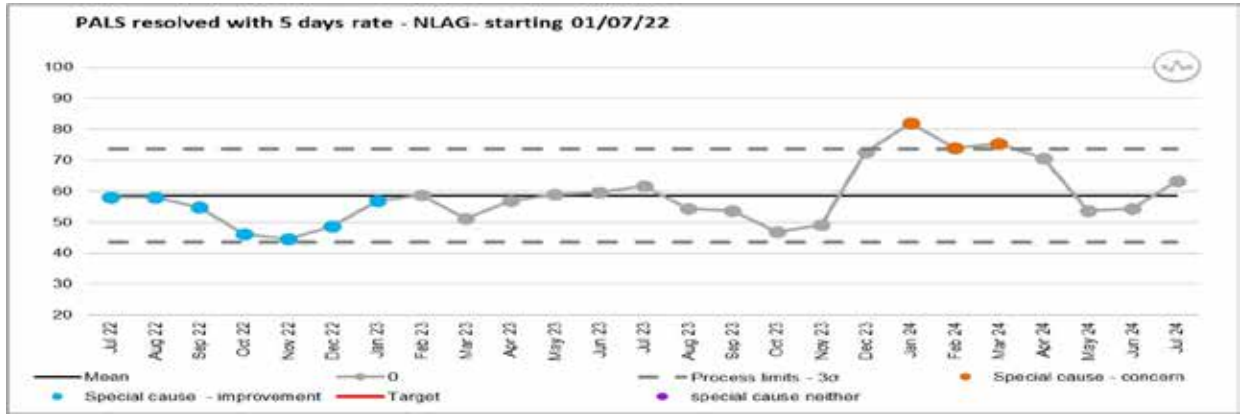
The complaints teams have been realigned and are now under single Group management which will assist in responsiveness across the group.

PALS







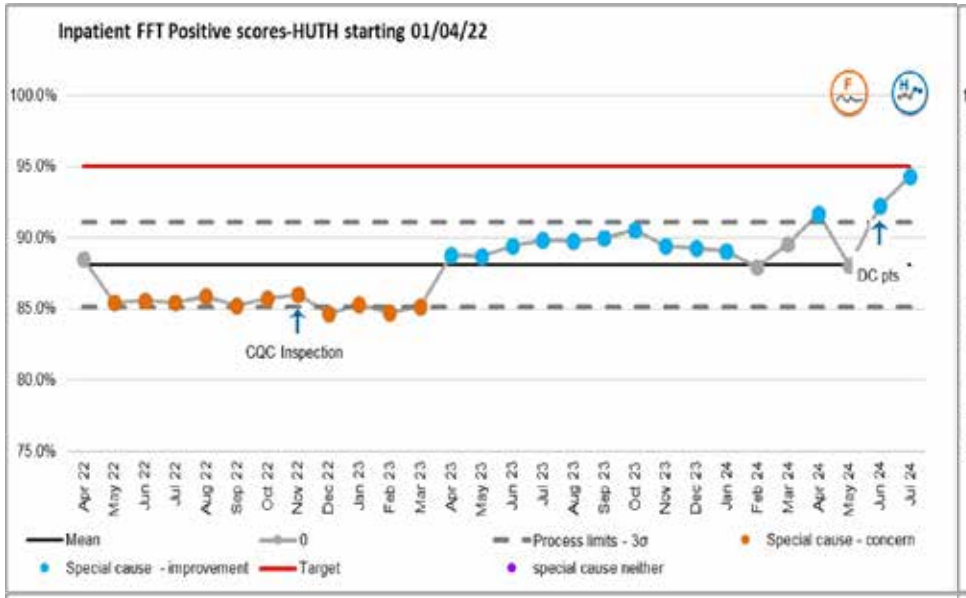


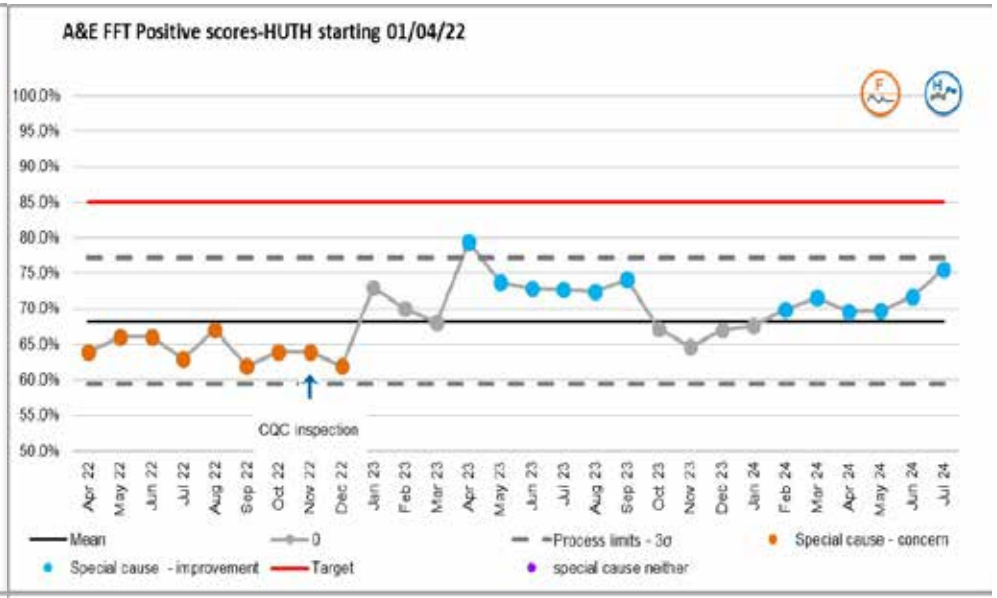
HUTH - There is normal variation in the rate of PALS contacts for the most recent period. The timeliness of completion has improved from June 2023 and now is static following the control limit revision.

