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, 12 June 2025 at 9.00 am to 1.30 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	**Staff Charter and Values** Sean Lyons, Group Chair	Attached	Information	
1.3	**Patient Story** Heather McNair, Interim Group Chief Nurse	Verbal	Discussion / Assurance	
1.4	**Declarations of Interest** Sean Lyons, Group Chair	Attached	Assurance	
1.5	**Fit & Proper Person Test: Annual Declaration** Sean Lyons, Group Chair	BIC(25)079 Attached	Assurance	
1.6	**Minutes of the Meeting held on Thursday, 10 April 2025** Sean Lyons, Group Chair	BIC(25)080 Attached	Approval	
1.7	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.8	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(25)081 Attached	Assurance	
1.9	**Acting Group Chief Executive's Briefing** Amanda Stanford, Acting Group Chief Executive	BIC(25)082 Attached	Assurance	**09:35**
1.9.1	**Group Vision, Strategy & Objectives** Amanda Stanford, Acting Group Chief Executive	BIC(25)083 Attached	Approval	
1.9.2	**NHS Operating Plan 2025-26, Commitments & Group Operating Model** Amanda Stanford, Acting Group Chief Executive	BIC(25)084 Attached	Assurance	
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(25)085 Attached	Assurance	**10:30**
3.1.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Dr David Sulch & Sue Liburd, NED Maternity & Neonatal Safety Champions	BIC(25)086 Attached	Assurance	**10:40**

3.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Heather McNair, Interim Group Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(25)087 Attached	Assurance	**10:50**
BREAK – 11:00 – 11:15				
3.2	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)088 Attached	Assurance	**11:15**
3.3	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(25)089 Attached	Assurance	**11:25**
3.3.1	**Freedom to Speak Up Guardian Report – Quarter Four – NLaG & HUTH (including Annual Report)** Fran Moverley & Liz Houchin – Freedom to Speak Up Guardians	BIC(25)090 Attached	Assurance	**11:35**
3.3.2	**Freedom to Speak Up Strategy** Fran Moverley & Liz Houchin – Freedom to Speak Up Guardians	BIC(25)091 Attached	Approval	**11:45**
3.3.3	**NHS Equality Delivery System (EDS) Submission** Lucy Vere, Director of Learning & Organisational Development	BIC(25)092 Attached	Approval	**11:50**
3.4	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(25)093 Attached	Assurance	**11:55**
3.4.1	**Annual Accounts – Delegation of Authority to the Audit, Risk & Governance Committees-in-Common** Emma Sayner, Group Chief Financial Officer	BIC(25)094 Attached	Approval	**12:05**
3.4.2	**Provider Licence and Code of Governance Compliance** David Sharif, Group Director of Assurance	BIC(25)095 Attached	Approval	**12:10**
3.5	**Capital & Major Projects Committees-in-Common Highlight / Escalation Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)096 Attached	Assurance	**12:15**
4. GOVERNANCE & ASSURANCE				
4.1	**Board Assurance Framework – NLaG and HUTH** David Sharif, Group Director of Assurance	BIC(25)097 Attached	Assurance	**12:25**
5. OTHER ITEMS FOR APPROVAL				
5.1	**Green Plan** Emma Sayner, Group Chief Financial Officer	BIC(25)099 Attached	Approval	**12:35**
5.2	**Health & Safety Policy Statement** Emma Sayner, Group Chief Financial Officer	BIC(25)100 Attached	Approval	**12:45**

5.3	**Safer Staffing** Heather McNair, Interim Group Chief Nurse	BIC(25)101 Attached	Approval	**12:55**
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		**13:05**
8.	**QUESTIONS FROM THE PUBLIC AND GOVERNORS**			
8.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**13:15**
9.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
9.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Sean Lyons, Group Chair / All	Verbal	Discussion	**13:25**
10.	**DATE OF THE NEXT MEETING**			
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 14 August 2025 at 9.00 am**			

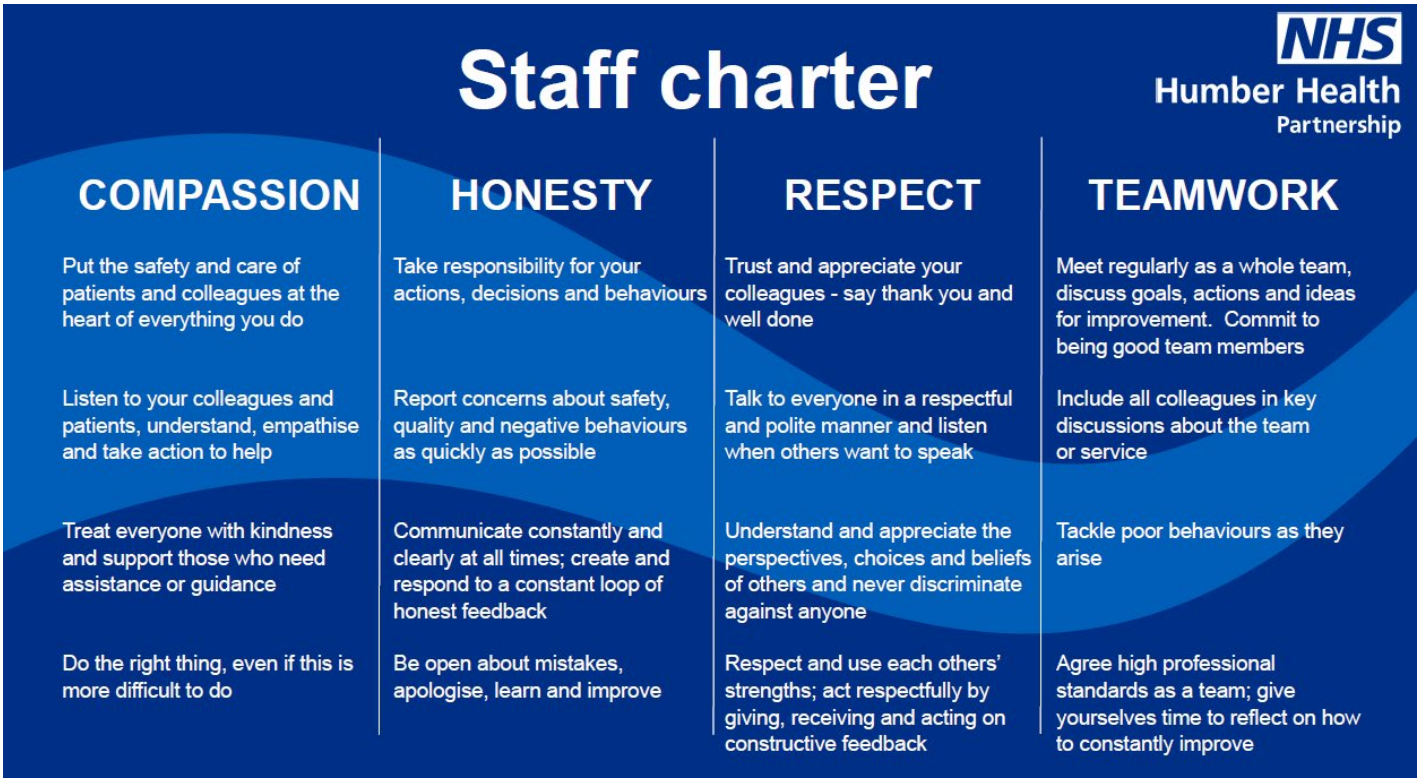
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – March 2025** Sue Liburd & Dr David Sulch, Non-Executive Directors Committee Chairs	BIC(25)102 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Finance, Estates & Performance Committees-in-Common Minutes – April & May 2025** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)103 Attached
6.2.2	**Finance Report – Month 1** Emma Sayner, Group Chief Financial Officer	BIC(25)121 Attached
6.3	**Workforce, Education & Culture Committees-in-Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – March & April 2025** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(25)104 Attached
6.3.2	**Guardian of Safe Working Hours Report – Quarter Four** Dr Kate Wood, Group Chief Medical Officer	BIC(25)106 Attached
6.4	**Audit, Risk & Governance Committees-in-Common**	
6.4.1	**Audit, Risk & Governance Committees-in-Common Minutes – January 2025** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(25)119 Attached
6.5	**Other**	
6.5.1	**Integrated Performance Report – NLaG and HUTH** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(25)107 Attached
6.5.2	**Trust Boards & Committees Meeting Cycle – 2025 & 2026** David Sharif, Group Director of Assurance	BIC(25)109 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.



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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)079

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	12 June 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	David Sharif, Group Director of Assurance
Title of Report	**Fit and Proper Persons Test: Annual Declaration**
Executive Summary	This paper sets out the annual assurance provided by the Group Chair that all Board directors remain fit and proper for their roles. It also details the current register of interests for Board members and highlights the review work to support the submission to NHSE. A verbal update at the meeting will be provided on the status of mandatory training compliance.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s)	N/A
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

1. Purpose

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

2. Background

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

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

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

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

2.5. The 2024-25 process was completed by the staff in scope, the Group Director of Assurance deputies and Human Resources. Appendix 1 details the tests applied on recruitment and for the purpose of the annual assessment of continued compliance.

3. Outcome of the Annual Fit and Proper Persons Checks

3.1. The Group Director of Assurance deputies systematically saved the completed declarations and the outcome of the Human Resources searches on each personal file. These approaches for HUTH and NLaG appointed/contracted directors was reflected in the associated spreadsheets.

3.2. A thorough internal review of **all new** staff records and a random review of existing staff records for **every** item by the respective Deputy Directors of Assurance was undertaken (each covering the other's Trust). Each review identified sufficient evidence required to comply with the FPPT although a

range of items required follow-up and a few instances where mandatory training compliance had elapsed. The Group Director of Assurance will seek greater harmonisation in future years to help strengthen the approach overall.

3.3. This review approach by the Deputy Directors of Assurance has supported:

- A review of the ongoing assessment of the fitness of directors by the Group Director of Assurance and the Group Chief of People Officer;
- A spot check sample review by the Group Chair and Group Director of Assurance.

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

3.5. During 2025-26 and in advance of year-end, colleagues will be reminded of the need to refresh their declarations (to meet the minimal requirement of one each year) and more if anything changes.

4. Recommendations

4.1. The Trust Board is asked to:

a) receive and take assurance that the Fit and Proper Persons Test has been conducted for the period 1 April 2024 to 31 March 2025 and that all Board members satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test;

b) note that directors will be reminded of the F&PPT requirements in advance of the timetable commencing in early 2026, and the importance of returning key documents upon request in a timely manner; and

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

Sean Lyons
Group Chair
June 2025

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

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

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

The annual assurance check consists of the following:

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

Appendix 2 - Director Register of Interests May 2025

Name and position	Interests
Executive and Other Directors	
Adam Creeggan, Group Director of Performance	None.
Amanda Stanford, Acting Group Chief Executive Officer	None.
Andy Haywood, Group Chief Digital Information Officer	Previous employer was a digital health consultancy that could potentially bid for services within the Trust. Procurement steps in place to remove Andy from any decision making and to ensure full transparency.
Clive Walsh, Interim Site Chief Executive – North	CRW Consulting Ltd – Sole Director. Spouse works for Birmingham Community Trust.
David Sharif, Group Director of Assurance	Trustee of WISHH Charity (HUTH).
Dr Kate Wood, Group Chief Medical Officer	Family member is Trust employee – Theatres Manager at Diana, Princess of Wales Hospital Grimsby (DPOWH). Associate for AQUA. Trustee of WISHH Charity (HUTH).
Emma Sayner, Group Chief Finance Officer	Director of Hull Citycare Ltd (Representing the NHS shareholding interest), Partner in Burton Lodge Guest House (no link to NHS), Board member on Care 2 Independence (Social Enterprise).
Ivan McConnell, Group Director of Strategy and Partnerships	None.
Jonathan Lofthouse, Group Chief Executive Officer	Group Chief Executive Officer for Northern Lincolnshire and Goole NHS Foundation Trust, as part of HUTH and NLAG working in a Group model. This includes attending the NLAG Council of Governors when requested. Wife Volunteers with the Look Good Feel Better work with the Queens Cancer Centre.
Myles Howell, Group Director of Communications	Wife works as Divisional General Manager in the UEC Care Group.
Sarah Tedford, Interim Site Chief Executive – South	None.
Simon Nearney, Group Chief People Officer	Director at Cleethorpes Town FC / The Linden Club. Family members working at NLAG and HUTH. Family member working at Hull City Council.

Name and position	Interests
Tom Myers, Group Director of Estates & Facilities	None.
Non-Executive Directors at HUTH and NLAG	
Sean Lyons, Group Chair at both NLAG and HUTH	Family member is a Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Linda Jackson, Vice Chair/Non-Executive Director (and Associate Non-Executive Director HUTH)	Associate Non-Executive Director at HUTH. Family members working at NLAG.
Murray Macdonald, Vice Chair / Non-Executive Director (and Associate Non-Executive Director NLAG)	NED at East Midlands Ambulance NHS Trust from January 2024. Independent Committee Member Yorkshire Housing from September 2024. Trustee Manby Scout Group – 2009. Associate Non-Executive Director at NLaG.
Non-Executive Directors at NLAG	
Gillian Ponder, Non-Executive Director and Senior Independent Director	None.
Julie Beilby, Non-Executive Director	South Cockerington Parish Councillor.
Simon Parkes, Non-Executive Director	Lay Canon and Chair of the Finance Committee of Lincoln Cathedral.
Susan Liburd, Non-Executive Director	Managing Director and Principal Consultant of Sage Blue. Director and Trustee of British West India Regiments Heritage Trust CIC.
Non-Executive Directors at HUTH	
Dr David Sulch, Non-Executive Director	Medicolegal reports on patients in the fields of stroke, geriatric or general medicine (split roughly 80:20 between defendant and claimant work). I have reported on the care of patients treated at HUTH and NLaG previously but do not do so now. Consultant Stroke Physician at Dartford and Gravesham NHS Trust. Medical Examiner at Medway NHS Foundation Trust.
Helen Wright, Non-Executive Director	Permanent role as Group FD of Eltherington Group Ltd – 3 days per week commencing 1st September 2024.
Jane Hawkard, Non-Executive Director	Director of JJJ+L Holdings Ltd (July 2020).
Professor Laura Treadgold, Non-Executive Director	As the Dean of the Faculty of Health Science at the University of Hull (since 02/01/24 – ongoing), the Faculty has a large research portfolio which receives funding from external bodies to undertake research.

Name and position	Interests
Sean Lyons, Group Chair at both NLAG and HUTH	Family member is a Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Tony Curry, Non-Executive Director	None.

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TRUST BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 10 April 2025 at 9.00 am
in the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Group Chair
Amanda Stanford	Acting Group Chief Executive
Emma Sayner	Group Chief Financial Officer
Sarah Tedford	Interim Site Chief Executive (South)
Clive Walsh	Interim Site Chief Executive (North)
Dr Kate Wood	Group Chief Medical Officer
Murray Macdonald	Vice Chair (HUTH)
Linda Jackson	Vice Chair (NLaG)
Julie Beilby	Non-Executive Director (NLaG)
Tony Curry	Non-Executive Director (HUTH)
Jane Hawkard	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG) (attended virtually)
Gill Ponder	Non-Executive Director (NLaG)
Dr David Sulch	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Jennifer Clarke	Member of the Public
Neil Gammon	Chair of the Health Tree Foundation Trustees' Committee
Myles Howell	Group Director of Communications
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Yvonne McGrath	Midwifery Director (For item 3.1.2) (attended virtually)
Simon Nearney	Group Chief People Officer
John Palmer	Trust Member (attended virtually)
Ian Reekie	Lead Governor
David Sharif	Group Director of Assurance
Melanie Sharp	Deputy Chief Nurse (For item 1.3)
Jackie Weavill	Governance Lead (Staff Governor)
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.

The following apologies for absence were noted:

Prof Laura Treadgold Non-Executive Director (HUTH)

1.2 Staff Charter and Values

Sean Lyons reminded everyone of the Staff Charter shared at the meeting and highlighted that everyone should always adhere to this in terms of behaviours during the meeting.

1.3 Patient Story

Melanie Sharp introduced the patient story "A Daughter's Story" which related to the care of the lady's mother.

Melanie Sharp felt the story highlighted that families did appreciate it when staff did apologise for mistakes when they occurred, and that learning was taken from this to improve.

Dr Kate Wood explained it was important to recognise how flow impacted on families. If flow through the organisation was how it should be the ambulances would attend patients sooner and Emergency Department (ED) delays would also improve, including other areas of the hospitals. Dr Kate Wood was pleased that as an organisation, staff had been able to communicate with the family and follow through on communication when they worked together.

Amanda Stanford felt the story highlighted how the organisations needed to balance how they worked in partnership with those that use the services and with families. There also needed to be an appreciation for how anxious families were during this time.

Melanie Sharp advised the story had recently been shared at the Patient Experience Group and Care Group Governance meetings to highlight that staff were able to resolve issues at the time and "make amend".

Tony Curry queried how this learning was taken forward and embedded into the learning and training within the organisations. Amanda Stanford explained that she had had several conversations with Deans in respect of embedding this into learning with students as this all factored into care.

Linda Jackson felt that the communication was correct in this situation and that often when families were involved, they would support looking after their loved ones whilst in hospital. Sue Liburd highlighted that the story shared had shown that two individual staff members had worked over their hours in caring for the patient. It was felt important to recognise that there should be no expectation that

this occurred and that handing over the care to a colleague should mean the care was equally as good.

Sean Lyons thanked Melanie Sharp for the patient story. Simon Nearney wanted to note that everyone often needed to be reminded that there were a lot of families that were appreciative of the care that had been provided as this was often not recognised.

1.4 **Declarations of Interest – BIC(25)047**

Sean Lyons referred to the report and sought any comments, none were received.

1.5 **To approve the minutes of the Boards-in-Common meeting held on Thursday, 13 February 2025 – BIC(25)048**

The minutes of the meetings held on the 13 February 2025 were accepted as a true and accurate record and would be duly signed by the Chair following the amendments listed below.

- Dr Kate Wood advised she had asked for the naming of particular doctors to be changed in the minutes. It was agreed this would be changed.

1.6 **Matters Arising**

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

1.7 **Action Tracker – Public – BIC(25)049**

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 there had been an expression of interest from an individual in respect of the Patron role. She hoped there would be a positive outcome reported back to the June 2025 Trust Boards-in-Common meeting.

Trust Boards-in-Common

- Item 1.7, 8 August 2024 – Chief Executive's Briefing – Flow Campaign. Sean Lyons explained there needed to be more understanding around flow in the organisation. A deep dive session at a Board Development would be held in May 2025. It was hoped this would then provide a picture of where the blockages were and the issues around this. Murray Macdonald advised that during a recent tour around one of the sites, the issues around flow had been noticeable, there were many patients that remained in hospital that did not need to be there from a clinical perspective. He felt there needed to be more attention at Board level on flow. Sarah Tedford advised this was being

focussed on and that she would provide an update as part of the Acting Group Chief Executive Briefing.

- Item 1.3, 13 February 2025 - Patient Story. Dr Kate Wood advised discussions had been undertaken with the Chief's of Services regarding referrals from the ED to specialties whether those patients needed to be seen face to face or if a telephone conversation was sufficient. She added that the quality of referrals from ED meant that a telephone conversation was sometimes required in respect of the management of the patient and whether they were to be admitted. Dr Kate Wood advised it had been agreed that ED would work with the Care Groups to ensure that the flow and decision making including the correct processes were in place both within the department and with others. If there was conflict as there had been on this occasion there would be other routes considered in respect of involving senior clinicians, unfortunately this had not happened on this occasion. It was agreed this item would be closed.
- Item 3.1.3, 13 February 2025 - Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports - Consideration for Maternity Sub-Board to be introduced. Amanda Stanford explained the Year 7 information had now been received which would allow more discussion around this. It was agreed an update would be provided at the June 2025 meeting.
- Item 3.2, 13 February 2025 - Performance, Estates & Finance Committees-in-Common Highlight Report - Audit, Risk & Governance Committees-in-Common to review risks. Simon Parkes advised this item was due to be discussed at the next Audit, Risk & Governance Committees-in-Common meeting in April 2025. It was confirmed an update would be provided at the June 2025 meeting.
- Item 3.2, 13 February 2025. Simon Nearney advised this item was due to be discussed during the meeting at item 3.3.1. It was agreed this item would be closed.

1.8 **Acting Group Chief Executive's Briefing – BIC(25)050**

Amanda Stanford referred to the report and noted key highlights. She added that a meeting had been held in respect of the Operational Plan and that commitment had been provided in terms of delivery over the next year. Amanda Stanford explained a process had commenced in respect of recruitment of an Interim Group Chief Nurse.

Dr Kate Wood explained there was currently concern in respect of Carbapenemase-Producing Enterobacterales (CPE) infection as there had been 53 cases at the Grimsby site over the last four months. She added that this was also affecting other Trusts nationally, it was advised that once this infected patients it was unfortunately difficult to eradicate. The Boards were advised that a weekly strategic meeting was being held with several groups feeding into that. It was noted that there would be a need for significant financial investment to support this that would be reviewed by Executive colleagues. It was recognised that good hygiene measures needed to be adhered to, including bare below the elbow and the use of hand gels. Work was being undertaken with other colleagues to identify how this had been addressed in terms of containment.

Sarah Tedford referred to flow and advised there was a need to improve on day-to-day activities to ensure this remained sustainable. There had been the introduction of a 'director of the day' which was a senior member of the team that were managing sites on a daily basis. This had been introduced over the past month and

would be under constant review. The focus around ambulance handovers continued with significant improvements in waiting times, the average waiting time was now 30 minutes. It was noted this did mean patients were therefore, moving through the system which required more work. She added that there would be work undertaken around how the ED flow worked from the Care Groups to support this work would be undertaken on ward rounds and how the system was used to support this. The teams had been asked to produce plans on how they would manage patients on a daily basis. In respect of the No Criteria to Reside (NCR) patients, this had reduced on the HUTH site last year due to a piece of work that had been undertaken, however, there had been significant issues on the NLaG site with no reductions. There had now been agreement with the system that numbers would be 10% below the bed base. There had recently been changes in personnel across the system and within a week this reduction had been achieved. This had been supported by earlier pathway referral of patients, and discharge planning commencing on the day of admission, by having relevant discussions.

Sarah Tedford advised HUTH had been successful in securing funding for the work on the ground floor which was currently underway. Sean Lyons referred to the Urgent Treatment Centre (UTC) at HUTH and queried whether the hours for this needed to be extended. Sarah Tedford advised there had been some changes in respect of this which had meant the reduction of patients due to them going through the UTC. There had been discussions with the clinical teams as they had not felt the benefit of this at the moment as there were other issues to address to support this.

Clive Walsh referred to the number of patients waiting over 65 weeks at the end of March 2025. The two areas of concern going forward were ear, nose and throat (ENT) and associated audiology. On the South Bank there were much smaller numbers, however, they were more complex and high-cost patients. Over a period of time there may be a different model in respect of those patients. There would also be two significant capital investments on the Castle Hill Hospital (CHH) site due to the expansion of the Day Surgery Unit (DSU) and Digestive Diseases. In respect of cancer on the North Bank, the faster diagnosis standard expected to continue to be met. On both Banks the 62-day standard had not been met for some time and this continued. The trajectory for next year was being set in respect of this, which was below the national requirement. It was felt this would be more realistic due to the volumes and constraints. The number of patients waiting more than 62 days had reduced, however, this was slow paced. Clive Walsh advised the organisations were in Tier 1 in terms of cancer and that meetings had taken place in respect of this. There was nothing further to report regarding this at the moment.

Sean Lyons raised a question as to what the approach would be in respect of artificial intelligence (AI) for waiting list validation. Clive Walsh explained there had been notification of a national fund in respect of waiting lists which would offer payments for every clock stop on the waiting list. A modest investment for staff that would be funded over time would mean a return of approximately £200,000. Gill Ponder advised that the Performance, Estates & Finance Committees-in-Common had discussed this at a recent meeting. There had been assurance provided that the plans to use AI would not result in any patient being removed from waiting lists without clinical review. Sarah Tedford highlighted that she had previously worked with AI and it had been very accurate in her experience.

Ivan McConnell referred to the report and wanted to thank colleagues and partners for the work undertaken with the Community Diagnostic Centres (CDCs) during the last two years. The Scunthorpe CDC had opened and had received patients. This facility would see approximately 150,000 patients a year and was hoped that it would support the regeneration of the Scunthorpe town centre. The Grimsby CDC had opened and would see approximately 100,000 patients a year. It was hoped this would also create more footfall into the Grimsby town centre and support the regeneration plan. Parking for patients and staff had also been negotiated during centre opening hours. The Hull CDC had been managed through the Council in Hull and was slightly ahead of plan. There was due to be a media launch for this on the 26 May 2025. This facility would see approximately 150,000 patients a year.

Ivan McConnell referred to the Goole & District Hospital (GDH) and advised the organisation was in the process of looking at potential options. Due to the current election period, detail was currently limited on what could be disclosed. He emphasised that there were no plans to close the GDH. Consideration would be to review how to meet the population health needs, and work would continue with local partners in support of this. He added that various engagement events had taken place since December 2024 with staff and residents. Ivan McConnell thanked Governor colleagues for their support with the engagement events. The information from events had been analysed and presented to the Integrated Care Board (ICB). From a service point of view, teams would be engaged in what would be required. In respect of the power issues raised previously, an independent engineer would prepare a review. The ICB had also committed to the Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) portable vans remaining on site. As part of the programme Professor Briggs and the Getting It Right First Time (GIRFT) team would review whether this could be an elective hub. It was noted this would be a national decision. Enhanced work with the local authority would be undertaken to review how the building could be used further as a community asset.

Murray Macdonald queried whether there had been any benefit to the organisations' flow due to the opening of the CDCs. Ivan McConnell explained it was too early to identify this, however, there may be risks as when tests were undertaken at the CDCs, patient may then need follow up treatment at the Trusts. It was noted that this would be covered as part of the flow work. Murray Macdonald questioned whether this was being tracked for review in the future. Ivan McConnell confirmed this would be the case. Amanda Stanford added that the organisations would need to support this by ensuring all capacity was used efficiently. Helen Wright explained there had been reassurance provided to the Capital & Major Projects Committees-in-Common that relevant data would be provided and reviewed at the appropriate point which would include what had gone well and what could be improved. This had been included into the work programme for the Committees.

Emma Sayner referred to the report and advised that the teams were currently closing down this financial year and reported a break-even position for both Trusts, which was a fantastic position. The capital funds received had also been mobilised as required during the year. It was noted this would all be subject to external audit. The organisations had delivered well in respect of the elective recovery position. The focus for 2025/26 would be on budgets being in the ledger for month 1 reporting. The Boards were advised that the letter received from Sir Jim Mackay was being reviewed to ensure it was part of the cost improvement and transformational plan. Sean Lyons raised a question as to whether suppliers were

being paid on time. Emma Sayner advised suppliers had been paid within required times and that this was something she felt was important. Helen Wright said that the end of year position was a great result and had been a team effort. She referred to the Sir Jim Mackay letter and questioned whether the reduction in corporate costs was based on the increases that had occurred since 2018/19. Emma Sayner explained the Trusts had modelled what this would be and that the financial value for the organisations would be £6.7 million. The organisations had already anticipated a significant reduction as part of the CIP work with PA Consulting and had started to review this.

Linda Jackson referred to the PA consulting point as this had been extended until the end of March 2025, she questioned what the plan would be in moving this forward. Emma Sayner explained there would need to be a sustainable solution in undertaking the required work. PA consulting had undertaken the work well and identified opportunities to be considered. The Executives would need to move this forward and oversee anything required. There would be a need to review how our own staff would be realigned to support that agenda. This would also be a positive opportunity for existing staff to enhance individual skills.

Linda Jackson recognised what was required, however, she had a concern that the papers suggested that staff were being asked to support a great deal at the moment. It was important that the teams were kept motivated in light of what was being asked of them. There would need to be consideration around how they would be supported. Amanda Stanford explained there would need to be an operating model for the year which would identify who could support the work. Support would also be required from the Executives in terms of what needed to be focussed on. On the 22 April 2025 the Executives would be holding an initial strategy session which would then continue once a month, to focus on what would be key issues to be addressed. It was noted the skills piece was a risk that was recognised; however, it was felt there was a need to engage with teams and build on the gap.

At this point Jane Hawkard joined the meeting.

Simon Nearney referred to the report and advised that the Learning and Innovation Centre had recently opened at CHH. The appraisal framework had been received that week; a meeting would be held to identify what was required as a group.

Amanda Stanford referred to the good news stories in the report for information.

Dr Kate Wood advised that the Electronic Patient Record Business Case had been approved the previous day at the NHS England Investment Board. There would be one final step to the process which related to Cabinet Office approval. This would then proceed with procurement. Sean Lyons thanked everyone who had supported the Business Case and congratulated them on it being approved.

Murray Macdonald referred to the Research, Innovation & Development Annual Report which was listed as an item for information and congratulated the teams as this was impressive due to the scale and variety of research undertaken. Sean Lyons queried whether there was any evidence that staff were being attracted to the organisation due to the research being undertaken. Dr Kate Wood explained this was probably not the case and it was recognised there was more work required in respect of this.

Sean Lyons thanked the teams in respect of the great work being undertaken across the organisations.

2. GROUP DEVELOPMENT

2.1 There were no items to discuss in respect of Group Development.

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

3.1 Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(25)052

Dr David Sulch referred to the reported and noted key points. In respect of the CPE outbreak, it was felt infection prevention levels had not shifted in the last year. It had been noted that good cleaning standards were critical in respect of CPE, and that it was encouraging that a report for cleaning standards had been positive across the sites with Diana, Princess of Wales Hospital (DPoWH) being better than the national average. The Committees had received presentations from staff members that worked in Audiology and Ophthalmology which had shared the challenges the services faced. The challenges in Audiology had been in respect of demand and the capacity for this. The teams had been very open and engaged when attending. Dr David Sulch particularly wanted to praise Natalie Griffiths who had attended the Committees. One issue being faced was that the majority of clinical staff in Ophthalmology were nearing retirement age which would cause issues in the future. Limited assurance had been received by the Committees in respect of this with the request for a further update in six months' time.

Dr David Sulch advised there had been some discussion around the extra contractual payments for clinical staff on the South Bank. The Committees had been advised that the quality impact on that was being mitigated. Positives highlighted at the meeting was in respect of HUTH Summary Hospital-level Mortality Indicator (SHMI) which was within expected range with ongoing improvements noted. The Committees had received a presentation from the Transcatheter Aortic Valve Implantation (TAVI) Service, and assurance had been received due to the robust processes in place.

Sean Lyons queried if the Ophthalmology telephone system was working well after being implemented. Clive Walsh advised that since it had been implemented it had not been reviewed, though there would of course be an opportunity to review that. Amanda Stanford advised there had been high numbers of complaints in that area. The majority of them had been in respect of patients not being able to speak to someone though she added that this had now improved.

Dr Kate Wood explained that the North and South Bank switchboards worked differently, however. Herself and Emma Sayner were working with the teams across the Group to review which would have oversight, as this was shared between both at the moment.

Sean Lyons referred to TAVI as discussion had been undertaken in respect of this with the ICB. Dr Kate Wood advised a comprehensive update had been shared at the Committees which had shown what the national picture was against what was provided at the organisation. The Trusts would like to have the opportunity to view

this from an external point of view to ensure this was in place correctly. This would then provide an additional layer of assurance.

Amanda Stanford explained that work around infection control continued to ensure improvements. Whilst this had been a challenge it had allowed more focus on what was required to ensure improvements were made across the group to provide assurance.

3.1.1 **Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG & HUTH – BIC(25)053**

Sue Liburd referred to the report and highlighted key points. She added that there were three core areas to raise one being in respect of learning lessons. It had been raised at the January assurance visit from the ICB that there needed to be consideration around diabetes particularly in women from economic communities as well as Asian women, in light of this there had subsequently been a deep dive. There had in particular been an increase in gestational diabetes cases, the deep dive would highlight any required improvements. In respect of staff experience, there had been a series of listening events which were ongoing particularly in respect of internally educated midwives. Linda Jackson queried what was being undertaken in respect of the freedom to speak up issues previously raised around rostering. Amanda Stanford advised this was around rotation, this had been paused in terms of reviewing the process and how this worked. Sean Lyons highlighted that during a recent walkaround with Amanda Stanford in that area this issue had been raised, he added that it was positive that staff were being open about those issues.

3.1.2 **Maternity & Perinatal Updates:**

Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(25)054

Amanda Stanford referred to the report and highlighted key points. She advised that a letter had been received from Mothers & Babies: Reducing Risk through Audit & Confidential Enquiries (MBRACE) and NHS Resolution (NHSR) advising of the requirements for the Maternity Incentive Scheme (MIS) Year Six. Due to this, further work was undertaken around aspects that were not compliant, and this had then been reviewed and advice received was that it was then compliant. A letter had been received to advise of this for NLaG.

Amanda Stanford advised that the MIS Year Seven had been received and that the meetings in preparation for this had again commenced. The same process would be undertaken in respect of evidence being monitored on a weekly basis against the technical guidance.

Yvonne McGrath referred to the report and went through further key highlights. She added that progress continued to be made against the action plan with additional resources being available to ensure this continued.

Linda Jackson referred to the report in respect of the unregistered care staff. It advised that this had reduced for neonates and maternity staff and she queried whether there were any concerns in respect of this. Secondly, the avoidance of term admissions to the Neonatal Intensive Care Unit (NICU) had been a startling difference between the two Trusts, she queried whether there was any context in

respect of this and if there were concerns. Yvonne McGrath advised that in respect of the unregistered care staff job roles these had been advertised and it was hoped they would be appointed to shortly. There had also been some transition work in respect of those roles. In respect of the second query, Amanda Stanford advised that there had been a visit to NICU at the Scunthorpe General Hospital (SGH) site. It had been recognised that there would be further work required there, however, the difference shown in the report in respect of admissions was due to the unit being smaller than the others. The further work required was around what babies were being seen at the units, this would then be shared at the Maternity Neonates Assurance Group.