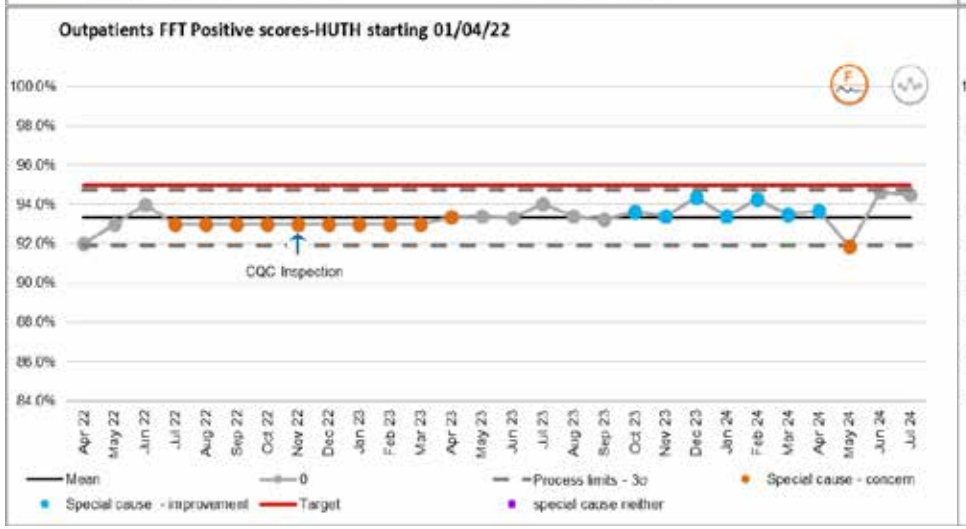
NLAG - There is normal variation in the rate of PALS contacts for the most recent period. The completion rate had improved but has returned to normal variation since April 2024.

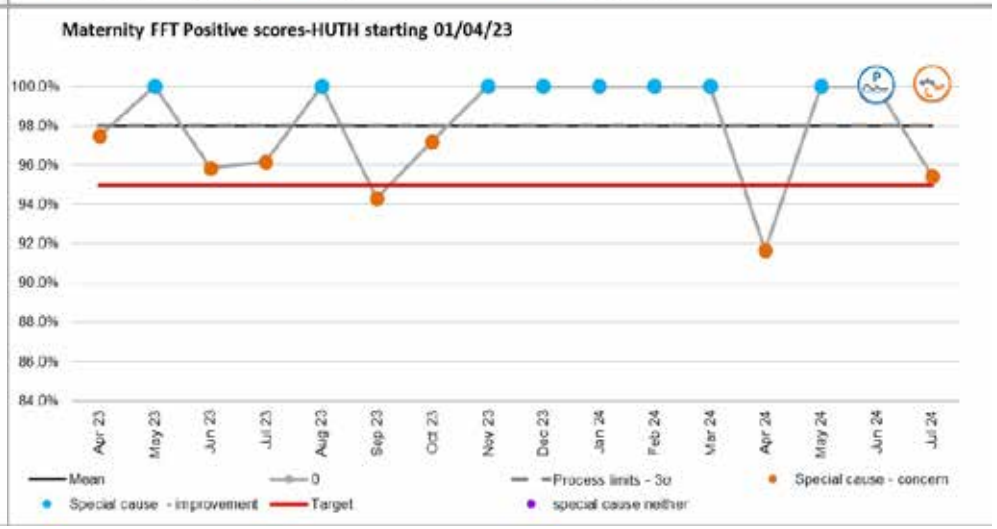
The PALs teams are now under consistent leadership and the scale of the new team will facilitate better responsiveness.

FFT - HUTH









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Inpatient FFT rates are improving. In addition, in line with national guidance, and to make HUTH performance comparable nationally, day case feedback has been included since June 2024. July 2024 performance is 94.31%, closer to the national target of 95%.