Helen Wright referred to the original Business Case that had been approved partly around the developments for triage and queried whether there had been any progress on the further work required around staffing. Amanda Stanford explained that the Business Case was nearly completed. One piece of work in respect of this included the newly recruited midwives that were due to commence in September 2025 which would support that, although, recognising they would need support in the interim. In addition to this work was being undertaken within the obstetric team to identify what requirements there would be to support Ockenden and the birth rate plus output. It was noted that the birth rate plus information had not been included within the Business Case hence why this had been halted until all information was included. Emma Sayner added that work had been undertaken in respect of triangulation between cost pressures and the run rate. Helen Wright further queried what the challenges were around leadership stability as highlighted. Amanda Stanford advised one Head of Midwifery was currently on planned leave which had impacted on this. Further to this new matrons were being implemented into the team, it was recognised there was more work required in terms of the new leaders and existing leaders in respect of improving culture. She added that the team had also commenced continued professional development through the braver than before programme which makes individuals think about their leadership with others. A request had been made to request further places on this programme. Discussion had also taken place with the organisation development (OD) team to provide additional support and oversight on that programme. Sue Liburd added that this would also include some co-creative work to review culture across the service in terms of the North and South Bank.

Sue Liburd referred back to previous points made in respect of recognising changes from reports that were shared, this had been acknowledged and future reports would highlight changes from the previous update. It was also noted that when percentages were included within reports it was important to show what figure this related to, to ensure it was clearer. Amanda Stanford stated that there was further work required in respect of data quality.

Jane Hawkard congratulated the team on the improvements with fetal monitoring compliance which had been an ongoing issue for some time. She referred to the internationally educated midwives and the issues that had been raised which had been disappointing. She queried when they should expect improvements to feel comfortable at work. She further queried whether it appeared staff recognised what impact they were having on them in how they were being treated. Sue Liburd explained that a comprehensive piece of work around those concerns was being undertaken, one issue being reviewed was the contractual element as some concerns had been raised around this. Further options being considered were to meet with individuals to identify how they were being treated. A benchmarking

exercise would be undertaken in respect of internationally educated staff versus white homegrown staff and newly qualified staff, feedback would then be shared with the different staff groups. It was noted this work was being moved at pace and included each band of staff. Sue Liburd added that she was supporting this with Lucy Vere from OD and that Yvonne McGrath was leading the work being undertaken. Jane Hawkard queried how there would be knowledge that improvements had been made for staff. Sue Liburd explained this would be through the Executive team, this would also be fed into the Quality & Safety Committees-in-Common and Workforce, Education & Cultures Committees-in-Common. Amanda Stanford added that this issue had been raised nationally as it was a broader issue. As an organisation there would be a need to check whether there was a large enough diverse workforce as it was felt there was not. Murray Macdonald felt the issues raised was in other areas of the organisation and not only maternity. He felt that at Board level there were some basic checks that could be put in place to identify whether anyone was being disadvantaged by reviewing the data available. He felt this should be moved up the agenda for Board oversight due to it being a wider issue. Sean Lyons agreed this was an important issue that the Boards should have sight of. Simon Nearney explained the data was shared through the Workforce, Education & Cultures Committees-in-Common as it formed part of the Committees Workplan, this was shared in various reports throughout the year. It was recognised that there were 3,000 Black, Asian & Minority Ethnic (BAME) staff across the organisations, however, there were disproportionately fewer up to leadership level.

Gill Ponder appreciated there were several reports that provided this data, however, she felt there would be more benefit if this was triangulated together to highlight what experience staff from other countries had at the organisations. Sean Lyons appreciated this was just one issue that needed to be addressed, it was important to listen and act on what was required to ensure staff felt comfortable and safe at work. It was noted this would be discussed further at Board level.

Sean Lyons thanked Yvonne McGrath for sharing the report.

3.1.3 **Quality Priorities – BIC(25)055**

Dr Kate Wood referred to the paper and advised it was the quarter three update. She explained it was a comprehensive paper that would need some additional work to ensure the correct quality improvements were in place. Dr Kate Wood reminded Board colleagues that there were four quality priorities as articulated in the report that still needed to be focussed on as a group over the next year. There was confidence around the implementation of the priorities with oversight through the Quality & Safety Committees-in-Common which would include Deep Dives.

Gill Ponder referred to the comments within the report in respect of the lack of engagement and resourcing. She felt that timescales were quite lengthy for delivering some of the priorities. She queried whether part of the struggle in achieving them was that staff did not see them as a priority due to the longer timescales. Dr Kate Wood agreed with the point made in respect of the timescales, however, the programmes of work had been in place for more than a couple of years and had not gained traction up to this point. With this in mind this would now be done differently. It was noted that the lack of engagement could be due to staff not realising what needed to be prioritised, it was hoped that these would now be worked through more effectively, and that this all tied into cultural issues. Gill

Ponder explained she was not challenging how long they were, she was referring more to whether staff were aware of them being a priority due to the lengthy timescales and whether they felt other issues were more of a priority due to this.

Amanda Stanford agreed there was a need to manage all that was being requested whilst recognising the improvement work that needed to be undertaken. She felt there was a need to focus on less key themes. Sarah Tedford explained that work with the operational teams had included asking the care groups to agree their objectives for the year going forward, it was noted the priorities were included within them.

Sean Lyons wanted to note that it was a good report. Dr Kate Wood highlighted that the report had been shared to draw the Boards attention to the work around the quality priorities and take the endorsement from the Quality & Safety Committees-in-Common that these were the quality priorities for the coming year, it was noted it would not be shared on a quarterly basis.

3.2 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(25)056**

Gill Ponder referred to report and noted key highlights. In respect of the positive financial outcome for year-end it was noted this had fortunately been the case for the last four years and that should be acknowledged. It was noted the underlining deficit had increased largely because of non-recurrent savings which the Boards needed to be aware of. This would mean a strain on the cash position for 2025/26. Gill Ponder reported the need and future focus on transformational change that would deliver recurrent savings.

Gill Ponder and the Committees wanted to congratulate the teams as they had done a sterling job in respect of capital spend and as this had been achieved despite receiving it later in the year. Gill Ponder advised that the Committees had also requested a decision milestone plan to be shared to underpin the delivery of the cost improvement plan (CIP) profile due to the significant step ups in September 2025 and February 2026 which needed to be planned for.

Julie Beilby referred to the point made in respect of non-recurrent savings and CIP. She felt it was important to address this as it could mean it not being achieved in future years. She queried whether the staff allocated to this work were developing and whether they needed more support. Emma Sayner appreciated there was a need to be better at accountability too. Linda Jackson felt the group needed to mature more in the ‘invest to save’ area to support the work being undertaken. It appeared to be aimed more at trying to cut costs rather than addressing how to do things differently. Amanda Stanford stated that it was important for staff to look more at where improvements could be made including visiting other organisations to see what was being undertaken. It was recognised that there was a process behind successful change and this needed to be clear.

3.3 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(25)057**

Tony Curry referred to the report and noted key highlights. He referred to the point in respect of the NLaG consultant body and advised that this had not been concluded. It was noted this did have an impact on the service due to no additional

activity. Discussions were still taking place in respect of this. In respect of the maternity support workers (MSW) banding it was noted there would be a wider review in respect of band two and three across the organisations in other specialties.

3.3.1 **National Staff Survey Response – NLaG & HUTH – BIC(25)058**

Simon Nearney referred to the report and advised the Workforce, Education & Cultures Committees-in-Common had focussed on this which included an action plan. It was noted a session had also been held as part of the Trust Board Development session in March 2025.

Simon Nearney explained that NLaG and HUTH were in the bottom quartile for survey results and that they had both deteriorated over the last year. Discussions had taken place with Executives and Care Groups at management team meetings and performance meetings to highlight what improvements could be made. The Human Resources Business Partners had also met with senior leaders to discuss this further. To address this, the Care Groups' teams were being asked to focus on three key actions that managers were able to do to turnaround issues being raised. Part of this ask was through the Putting People First sessions, which were due to commence the following week and would be hosted by the Executive team. A review of what staff required around all aspects of health and wellbeing including flexible working would also be considered. Any outcomes would be fed into the Workforce, Education & Cultures Committees-in-Common and the Trust Boards-in-Common as required.

Tony Curry queried why the essentials appeared to be the last issue that would be addressed in the year. Simon Nearney noted the point made; however, it was recognised that everything was not quick fixes. For those issues that could be resolved more quickly this would be the case.

Dr Kate Wood explained that Myles Howell had attended the Quality Board to share the information, and it had been received positively. It was noted this meeting was attended by the Care Quality Commission (CQC) and information had been shared more widely.

Simon Parkes felt the organisations needed to continue to put in place the correct things and continue to be consistent, as staff wanted to feel valued and appreciated. The organisations needed to find a way of showing that staff would be put first and to ensure this happened.

Julie Beilby explained that the Workforce, Education & Cultures Committees-in-Common had been clear that the test would be as to what were made over the next year and that some of those issues could be addressed by tackling the quick wins. It had been recognised that developing a more trusting relationship with staff was important in moving forward changes.

Murray Macdonald queried whether Executives were thinking about how this would be delivered and whether there were sub-measures for tracking this. One that stood out was "how did my boss treat me today" as the organisations were one of the worse in the country in respect of that measure. If this moved more positively over the next year, it could support others. Murray Macdonald felt it would be helpful to address some key issues to be developed over the next year to be tested through

the Committees. Simon Nearney agreed this should be discussed further at the Committees.

4. GOVERNANCE & ASSURANCE

4.1 Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(25)059

David Sharif referred to the report and noted key highlights. He added that a review of the cycle of quarterly reports would be reviewed. It was noted there had been a request to look at the performance risk score and that the Executives had had a discussion around this particular issue and colleagues had agreed that the risk score was appropriate; the primary reason being that the organisations were trying to achieve significant patient gain through achieving upper quartile performance. If this was not achieved there would detrimental patient performance in terms of activity and patient care. This would continue to be discussed through the next Performance, Estates & Finance Committees-in-Common. In terms of next steps, a presentation would be shared at the next Audit, Risk & Governance Committees-in-Common meeting in respect of risk register reporting including the allied governance in place to support that process.

5. OTHER ITEMS FOR APPROVAL

5.1 There were no items for approval at the meeting.

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 Items for Information / Supporting Papers

The following items for information were shared.

- Quality & Safety CiC Minutes – February 2025
- Performance, Estates & Finance CiC Minutes – February & March 2025
- Workforce, Education & Culture CiC Minutes – January & February 2025
- Integrated Performance Report (IPR)
- Documents Signed Under Seal
- Trust Boards & Committees Meeting Cycle 2025 & 2026
- Sir Jim Mackey, Chief Executive NHS England letter dated – 1 April 2025 – Working Together in 2025/26 to lay the Foundations for Reform
- Board Member Appraisal Guidance
- Research, Innovation & Development Annual Report
- Guardian of Safe Working Hours Report – Quarter Three

7. ANY OTHER URGENT BUSINESS

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

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Sean Lyons sought questions from the public and Governors. Jackie Weavill referred to the staff survey item and wanted to highlight that there were many small

fixes that did not cost much money which would make staff feel they were appreciated and make those staff feel better. Sean Lyons agreed this was a positive point to raise, it was recognised there were some fundamentals that needed to be resolved. Emma Sayner explained she had recently experienced this with another member of staff, she felt that when these issues were raised with Board members they should be highlighted.

Sean thanked everyone for their contribution during the meeting.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 There were no matters referred to the Committees-in-Common.

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 12 June 2025 at 9.00 am in Boardroom, Hull Royal Infirmary.

The meeting closed at 12:27 hrs.

Cumulative Record of Board Director's Attendance 2025/26

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	1	1	Gill Ponder	1	1
Jonathan Lofthouse	1	0	Emma Sayner	1	1
Julie Beilby	1	1	David Sharif	1	1
Tony Curry	1	1	Amanda Stanford	1	1
Linda Jackson	1	1	David Sulch	1	1
Jane Hawkard	1	1	Sarah Tedford	1	1
Sue Liburd	1	1	Laura Treadgold	1	0
Murray Macdonald	1	1	Clive Walsh	1	1
Ivan McConnell	1	1	Kate Wood	1	1
Simon Nearney	1	1	Helen Wright	1	1
Simon Parkes	1	1			

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(25)081

BOARDS-IN-COMMON ACTION TRACKER

2024 / 25

ACTION TRACKER - CURRENT ACTIONS - 10 APRIL 2025

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	February 2025	Agenda item for June 2025 meeting		June 2025 agenda
Boards-in-Common ACTION									
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	June 2025	The Flow Campaign was launched in September 2024. A further Campaign Report will be shared at the April 2025 meeting. Sarah Tedford provided a comprehensive update at the April meeting		April 2025 minutes, item Acting Group Chief Executive's Briefing – BIC(25)050
1.3	13.02.25	Patient Story		Sarah Mableson to discuss with Chief of Service whether patients not being seen by a consultant should be seen face-to-face when being discharged.	Sarah Mableson (to be reported by Amanda Stanford)	April 2025	Update to be shared at the April 2025 meeting.		April 2025 minutes
1.3	13.02.25	Patient Story		Sarah Mableson to query why the coroner referral was not made until the family complained. (This action would be reported back through Amanda Stanford).	Sarah Mableson (to be reported by Amanda Stanford)	April 2025	Update to be shared at the April 2025 meeting.		April 2025 minutes
1.8	13.02.25	Chief Executive's Briefing - Board Development Session on Flow to be arranged		Session on flow to be included on future Board Development Session	David Sharif	April 2025	Presentation made by CEO of YAS on ambulance handovers, plus Sarah Tedford on the Flow progress to date and future work		8 May 2025 Baord development session
3.1.3	13.02.25	Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports - Consideration for Maternity Sub-Board to be introduced		Consideration for Maternity Sub-Board to be introduced	Amanda Stanford	June 2025	Update to be shared at the June 2025 meeting.		
3.2	13.02.25	Performance, Estates & Finance Committees-in-Common Highlight Report - Audit, Risk & Governance Committees-in-Common to review risks		Simon Parkes and Jane Hawkard as NED Chairs of Audit, Risk & Governance Committees-in-Common to review that risks that related to performance were being referred through to the Quality & Safety Committees-in-Common appropriately	Simon Parkes / Jane Hawkard	April 2025	Update to be shared at the June 2025 meeting.		
3.2	13.02.25	Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge - Staff Survey Link		Simon Nearney to share link to staff survey information	Simon Nearney	April 2025	Upate to be shared at the April 2025 meeting.		April 2025 minutes

Key:

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

ACTION TRACKER - CLOSED ACTIONS

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
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	February 2025	Update to be provided at the February 2025 meeting.		February 2025 minutes
3.1	10.10.24	Quality & Safety Committees-in-Common Highlight Report - NED Visibility		NED visibility to be added to Board Development timetable session	Amanda Stanford	February 2025	A session was provided at the November 2024 Board Development session on Executive and Non-Executive Director visibility. Further updates would be provided.		February 2025 minutes
3.1.3	10.10.24	Maternity & Neonatal Safety Assurance Reports - NLaG & HUTH - Board Development Session		Board Development Session to be held to review what the organisations were required to complete in terms of statutory requirements and what this did to improvement patient care	Amanda Stanford	February 2025	Update to be shared at the February 2025 meeting.		February 2025 minutes
3.2.1	10.10.24	Winter Plan		Winter Plan to be shared at November 2024 Board Development Session	Clive Walsh	February 2025	Update to be shared at the February 2025 meeting.		February 2025 minutes
3.4	12.12.24	Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge		Ivan McConnell to provide an update on HASR at the February 2025 Trust Boards-in-Common meeting	Ivan McConnell	February 2025	Item added as an agenda item on the February 2025 meeting.		February 2025 minutes

Key:

Green	Completed - can be closed following meeting

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)082

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 June 2025
Director Lead	Amanda Stanford, Acting Group Chief Executive
Contact Officer / Author	Amanda Stanford, Acting Group Chief Executive
Title of Report	**Acting Group Chief Executive's Briefing**
Executive Summary	This report provides an overview of: • Reflections from the recent leadership conference and a focus on quality and safety • Headline messages from a visit from the NHS England Urgent and Emergency Care team on 19 May 2025, and the work we need to undertake across our teams to transform our pathways • Never Events within our Group organisation • Headline performance metrics and our Tier 1 status with NHS England; we are not on trajectory with our elective, cancer and urgent and emergency care waiting times and are putting remedial actions in place • Finance headlines: Month 1 reported figures are marginally away from plan as a planned deficit position; we are working on identifying further Cost Improvement Schemes to narrow the gap in the current plan, as well as to mitigate risk within the current high-risk schemes. • We were subject to a deep dive meeting with the NHS England regional team on 5 June 2025 – the headline slides about our Group Transformation Programme, shared at this session are attached to this report, and I will talk these through today. • Our work that is continuing on Putting People First; the sessions with our managers continue at pace and the level of engagement and commitment is commendable from our staff. As detailed in this report, our work on Putting People First will be continuous and key in improving staff engagement and patient care. • Overview of discussions with our Staff Network leads, including the Supreme Court ruling and that we, as a Group, are not changing our current approach or policy on single sex facilities for patients and staff, and are working on making spaces more inclusive; also discussions on our Group menopause policy as well as ways in which we can increase staff to access professional development opportunities. • Headlines of our good news stories, including paediatric day surgery accommodation, national awards and accolades for our staff, virtual reality support for health and well-being, marking Volunteers week and developments in bereavement support to children and young people.

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:

Acting Group Chief Executive Officer

Briefing to the Trust Boards in Common
Thursday 12 June 2025

1. Introduction

1.1 I have spent some time reflecting on our purpose and drivers for change over the last few weeks, particularly following our Top 100 senior leadership event on Wednesday 21 May 2025. My sincere thanks to all staff who engaged in the agenda for the day as well as to Quality Governance colleagues for preparing the afternoon workshop materials and to our excellent Communications, Events and Organisational Development teams, who made the event happen.

1.2 Our dedication to quality and safety is the cornerstone of our work, and it is essential that we maintain this focus even as we face significant financial challenges. We are at a pivotal moment where we must transform our services to ensure that we can continue to provide the best possible care. This transformation is not just about adapting to financial constraints; it is about seizing the opportunity to improve the flow of patients and, at the same time, reduce costs. By working more efficiently, we can enhance the patient experience and ensure that every contact counts. This requires us to be ambitious in our thinking, reflecting on what we currently do and finding radically different solutions to the delivery of care, investing in our staff and their skills, and supporting our staff to bring their ideas to fruition.

1.3 We are developing a comprehensive operational plan that will, amongst other things, seek to address the challenges in our Emergency Departments and reinvigorate our approach to patient flow. This is vital for us to improve the safety and quality of care our patients receive. On Monday 19 May 2025, we received a visit from Sarah-Jane Marsh, NHS England's Urgent and Emergency Care Director, to our Emergency Department (ED) at Hull Royal Infirmary. Sarah-Jane was genuinely impressed at how hard our teams are working and was keen that we heard that message. She was also clear though that we need to work differently in order to improve performance and improve the care we are giving to patients and that does not just mean in ED. Ensuring the smooth flow of patients within the hospital is a collective responsibility that extends beyond the emergency departments. Every department and staff member plays a crucial role in managing patient transitions, coordinating care, and maintaining efficient operations. By working together and communicating effectively, we can enhance patient experiences and outcomes, making sure that each patient receives timely and appropriate care throughout their journey in the hospital.

1.4 Across our Group, we need to understand and manage our risks, embrace technology, and develop a clear strategy for the next five years. This includes a detailed transformation approach, focusing on developing the capacity and skills we all need to transform services at pace. This strategy, including our key priorities, is on today’s agenda as well as our Group Operating Model, which I hope gives structure to these objectives.

1.5 In an ever-changing NHS it is crucial that we harness the collective power of our 19,000 staff. Our Putting People First initiative is not a 12-month project but an ongoing effort to fundamentally change the culture of our organisation. We must engage our whole workforce, communicate our goals clearly, embrace change, and help colleagues to thrive at work, providing the standard of care we all aspire to deliver. Our commitment to quality and safety will guide us through this transformation, and it is within our gift to shift our mindset to one of positivity and possibility

1.6 Our engagement with staff and stakeholders on our services at Goole and District Hospital. I provide more detail about the first joint engagement event with the Humber and North Yorkshire Integrated Commissioning Board held on Wednesday 28 May 2025 later on in this report. A further event is scheduled for this month and I really encourage staff and stakeholders to take

part.

1.7 I would also like to send a big thank you to everyone who helped to organise a very short notice visit from Secretary of State for Energy, Ed Miliband, who we were delighted to welcome to Castle Hill Hospital on Thursday 18 May 2025 to look around our solar fields. The visit coincided with legislation for Britain's new publicly-owned energy company, GB Energy, passing through Parliament and the Secretary of State was extremely impressed with our facility at the hospital as well as our ambitious plans for the future in terms of reducing our carbon footprint across our Group. It is no exaggeration to say that our hospitals are among the most sustainable in terms of reducing carbon emissions and further detail of the future plans will be shared with the Trust Boards in Common particularly through the reporting committee structure.

2. Patient Safety, Quality Governance and Patient Experience

2.1 I need to draw the Trust Boards in Common attention to the number of Never Events that have been reported over the past year in our Group, which is ten over the last 12 months.

2.2 Whilst these are all individual incidents, we should not, by definition, have these occurring to patients in our care. We will investigate and share the findings of these incidents and undertake Duty of Candour correctly and in line with our values.

2.3 We thank our staff who have identified and reported these Never Events. Honesty and accountability remain crucial to service delivery and we will ensure staff whose teams have been affected by these incidents are supported.

2.4 These highlight to me the journey and the distance we need to travel to really develop a learning culture in the organisation. We want every clinical intervention to be as safe as possible and we have a range of data to tell us what is going well in our organisation and where our safety culture needs to step up. This will be a key area of focus for the Executive team over the coming year.

2.5 I am very pleased to inform the Trust Boards in Common that the first outputs from our new Group-wide quality standards framework, Aspiring to Excellence (ACE) have been published, including our first ward with all green standards. I would like to thank our clinical teams for the way in which they have embraced this framework and to our colleagues for the rigour with which these reviews are being carried out.

2.6 We received the good news that we have delivered against all of the standards in the Maternity Incentive Scheme (MIS). The MIS is a financial incentive program designed to enhance maternity safety within NHS Trusts. It rewards Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns. This has not been easy and it is the result of a lot of hard work by many people working in our maternity teams. To everyone who has been involved in this piece of work, well done and thank you for this brilliant achievement.

3. Urgent and Emergency Care and Planned Care

3.1 The headline data position for Urgent and Emergency Care and Planned Care are included in today's Integrated Performance Report at agenda item BIC(25). Starting with our Group organisation's performance on ambulance handover and the four-hour Emergency Department standard, our performance for April 2025 is set out below.

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

3.3 On a 'footprint' basis, the north bank collective four-hour performance for April 2025 was 56.3%.

The plan requirement was a performance of 64.4%. The Unplanned Care Board continues to scrutinise short-and medium-term recovery plans to impact on each part of the patient journey and ED performance and patient experience. Three core objectives have been agreed: reducing non-admitted breaches, time to first clinician and improved frailty assessment. The data measures against these objectives are included in the performance report to the Performance and Finance Committees in Common.

3.4 The ambulance handover position for the north bank in April 2025 saw an improved position linked with a new set of actions implemented in partnership with Yorkshire Ambulance Service, which has been in place since December 2024. Our Group remains one of the most improved for ambulance handover nationally since January 2025, which the Chief Executive of Yorkshire Ambulance Service shared with the Trust Boards in Common at its development session in May 2025.

3.5 The south bank 'footprint' performance in February 2025 for all Type 1 and Type 3 activity, including the UTC in Goole, was 68.8% against a plan position of 73.5%. The same three objectives are in place for the south bank with a number of supporting actions agreed.

3.6 The ambulance handover position for the south bank is within normal variation. A series of actions have been agreed with East Midlands Ambulance Service, mirroring the success of the work on the north bank, and decreases in the number of ambulances taking place over 60 minutes has decreased compared with the pre-December 2024 position.

3.7 In respect of elective care, the April 2025 position for 65-week+ breaches was 99 breaches of the standard (62 north bank, 37 south bank), a reduction compared with February 2025. ENT, Breast Surgery, Plastic Surgery, ENT and Cardiology remain the most pressured specialties on across the Group. The target for 2025/26 for the year end is no more than 1% of the PTL exceeding 52 weeks. Currently, 3.6% of patients on the north bank and 2.3% of patients on the PTL on the south bank are over 52 weeks.

3.8 In respect of cancer care, our Faster Diagnosis achievement in March 2025 (latest reported data) was 77.5% on the north bank, which was an improvement on the previous month. However, wait to first appointment is a contributory factor with two week-wait performance at 68.7% - this needs recovery and improvement action. For the south bank, performance has significantly deteriorated, and was 60.1% in March 2025. Wait to first appointment is a contributory factor, with two-week performance at 77.5%, as well as waiting times in specific diagnostics.

3.9 We remain in Tier 1 with the national NHS England team for cancer service delivery. Cancer 62-day performance for March 2025 was 57.3% for the north bank and 60.2% for the south bank. We are working with NHS England North East and Yorkshire Regional Office on recovery assurance. Whilst 62-day performance at south bank improved by 0.4% and 62-day performance at HUTH improved by 6.7%, there is a +63-day backlog particularly on the north bank. Check and challenge meetings are in place. Concerns remain in the north bank as the 104+ day backlog is above trajectory with key issues identified.

4. Strategy and partnership developments

4.1 As noted at the start of this report, a key focus on strategy and partnership development has been our discussions around Goole and District Hospital.

4.2 We held the first Goole engagement event jointly with the ICB on Wednesday 28 May 2025. We had over 250 people attend in four hours, with a number of people spending a lot of time with us. ICB colleagues co-ordinated the event including media attendance. We had a breakout session with members of the local Campaign Group, which worked really well. This allowed us to engage with all interested parties who attended the day to develop some conversations and

relationships. My thanks go to a number of colleagues who facilitated the discussions, as well as to Ivan McConnell for undertaking media duties, including Look North and Hits Radio. The BBC article was also played on Radio Humberside and we appreciate the media coverage to encourage attendance at the next event.

5. Financial Performance and Estates and Facilities updates

5.1 In respect of the Group financial position, the Month 1 position was reported to the Performance, Estates and Finance Committee in March and the assurance and escalations report for this is at agenda item BIC(25)107.

5.2 The Month 1 position is as follows: the Group reported an in-month deficit of £2.5m, marginally adverse to plan. The Group is forecasting a deficit based on current straight-line projection, with mitigating actions expected to reduce this deficit. The underlying position is estimated at a deficit of circa £119.8m; recurrent CIP delivery will be key in improving the Group's underlying position.

5.3 Capital expenditure is behind plan, however capital schemes are progressing. The detail of this year's capital plan was shared during Q4 2024-25 and confirmed at Capital and Major Projects Committees in Common this quarter.

5.4 While we are continuing to close the gap in the Cost Improvement Programme, the month 1 position was £2.6m adverse to plan. Unidentified CIP stood at £47.7m with a risk adjusted forecast of £60.6m. The Group was in receipt of a deep dive review meeting with the NHS England regional team on 5 June 2025 and the headline slides about our Group Transformation Programme, shared at this meeting, are attached to this briefing. I will talk to these at the meeting.

6. Workforce Update

6.1 As referenced in the introduction to this report, we are Putting our People First. I have really enjoyed facilitating some of the staff engagement sessions in the last few weeks, and I know my Executive colleagues have as well.

6.2 There are some excellent ideas coming out of these sessions and we are able to talk directly with staff about what is going well and what is getting in the way of improving where we work and how we care for our patients. Our managers are taking the key messages into the organisation, about agreeing three actions in each team as to how to make improvements in the workplace and to able to be more engaged in the organisation.

6.3 We have also opened up a call across the organisation for improvements and really encourage staff to submit their ideas. We are looking for ideas for improving quality and safety, for improving efficiency or for reducing costs. Our Programme Management Office is undertaking reviews of all ideas submitted and will work staff to understand how we can bring these to life.

6.4 At Ask the Execs, we had a few questions about the workforce requirements and the corporate services growth reduction requirements that have been published by NHS England. We have a fortnightly review group in place, chaired by Simon Nearney, Group Chief People officer, to review the corporate services growth requirements in detail. We also have a workforce workstream within our overall Transformation programme, with several supporting workstreams to look at how we transform and improve parts of our workforce management, in which we have a good track record, such as reduction on agency spend and recruitment of substantive workforce.

7. Equality, Diversity and Inclusion (EDI)

7.1 I am meeting each month with our Staff Network Chairs and really appreciate the insight that this gives me to our workforce and how it feels working for our Group. These are safe space conversations, so without breaking confidences, I would like to share that we are discussing the

Supreme Court ruling about single-sex spaces and looking to make our facilities more inclusive over the coming months. Like all NHS organisations, we are awaiting formal NHS guidance on this ruling. In the meantime, I would like to reassure our patients and our staff that we are not changing our current policy around beds, bathroom or changing facilities. Our single-sex accommodation policy for patients remains the same and our staff can use the facilities they need to, as they currently do, and should continue to do so.

7.2 We have also discussed the Group's approach to menopause, as well as training and career development opportunities, particularly for staff from Black and Minority Ethic backgrounds and internally educated staff. I am really passionate that as a Group organisation and one of the largest employers in the region that we harness the talents of our staff and support staff in their career development. We have a lot of avenues to do this, at the same time as recognising that the landscape on funding has changed in recent years, and we need to be ready to do things differently.

7.3 We have had some excellent discussions and agreed some supportive actions; I look forward to our next session.

8. Good News Stories and Communications Updates

8.1 Castle Hill's Daisy Building now home to facilities for children and young people
Routine operations for children across East Yorkshire are being conducted in dedicated new facilities, designed with the needs of children and families in mind. In the space of just a few weeks, the ground floor of the Daisy Building at Castle Hill Hospital has been revamped and repurposed to operate as a standalone paediatric day surgery unit. Previously, operations such as tooth extractions, tonsillectomies and circumcisions which would ordinarily see children in and out on the same day would be carried out at Hull Royal Infirmary (HRI). This was less than ideal however, as the hospital's day surgery theatres were also used for adult patients and there was no dedicated children's recovery space, meaning valuable beds were often used for this purpose on paediatric inpatient wards. Now, in line with NHS best practice and to complement the £40m adult day surgery unit on site, quality care for children requiring routine operations in specialties such as orthopaedics, ophthalmology, and maxillofacial surgery is available in a separate, custom-designed space.

8.2 A dedicated team of nurses who have helped almost 200 vulnerable people in North Lincolnshire access healthcare services can continue their vital work. Described as 'angels' the Community Inclusion Team at NHS Humber Health Partnership have secured funding for another 12 months, with the potential to expand the team too. Since the team was set up in October 2023, they've been providing essential healthcare services to vulnerable people via community drop-in sessions and visits to people living in temporary accommodation. They have seen 196 patients who were previously not engaging with health services, with 645 contacts made. The team of three have been working alongside community partners and agencies including charities, safeguarding services and local housing associations.

8.3 One of our nursing healthcare support workers has been awarded a prestigious Chief Nursing Officer for England award in recognition of her hard work and dedication. The award celebrates enduring compassion and recognises the vital contribution of healthcare support workers in England and their exceptional supporting of nursing practice. Clare Webster, who works on ward 23 at Scunthorpe hospital was nominated by their former Deputy Ward Manager. Clare joined the ward in March 2018 as a Patient Care Navigator. Her nomination described her as someone who "takes the initiative and has come up with plans which have helped improve on patient safety and facilitation of safe discharges. Everyone on the ward, including the nurses in charge, can attest to how supportive Clare has been as she gets everything done within the wink of an eye." This award is testament to her hard work, professionalism and dedication, and the group is proud to have Clare as a member of our team.

8.4 A special virtual reality (VR) taster session is being held for patients with cancer and their loved ones. The Cancer Psychological Team, based at the Queen's Centre, Castle Hill Hospital, has introduced VR after being awarded a cancer innovation grant from the Humber and North Yorkshire Cancer Alliance last year. Funding to the tune of £1,600 was awarded to buy VR equipment to enable relaxation therapies to be delivered to young people being treated in the Teenage and Young Adult Unit (Ward 33). The project proved so popular that the cancer psychological team has now invested in further equipment which patients of any age and their loved ones are being invited to road-test for the first time on Tuesday 24 June. Patients are invited to use the headsets to transport themselves to a range of relaxing landscapes including beach, mountain and forest settings and even the Northern Lights. Feedback from young people on the TYA Unit has been very positive with patients saying the VR helps to ease their anxieties.

8.5 As we marked Volunteers Week 2025, our hospital staff were keen to celebrate the people (and the pups!) who help them help others, and to say thanks for all they do. For many people entering a hospital, one of the first people they are likely to bump into is a volunteer. Hospitals across the Humber have over 650 volunteers, working across Goole, Hull, Grimsby, Castle Hill and Scunthorpe, and that's not including all of the dogs! Their reasons for volunteering are many and varied: some want to share their talents such as Clive and Wendy who play piano each week for patients and visitors to the Queen's Centre; some want to gain experience to help with a future career in health;, and others, like therapy dog Sammy who volunteers at Scunthorpe General Hospital, are just happy with a quick fuss and a treat. Yet one thing they all have in common is the support they give to others, each playing an essential but sometimes unseen role in keeping our hospitals running smoothly. We offer our heartfelt thanks to them all.

8.6 A new animated video for bereaved children, which was launched at a recent event, has been created as part of an Ideas Fund project with local charity Fitmums & Friends. It draws directly on children's lived experiences to help others better understand and support other young people who are grieving, and aims to improve their mental wellbeing. Alex Wray, End of Life Matron, was heavily involved in her role as a researcher for The Forest Project, which gives young people the opportunity to participate in forest activities such as den building, campfire cooking, tool making, tree climbing and forest games. Alex commissioned an artist Bruno Martini to create the animation, which she hopes will be shared widely to raise awareness and spark conversations around childhood bereavement.

8.7 Transgender men and women have been urged by our screening teams to undergo breast screening every three years after the age of 50 if they are registered with their GP as female. Transgender men and transgender women who are registered with their GP as male are not routinely called for screening but can request an appointment if they have any concerns. Everyone aged 50 to 70 who is registered as non-binary with their GP is called for screening so no one misses out on this vital health check. However, many in both communities fail to keep their appointments, with a national survey, published in 2018, showing 27 per cent of the 108,000 respondents were worried, anxious or embarrassed about attending appointments or accessing health care. A marketing push has been extremely successful on social media attracting the attention of Pink News and receiving national acclaim.

8.8 Congratulations to Professor Ahmed - Professor Fayyaz Ahmed, our consultant neurologist based at Hull Royal Infirmary, attended the Royal Garden Party at Buckingham Palace in May in recognition of his public service. Professor Ahmed, who is also an honorary advisor with the British Association for the Study of Headache, a Trustee of the International Headache Society and the Migraine Trust, and a senior lecturer with Hull York Medical School, has made it his life's work to promote research, to facilitate new treatments and to improve both public and professional understanding of headache and migraine. He has also gone to great effort to raise the profile of Hull nationally and internationally, working with neurology colleagues to organise and host the biennial National Meeting on Headache in the city since 2005, attracting experts

from across the globe. Well done to Professor Ahmed.