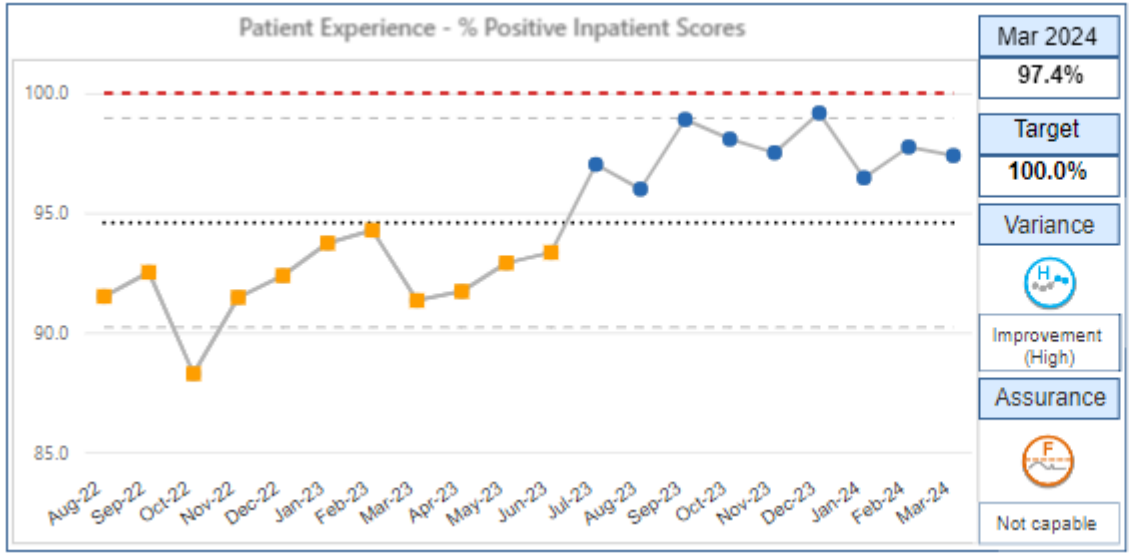
A&E FFT rates show a slow improving trend since November 2024 but July 2024 performance of 76% remains below the target of 85%.

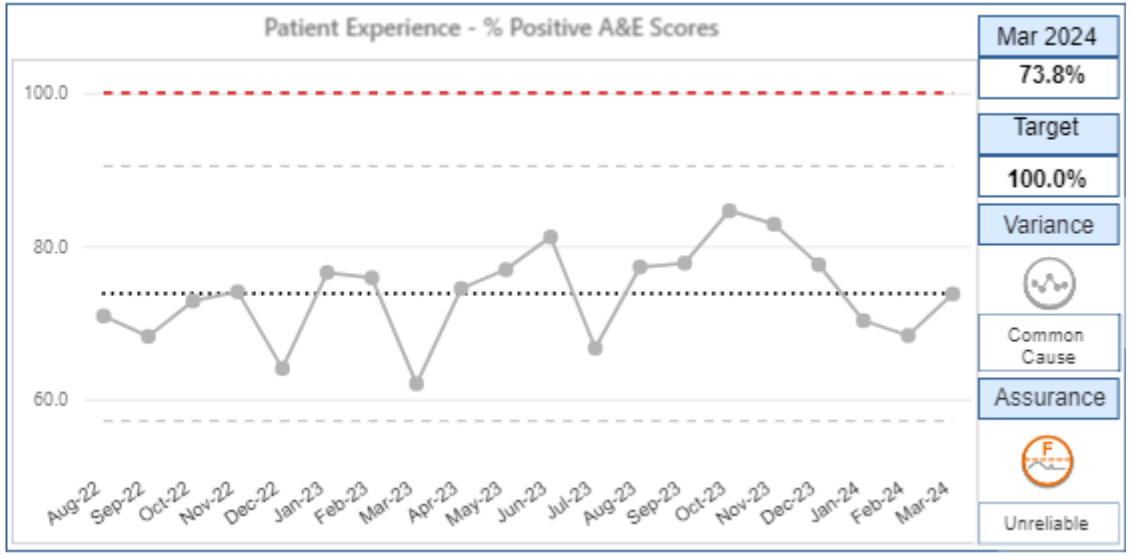
Outpatient FFT is within common cause variation and just under the target.

Maternity FFT scores show achievement of the target regularly but fluctuates.

Note: May 2024 data had lower response rates due to the SMS functionality provided externally not being available for a number of weeks which may account for lower outpatient and inpatient scores.

FFT - NLAG





Inpatient FFT rates are improving statistically significantly, achieving the national target of 95% and 86th centile nationally compared.

A&E FFT rates show common cause variation often under the 85% target, yet on the 73rd centile nationally compared.

7 - ANY OTHER URGENT BUSINESS

Sean Lyons, Group Chair

8 - QUESTIONS FROM THE PUBLIC & GOVERNORS

Sean Lyons, Group Chair

9 - MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON

Sean Lyons, Group Chair

10 - DATE OF THE NEXT MEETING

Sean Lyons, Group Chair

Thursday, 12 December 2024 at 9.00 am