Amanda Stanford
Acting Group Chief Executive
4 June 2025

NHS Humber Health Partnership

NHS Humber Health Partnership

Delivering Our Transformation Programme 2025/2026 and beyond

June 2025

Humber Health Partnership

We have designed and implemented a comprehensive transformation programme to deliver and sustain our financial £130m savings target for 2025/2026 and beyond

The programme is set within the challenges of quality/ safety and capacity/demand

- We delivered a target of £85m during 2024/205
- We have developed a comprehensive plan to support delivery for 2025/2026
- We have implemented a robust governance structure and process to support and challenge delivery
- We have changed our focus from money to one of transformation with a focus on quality, safety and productivity
- We have specific programmes of work targeted on efficiency and productivity
- We have identified an integrated approach to issues and risk management
- We are committed to ensuring we learn from our mistakes but may need support to delivery of our challenging target

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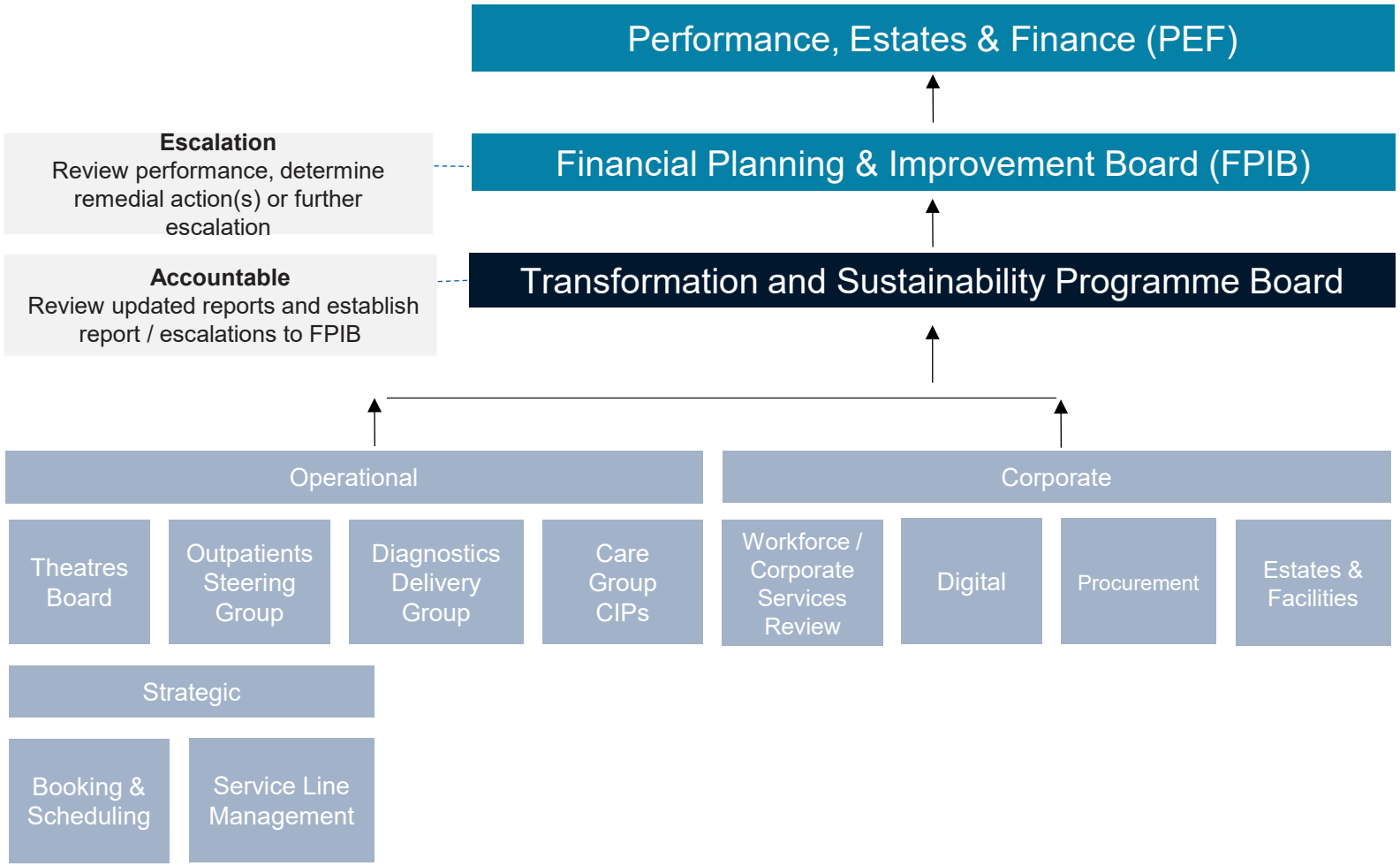
Partnership

We developed a programme governance structure during 2024/2025 with external support

We have strengthened that approach for 2025/2026 as we have brought programme management internally

- We have a comprehensive Programme Governance Structure in place
- We have a Transformation Programme Team in Place
- We have a 6 step Gateway Process – aligned to NHSE guidance – to manage delivery – this enables us to calculate risk adjusted targets at each Gateway
- Each programme of work has:
  - A dedicated SRO
  - A dedicated Project Manager (whom may be covering multiple projects)
  - A delivery Team
  - A PID
  - An EQIA
  - A two weekly reporting schedule
  - Risk and issues escalation
- We have developed an internal dashboard to allow us to report internally and externally – once

We have implemented a robust Governance structure to assure delivery



Tracking and Monitoring via integrated PMO / Finance BI Dashboard

Humber Health Partnership

Success Factors:

Governance Principles

Clear objectives, transparency and accountability (committee terms of reference (TOR) and role descriptions

Standardisation

Standardising processes and highlight reports ensures consistent implementation and reduces variations across projects

Risk Escalation

Clear risk escalation process in place to ensure risks are managed at the appropriate level and effectively and promptly escalated where necessary

Performance Monitoring

Regular reporting and tracking key performance indicators and milestones is critical for evaluating programme success, reports become more summarised at higher levels within the structure

We have undergone an NHSE and ICB review of our programme on 5th June – this provided assurance and challenge on what we need to do

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- A clear national message is “The money is the money”
- We demonstrated a clear understanding of where we are – had undertaken a good diagnostic process to get to that position
- We were praised for our openness and transparency
- They saw a narrative which demonstrated a clear shift in a move to transformation
  - Shift to non recurrent is good but a challenge
- We had demonstrated strong clinical leadership in process
- Governance and reporting – process and format good but
  - As a Board need to consider reporting and how we get a consistent and coherent narrative
  - Need to focus on pace of delivery - particularly high risk and unidentified schemes

We have undergone an NHSE and ICB review of our programme on 5th June – this provided assurance and challenge on what we need to do

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- Confidence in how we mapped our Gateway to the NHSE Assurance process
- EQIA approach is positive
- We demonstrated a recognition of challenges and complexity but ned to be able to report and discuss how we are dealing with the challenges
- Need to provide a framework for NHSE and ICB which sets out– who/what/when /where – delivery milestones of cost out is critical
- Need to review schemes and identify what they contribute to – for example Theatres whilst improving productivity delivers an IS benefit
- A recognition of the cultural challenges we face and the good work we are doing on our Cultural Programme – Putting People First

Summary Financial Plan

Humber Health Partnership

25/26 Draft Finance Plan		NLAG £'m	HUTH £'m	GROUP £'m	Comments
2024/25 Forecast Outturn @ Month 9		**(0.0)**	**(0.0)**	**(0.0)**	
	24/25 NR Technical B/S	(10.10)	(21.13)	(31.23)	
	24/25 NR Income / Expenditure	(19.16)	(20.40)	(39.56)	
	24/25 NR Core CIP Savings Delivery	(23.61)	(18.43)	(42.03)	
	24/25 FYE Investments	(1.42)	(11.13)	(12.55)	Detail provided
	24/25 FYE Pressures	0.00	(4.93)	(4.93)	
	Non Rec Elective Recovery Funding	0.00	1.43	1.43	Allocation vs 24/25 Forecast including FYE
2025/26 Opening Underlying Deficit		**(54.29)**	**(74.59)**	**(128.87)**	
Inflationary impacts	Tariff Uplift (4.15%)	18.32	28.19	46.51	As per Cost Uplift Factor (CUF)
	Convergence Efficiency Deflator (0.24%)	(1.30)	(1.20)	(2.49)	ICS
	Inflation Expenditure	(27.65)	(36.95)	(64.60)	Includes NI uplift, incremental drift and pay / non pay inflation as per National Guidance
	Inflation Expenditure CNST	(1.12)	(0.74)	(1.86)	As notified
	Inflation Other Income	1.20	1.90	3.10	Non Clinical Income including Education contract (estimated)
	Depreciation Support Income	1.25	1.55	2.80	
	Incremental Cost of Capital & PDC	(1.75)	(1.90)	(3.64)	
	Sub Total Inflationary Impacts	**(11.05)**	**(9.14)**	**(20.19)**	
Efficiency Factor (CUF)	**Tariff Efficiency Deflator (2.0%)**	**(9.43)**	**(13.59)**	**(23.02)**	Minimum efficiency requirement
Growth impacts	Growth Income	5.47	6.75	12.22	As per ICS confirmed allocation
	Growth Expenditure	(4.00)	(2.66)	(6.66)	Detail provided
	Elective Activity	(2.96)	(5.51)	(8.47)	
	Sub Total Growth	**(1.49)**	**(1.42)**	**(2.91)**	
Service Developments	Developments 25/26	(1.76)	(5.92)	(7.68)	Detail provided
25/26 Pressures	Reprovide for 24/25 support	0.00	(2.75)	(2.75)	Non recurrent impacts
	Other Pressures / Gap	0.13	0.20	0.33	Detail provided
	Sub Total Pressures and Developments	**(1.63)**	**(8.47)**	**(10.10)**	
2025/26 Planning Gap (excluding CIP)		**(77.88)**	**(107.20)**	**(185.09)**	
25/26 CIP Target		**61.68**	**68.32**	**130.00**	
2025/26 Planning Gap (including CIP)		**(16.21)**	**(38.88)**	**(55.09)**	
Non Recurrent Support	ICS Non Recurrent Income (Risk Share)	1.15	25.05	26.20	Allocations as per ICS funding allocation
	Non Recurrent Income Target	3.40	3.40	6.80	Allocations not confirmed
	Deficit Support Funding	11.66	10.43	22.09	Allocations as per ICS funding allocation incl. repayment
2025/26 Planned Deficit		**(0.00)**	**(0.00)**	**(0.00)**	

Unidentified CIP

Humber Health Partnership

UNIDENTIFIED - CLOSING THE GAP OPPORTUNITIES				
	HUTH	NLAG	HHP	Comments
Unadjusted Forecast	**45,923**	**37,988**	**83,911**	
Recurrent	32,173	26,315	58,488	
Non Recurrent	13,750	11,673	25,423	
Target	**68,320**	**61,680**	**130,000**	
Unidentified	**22,397**	**23,692**	**46,089**	
Opportunities:				
Procurement	544	133	677	Shortfall in tracker compared to £3m plan
Vacancy Factor Understatement	4,051	2,231	6,282	Net of Corporate 2%
Care Group Unidentified	9,637	7,282	16,919	at 2%
Corporate Unidentified	860	509	1,369	at 2%
E&F Unidentified	475	0	475	NLAG over delivery offsetting HUTH
E&F extra 2%	1,406	928	2,333	Delivered £8m 24/25, £3.2m non-recurrent
Corporate extra 2%	1,110	845	1,954	**Possible double count:** Could be from vacancy factor
Additional Workforce	1,490	2,306	3,795	**Possible double count:** Could contribute to delivery of unidentified
Productivity	0	268	268	Shortfall compared to scoping
			0	
Total Mitigation	**19,571**	**14,501**	**34,072**	
Remaining Unidentified	**2,826**	**9,191**	**12,017**	

Stretch included in M1 Forecast	4,388	4,398	8,786
Further Potential Double Count	4,703	7,310	12,012
Realistic Unidentified	**11,916**	**20,899**	**32,815**

Risks and Mitigations - update

NHS Humber Health Partnership

Updated Risk Position	Plan 31/03/2026 Year Ending £'000	Plan 31/03/2026 Year Ending £'000	Plan 31/03/2026 Year Ending £'000	Comments	Current risk status	Risk adjusted £'000
Risks and mitigations	HUTH	NLAG	Group		RAG	Group
(Risks)/(Offsets to benefits):						
Additional cost risk - HCD growth (ICS block funded)	(4,000)	(1,000)	(5,000)	ICS Risk Share: Growth		(2,500)
Additional cost risk - CDC 15% cost reduction	(1,840)	(1,912)	(3,752)	ICS Risk Share: CDC		(375)
Additional Cost risk - emerging		(2,800)	(2,800)	CPE outbreak, Esclation beds		(2,800)
Additional cost risk (inflation)	(2,000)	(1,500)	(3,500)	Inflationary pressures above CUF		(1,750)
Efficiency risk	(2,826)	(9,191)	(12,017)	Unidentified CIP		(12,017)
Efficiency risk	(9,090)	(11,708)	(20,798)	Very high risk - including potential double counts		(20,798)
Income risk	(3,400)	(3,400)	(6,800)	Income target - not yet indentified		(6,800)
Income risk - Contract Dispute	(128)	(2,100)	(2,228)	Lincs ICB		(2,228)
Mitigations/benefits:						
Additional cost control or income		5,000	5,000	Opportunity to review costs not yet fully implemented / income generation (Growth)		2,500
Transformational / Pathway changes	8,000		8,000	Utilisation of additional capacity to facilitate repatriation of Independent Sector activity (subject to agreement of funding mechanism)		800
Non-recurrent mitigation	3,000	3,000	6,000	Non Recurrent flexibility / non -recurrent income		6,000
Total Provider Net Risk	**(12,284)**	**(25,611)**	**(37,895)**			**(39,968)**

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)083

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 June 2025
Director Lead	Amanda Stanford, Acting Group Chief Executive
Contact Officer / Author	Linsay Cunningham, Deputy Director of Strategy and Partnerships
Title of Report	**Group Vision, Strategy & Objectives**
Executive Summary	The report provides an update on progress with the development of the Group Strategy and underpinning strategies and plans. The Board is asked to: • approve the Group Strategy on a Page and Two-year Delivery Plan • discuss and agree the next steps for: – approving the overall Group Strategy – communicating the strategy within the group and to external partners – completing the remaining underpinning strategies and delivery plans – embedding delivery of the strategy within the organisation – monitoring delivery of the strategy
Background Information and/or Supporting Document(s) (if applicable)	• Group Strategy on a Page • Two Year Delivery Plan
Prior Approval Process	Multiple drafts have been reviewed through Board development sessions and Group Executive
Financial Implication(s) (if applicable)	Having a clear Group Strategy in place is a core building block and will support the group in its ability to live within our means and deliver financial sustainability.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Population health is one of the core pillars of the Group Strategy. The Strategy prioritises efforts to improve the health of the population and sets out how we will shift toward an equity approach to service delivery – focusing our efforts on those with the greatest needs. This proactive approach to tackling health inequity is supported by efforts to embed equality, diversity and inclusion in all we do.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Group Vision, Strategy & Objectives Update
Trust Boards-in-Common
12 June 2025

Background

The Humber Health Partnership (HHP) group formed in August 2023 and began operating under a new Humber-wide Care Group structure from 1st April 2024.

Following the launch of the new Care Group structure and operating arrangements, extensive engagement was undertaken across the organisation, with partners and other stakeholders to develop a strategic framework to shape the priorities and actions for the group over the coming years.

The group strategic framework was developed and shared with key leaders within the organisation in July 2024 and subsequently shared with a range of external partners and stakeholders.

Overview of work to date

Over the past 10 months, since launching the strategic framework, engagement has been ongoing through Care Groups, corporate directorates, with staff and key external partners to develop a series of underpinning strategies and plans.

Underpinning strategies have been developed for a range of key delivery areas that will support delivery of the group strategic framework. Many of these documents have been completed and others are under development – a summary of the timeline for completion is included as Annex A. In addition to developing the underpinning strategies, work has been undertaken to refine and further develop the Strategic Framework and produce an overarching group strategy with the following supporting documents:

- Strategy on a Page
- Two-year delivery plan
- Strategy delivery dashboard
-

The Strategy on a Page has been refined to produce a clear articulation of the aims and ambitions of the group and to enable every member of staff to clearly see how their role will support delivery of the three strategic goals of the overarching group strategy.

A two-year delivery plan has been developed to support the Strategy on a Page, which sets out the high-level actions in each area that need to be taken over the next two years in order to build the solid foundations the new group needs to transform and meet current and future challenges.
The detailed underpinning strategies provide further detail on each high-level action, setting out how and when these will be delivered and how success will be measured. These more detailed strategies and plans will give further clarity to teams on what they need to deliver over the coming three years. Some of these strategies have been completed and others are still in development – these will be brought to board for approval according to the timetable set out in Annex A.

Measuring successful delivery of the strategy is vitally important. Work has commenced to develop a dashboard that will enable executive and non-executive members of the boards to monitor and track progress against delivery of the group strategy. The dashboard will continue to be developed as each of the underpinning strategies are completed and approved by the Trust Boards in Common.

Proposed next steps

The following next steps are proposed:

- The overall group strategy is finalised for Board approval and publication by July 2025, supporting delivery of the agreed Strategy on a Page.
- A communications plan is put in place to share the overall group strategy within the organisation and to partners and external stakeholders. The communication plan will seek to ensure the strategic goals are widely known and understood across the group and with external partners and stakeholders as appropriate. This will include communication assets and corporate templates to embed the group strategic goals within key communications.
- The underpinning strategies that are outstanding are completed according to the timetable set out in Annex A and aligned to the overall group strategy.
- Care Groups, building on work undertaken to date, develop two-year plans with clear objectives and timescales for delivery, which will support delivery of the group strategy at a Care Group level.
- Individual, team and directorate objectives are aligned to the group strategy to ensure delivery of the strategic goals is embedded across the whole organisation.
- The strategy delivery dashboard is further developed to enable the Board to track progress against delivery of the group strategy.
- A strategy re-fresh is undertaken in around 18-24 months.

Recommendation

The Board is asked to:

- Approve the Strategy on a Page and two-year delivery plan and the overall group strategy in principle
- Agree the next steps as set out above

Linsay Cunningham - Deputy Director of Strategy and Partnerships

Annex A – Timeline for completion of key strategic documents

	Strategic Document	Led by	Completed by
Patients	Quality and Safety Strategy	Group Chief Nurse and Group Chief Medical Officer	June 2025
	Clinical Strategy	Group Chief Medical Officer and Group Chief Nurse	Sept 2025
	Care Group Delivery Plans	Interim Group Chief Delivery Officer	March 2026
People	People Strategy	Group Chief People Officer	Feb 2025
Population	Health Inequity Action Plan	Group Chief Strategy and Partnerships Officer and Group Chief Nurse	Dec 2025
Pioneers	Research and Innovation Strategy	Group Chief Medical Officer	May 2025
	Digital Strategy	Group Chief Digital Officer	May 2025
Partnerships	Partnerships Strategy	Group Chief Strategy and Partnerships Officer	June 2025
Public Purse	Green Plan	Group Director of Estates	June 2025
	Estates Masterplan	Group Director of Estates	March 2026
	Finance Strategy	Group Chief Finance Officer	Sept 2025

Strategy on a Page (2025 - 2030)

United by Compassion – Driving for Excellence

NHS Humber Health Partnership

In five years...

we will be one of the leading hospital groups in the UK, delivering safe, sustainable and inclusive healthcare services

Guided by our values...

Compassion | Honesty
Respect | Teamwork

We will achieve this by focusing on our...

Patients

We will make sure our patients get the safe, quality care they need and have a good experience

People

We will put our people first, supporting our teams to be the best they can be and grow our future workforce

Population

We will focus our efforts on those with the greatest needs and help people in our communities to live well

To deliver our strategic goals...

Our Patients get the best care

CQC Outstanding

Top 25% performance

Our People feel proud to work here

75% recommend as a place to work and be treated

Our Population live more years in good health

Gap in access for people from deprived areas halved

We will strive to be...

Pioneers

We will embrace digital and tech, prioritise research and innovation and build skills for transformation

We push the boundaries

Partners

We will work well with others, build trust and develop ambitious partnerships for the future

We work in partnership

Guardians of the Public Purse

We will live within our means, deliver value-based care and reduce our impact on the planet

We use our resources well

Two Year Delivery Plan (2025/26 - 2026/27)

Building solid foundations

NHS Humber Health Partnership

Over the next two years, our focus will be on delivering **"Brilliant Basics"** and building capacity and capability for **transformation**

Patients

- Reduce waiting times for elective care, cancer diagnosis and treatment and urgent and emergency care, to meet national targets
- Standardise clinical pathways across the group to eliminate unwarranted variation
- Launch a rolling programme of service transformation to design and deliver safe and sustainable models of care that meet patient needs
- Strengthen our patient safety culture and supporting processes
- Implement the maternity and neonatal improvement programme
- Improve in quality priority areas, including end of life care, sepsis, deteriorating patients, medication safety and Mental Capacity Act compliance
- Refresh our involvement approach to ensure we are listening to and learning from patients and their loved ones' experiences

People

- Deliver our cultural transformation programme through our 'putting people first' approach
- Develop compassionate and inspirational leaders
- Harmonise people policies, practices and systems across the group
- Promote diversity, inclusion and fairness to foster a sense of belonging within teams
- Develop talent and skills specifically aligned to current and future service and workforce needs
- Ensure we provide the fundamental basics for our people - rest spaces, regular breaks, nutritious food, psychological safety and well-being support for our staff

Population

- Improve the way we capture and use data to identify and understand inequity
- Work with communities to coproduce a group health inequity action plan
- Undertake targeted work with partners to identify and address unmet health needs
- Provide tools and support to frontline teams to understand and address health inequity

Pioneers

- Develop a Transformation Academy to build skills and equip the organisation for major change
- Increase opportunities for clinical teams to develop research careers and secure additional funding to grow NMAHP-led research
- Launch a Group Innovation Portal through which staff can share their ideas and access tailored support from our Innovation Hub

Partners

- Make it easier for frontline teams to collaborate with other health and care providers; through toolkits, training, and simpler processes
- Identify new external partnerships to leverage investment into the region and drive innovation
- Develop our communications and engagement approach to shape a new relationship with our communities

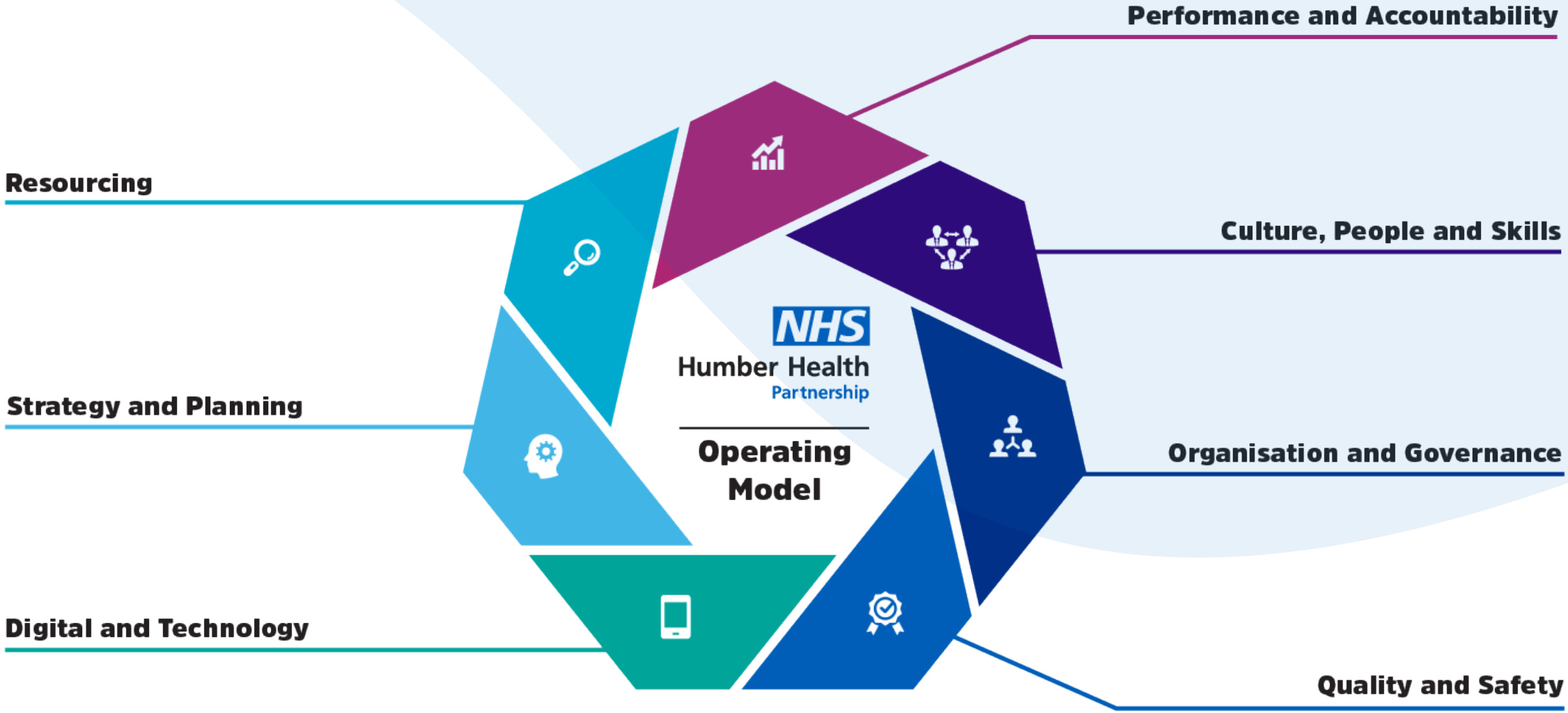
Public Purse

- Launch a transformation programme to systematically improve efficiency and productivity and eliminate waste and duplication in all areas
- Invest in core digital infrastructure (new EPR) to provide secure digital foundations that enable transformation
- Develop clear plans to deliver sustainable infrastructure (physical, digital, people, financial) for the future

NHS Humber Health Partnership

NHS Operating Plan 2025-26, Commitments and Group Operating Model

NHS Operating Plan 2025-26 submission	• To confirm – submission approved by the Trust Boards in Common in April 2025 was sent in to the Humber and North Yorkshire ICB as part of the system plan submission. • No changes have been made to the submission. • There will be close scrutiny of delivery of our system and our Group plans through NHS England Regional and National teams.
Commitments	• The NHS Operational Plan 2025-26 set out a number of mandated deliverables, specifically: improving patient waiting times as well as reducing waiting list volumes, delivering transformational financial plans on a system basis; improving the quality and safety in specific areas particularly maternity services and cardiovascular disease; improving access to healthcare services and reducing health inequalities; meeting workforce requirements around variable pay spend and corporate services workforce growth management. • We have a number of commitments specific to NHS Humber Health Partnership: quality and safety of services in response to regulatory requirements; transformation of care pathways and service delivery through digital technology; delivery of our transformation and financial plan requirements; delivery of our workforce requirements.
Group Operating Model	• This translates all of our 2025-26 mandated requirements, both local and national, into one Operating Model • This shows the connected nature of the commitments – these are not mutually exclusive and need to be delivered as a collective • This gives absolute clarity of the ask – what every individual, team, Care Group, corporate service and site triumvirate need to deliver • This will be used to review our committee and Performance and Accountability framework to deliver these requirements, to have decision-making, escalation and earned autonomy as part of how this Group Operating Model works


Performance and Accountability
Resourcing
Culture, People and Skills
NHS
Humber Health
Partnership
Strategy and Planning
Organisation and Governance
Operating
Model
Digital and Technology
Quality and Safety

Performance and Accountability

- 18-weeks – improvement to 65% nationally; local 5% minimum imp.
- 18 weeks for first appointment to 72% nationally/5% locally imp.
- 52 weeks - no more than 1% of total waiting list size
- 62 day cancer standard of 75%
- Cancer Faster Diagnosis Standard of 80%
- 78% minimum four-hour in ED standard
- Imp. in 12 hour ED performance
- Average Category 2 ambulance response time to 30 minutes

People and Culture

- Improve staff engagement score each quarter through team improvement actions from Putting People First
- Undertake effective people management within Group KPIs
- Reduce agency expenditure as far as possible, with a minimum 30% reduction
- Deliver corporate services growth reduction requirements from NHS England letter by end Q3

Organisation and Governance

- Update and implement revised Performance and Accountability framework through Site Triumvirate teams and for Corporate Services
- Match decision-making/tactical committee structure to Performance and Accountability framework
- Match corporate service capacity to meet Site triumvirate, Transformation and Care Group requirements*
- Service Line Reporting end Q2

Quality and Safety

- Deliver milestones of Group Transformation Projects (%CIP, EF&D, workforce, procurement, outpatients, theatres, diagnostics)
- Improve safety in maternity and neonatal services per national plan
- Deliver improvements plans for Group Quality Priorities
  1. Deteriorating Patient and Sepsis
  2. End of Life Care
  3. Medication Safety
  4. Mental Capacity Act
- Deliver CQC action plan requirements in full

Digital and Technology

- Deliver milestones in Electronic Patient Record programme
- Deliver key digital projects to enable pathway transformation (DoctorDr, etc)
- Deliver Bed Management solution pan-Group
- Implement planned clinical service upgrades inc. replacement equipment and reporting (LIMS, PACS)

Strategy and Planning

- Implement Group data structure and reporting
- Reduce inequalities in line with theCore20PLUS5 approach
- Meet hypertension and CVD treatment targets – percentage increase requirements
- Deliver remaining supporting strategies to Group strategy
- Make progress against strategy objectives in year 1
- Forward look to capital and revenue inc. 10 Year Plan

Resourcing

- Deliver a balanced net system financial position for 2025/26, including delivery of our financial plan and £130m efficiency requirement
- Deliver requirements of Group Capital plan
- * Implement ward to board dashboards for Performance and Accountability, Site and Care Group requirements – Q&S, workforce, transformation, money

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC (25) 085

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 June 2025**
Director Lead	**Sue Liburd and David Sulch, Chairs of CIC**
Contact Officer / Author	**Sue Liburd and David Sulch, Chairs of CIC**
Title of Report	Quality and Safety CIC Highlight Report
Executive Summary	This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their Time Out held on Tuesday 29 April 2025 and Committee meeting on 29 May 2025 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC had the time out session to review its Terms of Reference and workplan. **The Boards in Common are asked to** • Note the issues highlighted 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:

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

Report for meeting of the Trust Boards to be held on:	Thursday 12 June 2025
Report from:	Quality and Safety Committees in Common
Report from meeting(s) held on:	29 April 2025 and 29 May 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common (CIC) at their meeting(s) held on 29 April 2025 (time out) and 29 May 2025 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 April 2025

- Terms of Reference
- Board Assurance Framework
- Quality and Safety Strategy
- Workplan

29 May 2025

- Board Assurance Framework
- Risk Register Report (Q&S Risks Q4)
- Quality Priorities Q4
- Quality Strategy Update
- CQC Improvement Plan
- Nursing Assurance Report (ACE)
- Maternity and Neonatal Assurance Report
- Children and Young People Assurance Report including Governance Update
- Learning and Improvement Report Q4
- Equality and Quality Impact Assessment
- Safeguarding including MCA and DOLS
- IPC BAF Q4
- Draft Quality Accounts
- Integrated Performance Report
- Patient Experience Report Q4
- Patient Experience Annual Report
- Clinical Effectiveness Report Q4 and Annual Report
- End of Life Annual report 2023/24

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 April 2025

a) The CIC discussed the items above. There were no issues to escalate to the Board.

29 May 2025

a) HUTH/NLAG CQC Actions – The CIC expressed their concern regarding the lack of progress with the outstanding actions. A number of events are taking place to help unblock any long standing issues. The CIC were not assured in relation to the actions being taken and progress being made.
b) The Children and Young People's report highlighted workforce issues relating to RSCNs which was impacting on the Facing the Future standards. A review of the service was required to develop a sensible option for sustainability. The CIC agreed to request endorsement by the Board to have a Children and Young People's Board.
c) ACE Ward Accreditation Scheme – The CIC expressed concern regarding IPC basics such as bare below the elbows and hand hygiene. The CIC gave reasonable assurance for the North and limited assurance for the South in relation to the IPC BAFs.

4.0 Matters on which the committees have requested additional assurance:

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

29 May 2025

a) The CIC discussed, as part of the risk debate the emotional impact on frontline staff due to operational pressures and referred this item to WECC.
b) Additional assurance was requested relating to the risk register. The CIC asked for clarity around the risks arising from the issues stated and the mitigations that were in place. A risk training programme was being developed to help staff manage their risks.
c) Maternity and Neonatal – HUTH and NLAG declared full compliance with the Year 6 CNST standards. However there was some workforce fragility regarding senior leadership sickness absence. Reasonable assurance was given by the CIC.
d) 9 Never Events over the last 12 months from May 2024 to April 2025 were noted. A Safe Surgery Group has been established to review and manage the issues.
e) The CIC received annual reports relating to End of Life Care, Clinical Effectiveness and Patient Experience. Reasonable assurance was given for all 3 reports.

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:

29 April 2025

The Quality and Safety BAF risks were presented to the CIC and there were no proposed changes to either of the risk ratings. It was agreed that the BAF should be prioritised on future agendas and more time allocated to it.

29 May 2025
The Quality and Safety BAF risks were presented to the CIC, there were no proposed changes to either of the risk ratings. The CIC discussed Martha's Rule and Patient Safety Specialists and how these areas should be included in the BAF. It was agreed that actions would be added to ensure this work was captured.

The CIC probed the risk trajectories and whether they were ambitious enough. This would be discussed through the BAF review process.

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, Chair of the Committees in Common

David Sulch, Chair of the Committees in Common

29 April 2025/29 May 2025

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)086

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 June 2025
Director Lead	N/A
Contact Officer / Author	Sue Liburd, Non-Executive Director David Sulch, Non-Executive Director
Title of 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, HUTH, Maternity & Neonatal Voices Partnership (MNVP) and the Local Maternity & Neonatal System (LMNS). The report sets out matters of risk to escalate which include the current fragility in senior leadership roles, but note the positive progress being made in the delivery of maternity and neonatal service across the Group.
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) • 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)	
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

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Maternity & Neonatal Safety Champion's Report
For the Month of June 2025

Executive summary:

The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that the following are in place:

- Delivery of high-quality clinical care across maternity & neonatal service & facilities.
- Sufficient workforce numbers to deliver the maternity & neonatal services.
- Timely and relevant learning and training systems.
- Effective team working.
- Authentic engagement mechanisms with service users and the collection of meaningful feedback.
- Feedback is utilised to improve the delivery of quality care and services.

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 boards in common. The report includes risks and concerns requiring escalation as well as good practice, improvement and innovation.

Activities undertaken this month:

The Maternity & Neonatal Safety Champion's activities undertaken between 01 April to 04 June 2025 have included the standard programme of walk rounds, meetings with service executive leads, plus attendance at maternity and neonatal assurance and service meetings as follows:

Hull University Teaching Hospitals (HUTH)

- 04 June: HNY/LMNS Delivery Board.

Northern Lincolnshire and Goole (NLaG)

- 1 April: International Midwives - Review of concerns.
- 2 April: HNY/LMNS Delivery Board.
- 7 April: International Midwives - Follow up Listening Event.
- 29 April: Safety Champion Walkaround at HUTH.
- 7 May: HNY LMNS Perinatal Quality Surveillance Group.
- 21 May: Top 100 Leaders - Maternity Services Review Breakout.
- 27 May: MNVP - Maternity Services Culture Complaint.
- 02 June: Midlands Maternity Safety NEDs Forum.
- 4 June: HNY LMNS Delivery Board.

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
Attention is being given to better dissemination of learning from Maternity & Newborn Safety Investigations (MNSI) and internal reviews.	HUTH 94% positive maternity services feedback in March. NLaG 100% positive feedback in February and 86% neonatal satisfaction in March.	• Persistent incivility hotspots at HUTH and staff reported cultural issues at DPoW. • Internationally Educated Midwives at NLaG raised concerns about integration and support. This triggered listening events and contract review process. This work is ongoing.

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Good practice, improvements & innovation to share:

The Safety Champions note:

CNST Year 6 Compliance

- Both HUTH and NLaG achieved 100% compliance (Blue rating) across all 10 CNST safety actions.
- Compliance with duty of Candour remains at 100% across both trusts with evidence of multilingual support and consistency of documentation.

Training Compliance

- Both Trusts achieved 90% compliance in core training modules for maternity and neonatal training across most staff groups, particular credit is given to anaesthetic staff. Training includes - Fetal monitoring, multi -professional maternity emergencies training and neonatal life support training.

CNST Year 7

- Guidance was published in April 2025.

Risks & concerns to escalate:

The Safety Champions note:

Maternity Service Leadership

- The maternity services are experiencing senior leadership fragility due to unexpected, unplanned necessary absences.

Maternity Support Worker Mapping Exercise

- In May 2024 there was a request from NHS England to scope all Maternity Support Workers (MSWs) against a competency, education and career development framework. The report following completion of the exercise was presented to the HNY Local Maternity & Neonatal System (LMNS) Board on 04 June 2025. The feedback for both HUTH and NLaG reflected the emotions that MSWs experienced during the active industrial action centred on banding and remuneration concerns, and the discussions that were ongoing during the review period.
- More positively, both Trusts have a significant number of MSWs enthusiastic for career progression and individuals curious about undertaking degree apprenticeships in the future.
- CQC recommendation - MSWs will be mandated to complete the Care Certificate when new in post. For those currently not holding the qualification Trusts will be asked to take steps to ensure completion.

Equipment and Capacity gaps

- Concern about insufficient caesarean section capacity at HUTH which may pose operational and clinical risk.
- Delays in replacing diathermy machines at HUTH.

Activities planned next month:

19 June: Maternity and Neonatal Assurance Group
30 June: Belonging and Inclusion in Maternity & Neonatal Care Staff Conference

Sue Liburd
Non-Executive Director
Maternity & Neonatal Safety Champion
Northern Lincolnshire & Goole NHS Foundation Trust
04 June 2025

David Sulch
Non-Executive Director
Maternity & Neonatal Safety Champion
Hull University Teaching Hospitals

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)087

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 June 2025
Director Lead	**Heather McNair, Interim Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	**Maternity & Neonatal Assurance Report**

Executive Summary	• Service User Satisfaction:
	  ○ HUTH reported 94% positive maternity feedback in March.
	  ○ NLAG achieved 100% positive maternity and 86% neonatal satisfaction in March.
	• CNST MIS Year 6: Both Trusts met all 10 safety actions with full compliance (Blue rating).
	• HUTH: Apgar data validation reduced the outlier concern; improved monitoring processes implemented.
	• Training Compliance:
	  ○ Achieved over 90% compliance in core maternity and neonatal training modules across most staff groups.
	• Recruitment & Workforce:
	  ○ HUTH: 22 newly qualified midwives recruited; Band 7 MPL roles filled and Matron recruited
	  ○ NLAG: Recruitment & Retention Lead appointed substantively; first Maternal Acute Illness Management course held.
	• Safety and Learning: Numerous cases reviewed with lessons disseminated. Strong compliance with Duty of Candour (100%).
	
	Challenges
	
	• Staffing Pressures:
	  ○ HUTH reported significant shortfalls in actual vs. planned staffing hours (as low as 52.75% for neonatal unregistered care staff).
	  ○ NLAG staffing levels were higher but still below optimal in some areas.
	• Workplace Culture:
	  ○ Reports of incivility and cultural issues at DPOW and concerns from internationally educated midwives.
	• Environment and Equipment:
	  ○ Delays in equipment replacement (e.g., diathermy machines at DPOW); capacity issues in HUTH for caesarean sections.
	
	Initiatives and Improvements
	
	• Listening to Staff: New staff experience workstreams and targeted engagement events launched.
	• Service Improvements: Revised neonatal intensive care (IC) criteria post-peer review at SGH; increased oversight and pathway changes implemented.

	• Screening Performance: High compliance in antenatal screening indicators across both trusts, though NLAG slightly exceeded avoidable repeat test thresholds MIS Year 7 • Claims Scorecard Triangulation (Q4 2024/25): o Key themes for HUTH include: o ATAIN sustained decrease in hypothermic admissions o CTG classifications and management – escalated to fetal monitoring team to review for learning and teaching o Delay in IOL and ARM >24hrs continue to be Datixed o BadgerNet documentation standards o Key themes for NLAG: o The introduction of Badgernet has caused issues with documentation o Staffing levels - mitigated with escalation policy. No harm caused by staffing levels. • Perinatal Mortality Review Tool Reports (Q4 2024/25): 100% compliance against CNST standards for both HUTH & NLAG
Background Information and/or Supporting Document(s) (if applicable)	Q4 Claims Scorecard – HUTH Q4 Claims Scorecard – NLAG Q4 Perinatal Mortality Review Tool (PMRT) Report – HUTH Q4 Perinatal Mortality Review Tool (PMRT) Report – NLAG
Prior Approval Process	**Quality & Safety Committees in Common**
Financial Implication(s) (if applicable)	**N/A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

April & May 2025

Contents

1: Executive Summary & Highlight Report

This report outlines the progress, key achievements, and areas for improvement across maternity and neonatal services at Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) during April and May 2025.

Key Achievements

- Service User Satisfaction:
  - HUTH reported 94% positive maternity feedback in March.
  - NLAG achieved 100% positive maternity and 86% neonatal satisfaction in March.
- CNST MIS Year 6: Both Trusts met all 10 safety actions with full compliance (Blue rating).
- HUTH: Apgar data validation reduced the outlier concern; improved monitoring processes implemented.
- Training Compliance:
  - Achieved over 90% compliance in core maternity and neonatal training modules across most staff groups.
- Recruitment & Workforce:
  - HUTH: 22 newly qualified midwives recruited; Band 7 MPL roles filled and Matron recruited
  - NLAG: Recruitment & Retention Lead appointed substantively; first Maternal Acute Illness Management course held.
- Safety and Learning: Numerous cases reviewed with lessons disseminated. Strong compliance with Duty of Candour (100%).

Challenges

- Staffing Pressures:
  - HUTH reported significant shortfalls in actual vs. planned staffing hours (as low as 52.75% for neonatal unregistered care staff).
  - NLAG staffing levels were higher but still below optimal in some areas.
- Workplace Culture:
  - Reports of incivility and cultural issues at DPOW and concerns from internationally educated midwives.
- Environment and Equipment:
  - Delays in equipment replacement (e.g., diathermy machines); capacity issues in HUTH for caesarean sections.

Initiatives and Improvements

- Listening to Staff: New staff experience workstreams and targeted engagement events launched.
- Service Improvements: Revised neonatal intensive care (IC) criteria post-peer review at SGH; increased oversight and pathway changes implemented.
- Screening Performance: High compliance in antenatal screening indicators across both trusts, though NLAG slightly exceeded avoidable repeat test thresholds.

Conclusion

Both HUTH and NLAG demonstrate strong commitment to maternity and neonatal safety through robust governance, staff training, user engagement, and transparent reporting. While service user satisfaction remains high, efforts are ongoing to address workforce, cultural, and data quality challenges.

Key Highlights 2.1 CNST MIS Year 6: 10 Steps to Safety

Hull University Teaching Hospitals NHS Trust

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

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

Safety action	Red	Amber	Green	Blue	
1 National Perinatal Mortality Review Tool					
2 Maternity Services Data Set (MSDS)					
3 Transitional Care Services					
4 Clinical Workforce Planning					
5 Midwifery Workforce Planning					
6 SBLCB V3					
7 Service User Feedback / Co-produced Services					
8 Training					
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**0**	**0**	**0**	**10**	

Northern Lincolnshire and Goole NHS Foundation Trust

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					
2 Maternity Services Data Set (MSDS)					
3 Transitional Care Services					
4 Clinical Workforce Planning					
5 Midwifery Workforce Planning					
6 SBLCB V3					
7 Service User Feedback / Co-produced Services					
8 Training Plan					
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**0**	**0**	**0**	**10**	

MIS Year seven guidance was published in April 2025. The MIS Delivery Group takes place on a weekly basis to discuss any risks identified with oversight from the Site Director of Nursing. The most significant risks are associated with Safety Action 6 and Safety Action 5.

2.3 Perinatal Quality Surveillance Model – February 2025

Hull University Teaching Hospitals NHS Trust

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

Maternity Support Programme	Yes

Data measure	February 2025
Findings of review of all perinatal deaths using the real time data monitoring tool	4 notifications to PMRT. 3 x NND and 2 x SB. PMRT reviews: • 96662 – 23+2 NND - B, B, A, • 95990 – 23+2 NND - B, B, A, • 96445 – NND >28 days - B, B, A
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	0
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	W327191 – Moderate. WB IMDD 8. 4000l MOH and ITU transfer. MIRM review conducted. Downgraded to low harm. Well managed MOH and escalation. Part of ongoing thematic review of PPH >1500ml.
Compliance with duty of candour	100%
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report

Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	Reviewed daily and plans put in place to mitigate risk e.g. Double pay incentive, use of mutual aid across the group.		
Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	21370.25	18170.22	85.03%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	8392.75	5604.42	66.78%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	17232.25	11958.08%	69.39%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	944.00	498.00	52.75%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	Reviewed daily and plans put in place to mitigate risk e.g. use of locums and offer of enhance rates where required.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Please refer to body of report		
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No		
Coroner Reg 28 made directly to the Trust	0		
Progress in achievement of CNST 10	Please refer to body of report		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Maternity Support Programme	No

Data measure	February 2025
Findings of review of all perinatal deaths using the real time data monitoring tool	2 perinatal deaths in February 2025. Key themes identified from **Q4** cases PMRT or continued from previous quarterly reviews are as follows: • All postnatal bloods and investigations not being taken. • Management for reduced fetal movements not followed as per policy. • Growth surveillance not carried out as per policy • Written information not given antenatally regarding reduced fetal movements. • Specific birth planning advice not given • Post mortem not carried out due to confusion over consent forms • Fetal monitoring not followed as per policy • Bereavement checklist not fully completed • Risk assessment not updated in the intrapartum period • Pre-term birth optimisation not carried out as per policy.
Number of cases referred to MNSI/ENS	1
Family's informed of referral to MNSI/ENSR	1
Findings of review of all cases eligible for referral to MNSI	At the rapid review, care issues identified of consultant not seeing the patient in ANC and proteinuria not being investigated which have been actioned.

Compliance with duty of candour *(within 10 working days)*	100%		
Number of incidents graded as moderate or above / action taken	No moderate cases in April		
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 consultant cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual. Reviewed daily and plans put in place to mitigate risk e.g. DPI, use of mutual aid across the group.			
Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	10,609.2	9,729.6	91.7%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	4,298.0	4,016.9	93.5%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	5,152.0	4,594.7	89.2%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	2,576.0	1970.3	76.5%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	100% compliant – no gaps identified.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Concerns raised about the culture at DPOW on a walkaround particularly around the rotation at DPOW.		
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No		
Coroner Reg 28 made directly to the Trust	0		
Progress in achievement of CNST 10	Please refer to body of report		

2.3 Perinatal Quality Surveillance Model – March 2025

Hull University Teaching Hospitals NHS Trust

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

Maternity Support Programme	Yes

Data measure	March 2025
Findings of review of all perinatal deaths using the real time data monitoring tool	3 notifications to PMRT – 1 neonatal death, 1 stillbirth, 1 late fetal loss. PMRT 26/03/2025 - External attendance and MNVP attendance. 96528 – NND >28 days. Graded B, A, A. 96455 – AN SB 38+3. Graded B, A. 97125 – NND 22+1 Graded C, B, A. (Graded C due to pre-term optimisation)
Number of cases referred to MNSI/ENS	1 – See table below (W332053)
Family's informed of referral to MNSI/ENSR	1 – See table below (W332053)
Findings of review of all cases eligible for referral to MNSI	MI-040973 – no concerns from MDT at MIRM. MI-038053 – final report received, tripartite arranged for 30.04.2025. Action plan agreed to be approved at Pan-group Governance. MI-038632 – awaiting final report.
Number of incidents graded as moderate or above and what action is being taken	W332052/W332048 – maternal cardiac arrest and perimortem CS, AAR complete, referred to MNSI and accepted due to family concerns. W331973/W331423 – confirmed IUD following assault, reviewed at MIR, downgraded to no harm incident following discussion with head of patient safety on harm level post review.
Compliance with duty of candour	100%

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report		
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	Reviewed daily and plans put in place to mitigate risk e.g. Double pay incentive, use of mutual aid across the group.		
Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	20767.83	16922.35	81.48%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	8344.5	5383.08	64.51%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	17088.5	11601.92	67.89%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	935.5	588.25	62.88%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	Reviewed daily and plans put in place to mitigate risk e.g. use of locums and offer of enhance rates where required.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Please refer to body of report		
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	No		
Progress in achievement of CNST 10	Please refer to body of report		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Maternity Support Programme	No

Data measure	March 2025
Findings of review of all perinatal deaths using the real time data monitoring tool	0 perinatal deaths in March 2025. Key themes identified from **Q4** cases PMRT or continued from previous quarterly reviews are as follows: • All postnatal bloods and investigations not being taken. • Management for reduced fetal movements not followed as per policy. • Growth surveillance not carried out as per policy • Written information not given antenatally regarding reduced fetal movements. • Specific birth planning advice not given • Post mortem not carried out due to confusion over consent forms • Fetal monitoring not followed as per policy • Bereavement checklist not fully completed • Risk assessment not updated in the intrapartum period • Pre-term birth optimisation not carried out as per policy.
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	N/A
Findings of review of all cases eligible for referral to MNSI	N/A

Compliance with duty of candour *(within 10 working days)*	N/A		
Number of incidents graded as moderate or above / action taken	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 consultant cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual. Reviewed daily and plans put in place to mitigate risk e.g. DPI, use of mutual aid across the group.			
Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	11,745.9	10,738.6	91.4%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	4,758.5	4,540.9	95.4%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	5,704.0	5,319.2	93.3%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	2852.0	2179.8.3	76.4%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	100% compliant – no gaps identified.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Work ongoing to address concerns raised around rotation		
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

Positive News

Response to potential alarm-level outlier status - National Maternity and Perinatal Audit (NMPA0

Introduction
On 19 February 2025, Maternity Services at Hull University Teaching Hospital (HUTH) received a letter from the Royal College of Obstetricians and Gynaecologists (RCOG) regarding a potential alarm level outlier status in the forthcoming National Maternity and Perinatal Audit (NMPA) report, which covers births during 2023.

As part of the audit process, three measures have been selected as indicators which are subject to 'outlier reporting'. These indicators have been case-mix adjusted to take into account the different maternal demographic and clinical characteristics at each trust/board.

The indicator where HUTH has been identified as having a potential alarm-level outlier is as follows:

- **Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7**

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.45	100	4334	2.31	2.46	1.99

The table above shows that HUTH has an adjusted result of 2.46% which lies outside the expected range of values for a trust/board of this size and is higher than the upper 99.8% control limit (greater than 3 standard deviations above the mean).

Method of Data Submission
No data is submitted to the NMPA, data is sourced from the Maternity Services Data Set (MSDS) and supplied directly to the NMPA by NHS England.

Acceptance / rejection of potential outlier status
The Trust were asked to review the quality and completeness of data for accuracy and reply to the NMPA by 25 March 2025 with the outcome of the review. The review confirmed that data errors have been identified which call into question the accuracy of the results.

Investigation
The Information Services team provided a patient sample to include liveborn all singleton babies born between 34+0 and 42+6 weeks of gestation between 1 January 2023 and 31 December 2023. From this, liveborn singleton babies born between 34+0 and 42+6 weeks of gestation with an Apgar score of less than 7 at 5 minutes of age were identified.

Whilst the notification specifies a numerator of 100 cases with an Apgar score below 7 at 5 minutes, the sample provided by Information Services identified slightly more cases (106). The difference may be due to records excluded by the national team as per the technical guidance i.e. missing information such as gestational age, number of babies (multiplicity), or fetus outcome (stillbirth or livebirth).

For the 106 cases identified it was agreed that a representative sample (25 cases) were to be reviewed to identify potential data quality issues and continued review of the remaining cases if issues were identified. This entailed checking the Apgar scores recorded in the handheld labour and delivery record against the scores recorded on the MSDS to check for accuracy. Data was collected by the HUTH Maternity Audit and Compliance Manager.

Findings
An initial sample of 29 cases were reviewed. The Apgar scores were correctly input in 16 (55%) cases. The remaining 13 (45%) records reviewed found that 11 had an Apgar of 7 or above. As a result, all remaining records were requested for review due to data errors. In total, 104 maternal notes were reviewed. The remaining 2 records were unavailable and therefore unable to validate.

Of the 104 cases, 67 (64%) matched the Apgar score submitted. 37 (36%) cases were found to differ from the data submitted. 3 cases had an Apgar score below 7 and 34 had a score of 7 or above. Of the 34 that had an Apgar score of 7 or above, 29 of these had an Apgar score of ‘0’ submitted. When reviewing the handheld records, it appeared in the majority of cases, that there had been a data input error where the Apgar score had been missed by the Midwife when documenting on the electronic system.

It was noted that at least 3 of the cases were classed as 'born before arrival' (BBA) and born out of the hospital with no Midwife present. These are therefore assumed from parents' explanations and in 1 case, the midwife did not document any Apgar score due to uncertainty, resulting in a submission of '0'.

From reviewing maternal records, 70 babies had an Apgar of below 7 (including the 2 notes that were unavailable). **This alters the unadjusted result for the Trust from 2.31% to 1.62% and below the upper control limit.**

Further Assurance

- Since 2023, further monitoring and review mechanisms have been put in place. At present, HUTH has a Quality and Safety Maternity Matron and two clinical governance midwives. If a baby has an Apgar score below 7 at 5 minutes, this should be reported through the Datix system. Cases are then reviewed at a Maternity Incident Review Meeting. If the baby is over 37 weeks and the baby is admitted to the neonatal unit, it will be included in an ATAIN (avoiding term admission into neonatal units) review. The clinical governance team conduct weekly data validation of the term admissions and thematic reviews every 2 weeks of these cases. Apgar scores are highlighted in this. Any concerns from the Neonatal Governance meeting are also escalated into a Maternal Governance meeting.

- In March 2024, Hull University Teaching Hospitals NHS Trust migrated to 'BadgerNet', a digital system for documentation. Apgar scores are a mandatory field on BadgerNet when completing the post-birth smart form. The system allows documentation of Apgar scores under 'BBA/NA' but does not ask for a numerical figure – this has been reviewed by the Digital Midwife for future submissions.

Positive News- Hull University Teaching Hospitals NHS Trust

- Four Midwifery Practice Leads appointed to and will commence in post as soon as possible. Remaining posts are out to advert
- Matron for Community and MLU appointed
- 7.6 WTE Core Midwife for triage posts (internal recruitment) and 3.8 MSW for triage recruited
- 22 WTE posts offered to newly qualified midwives who will commence in post in the Autumn
- Maternity Incivility Tool relaunched on the 1st of May

Positive News- Northern Lincolnshire and Goole NHS Foundation Trust

- Infant Feeding Co-ordinator appointed at Scunthorpe
- Recruitment for newly qualified midwives will occur on the 19th of May
- First Maternal Acute Illness Management course held at NLAG on 24th of March, plans for further roll-out dependent on finance to release faculty.
- Recruitment and Retention Lead now substantively appointed
- Since the Greatix System commenced in November 2022 456 certificates have been to maternity staff for their outstanding achievements
- Visit by Gill Hunt of NHS England to DPOW Maternity Unit on 28th of April
- The Grace Work Experience programme has its 4th student securing a place at university to train as a nurse or a midwife

Areas of Concern- Hull Royal Infirmary

- Incivility reporting tool indicating some 'hotspots' of concern, the incivility reporting tool is reviewed regularly with actions taken as required.
- Caesarean section capacity

Areas of Concern- Northern Lincolnshire and Goole NHS Foundation Trust

- Internationally Educated Midwives escalation of concerns; further listening event undertaken and a review of contracts and transition from Band 5 to Band 6 has been completed with a plan for 1:1 meeting with each member of staff, an initial plan has been completed to collaboratively and systemically address the concerns. A listening event was arranged for the North Bank IEMs, however this was at short notice and poorly attended, therefore a further date has been arranged.
- Grievances around the rotation consultation at DPOW- plans in place for further listening events with a staff to achieve a resolution
- Delay in replacement of diathermy machines- with TACC team to resolve and considering interim plan to negate the risk

Item 4: Maternity Training Compliance

HUTH and NLAG have achieved the 90% compliance for MIS year six.

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

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

Hull University Teaching Hospitals NHS Trust

Fetal Monitoring – incorporating Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).		
Staff Group	**March 2025**	**April 2025**
Obs consultants & SAS grade doctors	84%	79%
Other medical staff on obs rota	86%	88%
Midwives	94%	90%

PROMPT - To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.		
Staff Group	**March 2025**	**April 2025**
Obs consultants & SAS grade doctors	95%	80%
Other medical staff on obs rota *(commenced **before** 01 July 24)*	75%	75%
Midwives	93%	94%
Midwifery Support Workers	95%	95%
Anaesthetic consultants	88%	100%
Anaesthetic staff on Obs rota	28%	39%

Neonatal Resuscitation		
Staff Group	**March 2025**	**April 2025**
Neonatal/paediatric consultants / SAS grade doctors	90%	80%
Neonatal/paediatric junior doctors	67%	67%
Neonatal nursing staff / senior nurses	93%	94%
Midwifery Support Workers	Not applicable	Not applicable
Advanced neonatal nurse practitioners	40%	50%
Midwives	96%	90%

Northern Lincolnshire and Goole NHS Foundation Trust

Fetal Monitoring (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).						
	March 2025			**April 2025**		
Staff Group	**DPOW**	**SGH**	**Trustwide**	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	100%	86%	93%	100%	100%	100%
Other medical staff on obs rota	95%	76%	86%	75%	71%	73%
Midwives	98%	98%	97%	97%	93%	95%

PROMPT To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.						
	March 2025			**April 2025**		
Staff Group	**DPOW**	**SGH**	**Trustwide**	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	75%	86%	80%	88%	100%	93%
Other medical staff on obs rota	90%	88%	89%	81%	86%	83%
Midwives	96%	98%	97%	97%	94%	96%
Midwifery Support Workers	95%	96%	95%	94%	93%	93%
Anaesthetic consultants	100%	100%	100%	100%	85%	92%
Anaesthetic staff on Obs rota *(5 new starters)*	81%	83%	82%	88%	71%	80%

Neonatal Resuscitation						
	March 2025			**April 2025**		
Staff Group	**DPOW**	**SGH**	**Trustwide**	**DPOW**	**SGH**	**Trustwide**
Neonatal/paediatric consultants / SAS grade doctors	86%	100%	93%	86%	100%	93%
Neonatal/paediatric junior	95%	88%	91%	95%	88%	93%
Neonatal nursing staff / senior nurses	96%	72%	83%	95%	84%	87%
Midwifery Support Workers	Not applicable					
Advanced neonatal nurse practitioners	100%	-	100%	-	-	100%
Midwives	96%	94%	95%	96%	90%	93%

Item 5: Learning lessons Hull University Teaching Hospitals NHS Trust

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

MNSI number	IMD/Ethnicity	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-040973	1 – White European	Yes – Referral sent 06/05/205	Yes	Yes – Romanian	Yes	Yes	Note sending stage – accepted due to family concerns.
MI – 038053	1 – White British	No	Yes	Yes	Yes	Yes	Final report received, planned for dissemination and sharing of learning, Tripartite complete. PSIRF panel 06/05/2025.
MI-038632	4 – Asian (Other)	No	Yes	Yes	Yes	Yes	Final report received. Draft action plan awaiting pan-group approval May. DoC 2 sent as out of country with no return date (to arrange tripartite if wishes upon return).

5.2 Detail of incidents graded moderate or above and rapid reviews (February 2025 onwards)

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
W334178 - Admitted 11/4/25 with PV bleed Cervical cerclage performed IUD confirmed 16/4/25	1 – Black African	Obstetric	Moderate but downgraded to Low Harm following MIRM – for PMRT.	MIRM review highlighted good escalation and x2 PPC consultant MDT with regards cerclage. Partogram complete.
W333499 -09/04/2024 Second return to theatre for EUA under GA. 3.8 litres loss further 2 RBC 4FFP 100mls from cell salvage, robinsons drain inserted. Pack and balloon removed in theatre.	White British	Obstetric	Moderate harm – escalated to learning response panel (proposing AAR).	Consultant in main theatres (not W&C). Delay in recognition of intra-abdominal bleeding with dropping Hb despite BTX. Over inflation of bakri balloon. Clinical indication was there? reliance on CT scan. ST3 stated would feel judged/criticised for laparotomy in review? Culture within HUTH.
W332840 – 01/04/2025 Patient born via Emergency C-Section through thick Meconium. Admitted to NICU however remained critically unwell and therefore referred for ongoing treatment - ECMO. Baby transferred to Leicester for further care.	8 – White British	Obstetric	Moderate – Uplifted to learning response panel. AAR planned. DoC provided and family contacted	Human factors and 40mins from classification of pathological CTG to declaring CAT 1 EMLSCS. Consultant unable to be contacted x3 times (was resident). Baby discharged home following ECMO on oxygen but well.

W332162/W332048 – 24/03/2025 Unexpected admission to ICU at HRI Third floor staff member called at 19.31pm to attend an obstetric emergency. Staff member arrived and found it to be a peri-mortem LSCS post cardiac arrest in the birthing room on labour ward. Patient transferred into theatre 4 once baby had been delivered Baby on NICU MOH activated in theatre	1 – White European	Obstetric	Severe/Moderate – AAR conducted 11/04/2025 and involved MDT specialities	Appropriate AN care, admitted with high blood pressure and IOL planned iPad interpreter used throughout epidural siting (ID recorded in badger notes), Emergency bell used, Crash call 2222 used, Good MDT working, further obstetric involvement sought, Thorough documentation MOH activated PPH well managed Hysterectomy considered but avoided, uterus remains intact (G1P1)- babies condition was unknown at time Other services and specialists involved – anaesthetic's, ICU, interventional radiology On site matron informed Hot debrief done by Clinical director and LW lead – well attended and appreciated Staff TRIM referrals completed DOC done MNSI consent sought via interpreter and leaflet provided in own language Escalated to Weekly Learning Response Panel for senior oversight and AAR conducted Accepted by MNSI – cooled term baby (ENS applicable)
W331973/W331423 29/40 confirmed IUD following assault	White British IMD 3	obstetric	Fatal and moderate. Downgraded post review.	MDT review in MIRM, no learning identified. Discussion with Head of Patient Safety on Harm level post review – downgraded to no harm incident. Workforce hybrid debrief planned for 10.04.25 and further support to be offered.

5.3 Maternity & Newborn Safety Investigation cases (ongoing)

Northern Lincolnshire and Goole NHS Foundation Trust

MNSI number	IMD/Ethnicity	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-039094	IMDD 8 White British	No	Yes	Yes	Yes – posted 29/11/24	Yes	No safety concerns identified at rapid review. MNSI have now sent the report with no safety concerns or recommendations.
MI-039193	IMDD 1 Any Other (Afghanistan)	No	Yes	Yes (Bengali)	Consent not obtained therefore rejected by MNSI. DoC not required	N/A	Consent from family not obtained for MNSI investigation despite sending information in their language Pashto. Discussed at Learning Response Panel – due to no concerns identified at rapid review, plan to review at PMRT.
MI-039623	IMDD 1 White British	No	Yes	Yes	Yes – posted 24/2/25	Yes	Rapid review undertaken and identified issues with no identification of SGA and a lack of escalation of proteinuria by an MSW. Learning actioned. MNSI currently fact finding and have commenced staff interviews.

MI-040240	IMDD 6 White British	Yes M25CT600/001	Yes	Yes	MRI NAD and parents not contactable – rejected by MNSI	N/A	Rapid review undertaken and no care issues identified. A well-managed emergency with staff receiving positive letters of acknowledgement of good care. This has been rejected by MNSI due to a normal MRI and no parental concerns escalated.

5.4 Detail of incidents graded moderate or above and rapid reviews (February 2025 onwards)

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
336324 – Diathermy burn to patient during intraoperative procedure.	IMDD 1 White British	Obstetric	Moderate	Surgeon explained the incident to the patient and she apologized, I applied a small dressing on the ankle.
336868 – Birth trauma following failed instrumental	IMDD 3 White British	Obstetric	Moderate	Clinical lead discussed with Operating Consultant regarding the appropriate use of the fetal pillow.
336899 – Intrapartum stillbirth	IMDD 1 White British	Obstetric	Moderate	Rapid review undertaken and immediate actions identified including escalation by MSW with abnormal results and reviewing scan findings with sonographer. Escalated to MNSI.
337880 –Antepartum stillbirth	IMDD 2 White British	Obstetric	No harm	Rapid review undertaken with no recommendations identified.
338878 – Baby transferred for active cooling	IMDD 6 White British	Neonatal	No harm	No learning identified. Managed well. Letters of positive acknowledgement sent to staff

339699 – Concealed pregnancy. Pathological CTG. GP and ED had missed opportunities in the pregnancy	IMDD 4 White British	Obstetric	No harm	An MDT Learning Response has been requested due to the missed opportunities by the GP and ED at presentations during the pregnancy
339850 – Bladder injury at LSCS	IMDD 2 Romanian	Obstetric	Moderate	This is a known risk of the surgery. No learning identified
340893 – Antepartum stillbirth	IMDD 9 White British	Obstetric	No harm	Reminder to staff of measuring the SFH and the time intervals between measurements

Item 6: Listening to our staff

- Ongoing work on Maternity Safety Champion Culture Improvement Plan- plan for timeout day with Perinatal Leadership Team and other key stakeholders
- Plans in development for the establishment of a Staff Experience Workstream across Family Services
- Safety Champion Walkaround at HRI 29th of April 2025
- Survey out to rotation staff at HRI to review and improve how rotations work for staff

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

Northern Lincolnshire and Goole NHS Foundation Trust

% of interventions fully Implemented	Assessment three	Assessment four	Assessment five	Assessment Six	Assessment Seven
Review quarter	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25
Assurance review date	20 Mar 24	10 June 24	19 Sept 24	11 Dec 24	14 Mar 25
Element 1: Smoking in pregnancy	70%	70%	90%	80%	80%

Element 2: Fetal growth restriction	90%	90%	85%	90%	90%
Element 3: Reduced fetal movements	100%	100%	100%	100%	100%
Element 4: Fetal monitoring in labour	80%	80%	100%	80%	100%
Element 5: Preterm birth	81%	67%	74%	74%	78%
Element 6: Diabetes	67%	83%	83%	83%	83%
TOTAL	**81%**	**77%**	**83%**	**81%**	**84%**

Following peer validation of evidence submitted for quarter 3 2024/25 by the LMNS, a grading of "significant assurance" was assigned with an overall compliance of 84% for all 6 elements. Further improvement work is required to reach full implementation by March 2026 as per the trajectories set by the LMNS.

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			100%	1	5/5	100%
Element 5	81%	22/27	June '24	Sept '24	92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Hull University Teaching Hospitals NHS Trust

% of interventions fully implemented	Assessment three	Assessment four	Assessment five	Assessment Six	Assessment Seven
Review quarter	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25
Assurance review date	19 Mar 24	10 Jun 24	18 Sept 24	11 Dec 24	12 Mar 25
Element 1: Smoking in pregnancy	50%	60%	70%	80%	90%
Element 2: Fetal growth restriction	90%	95%	100%	100%	100%

Element 3: Reduced fetal movements	50%	50%	50%	100%	100%
Element 4: Fetal monitoring in labour	20%	20%	40%	80%	60%
Element 5: Preterm birth	67%	70%	67%	89%	85%
Element 6: Diabetes	83%	83%	83%	100%	100%
TOTAL	**69%**	**73%**	**76%**	**91%**	**90%**

Following peer validation of evidence submitted for quarter 3 2024/25 by the LMNS, a grading of “significant assurance” was assigned with an overall compliance of 90% for all 6 elements. Further improvement work is required to reach full implementation by March 2026.

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			100%	1	5/5	100%
Element 5	81%	22/27	June '24	Sept '24	92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Item 8: Avoiding Term Admissions to NICU target <5%

Northern Lincolnshire and Goole NHS Foundation Trust

% of term babies that required admission to the NNU DPOW				
Month	Number of Births	Number of Births (≥37 weeks gestation	Number of Term Baby Admissions to NNU	%
Dec 2024	166	146	9	5.4%
Jan 2025	171	159	8	4.7%
Feb 2025	148	131	6	4.0%
Mar 2025	181	161	15	8.2%
Apr 2025	154	147	10	6.5%
% of term babies that required admission to the NNU SGH				
Month	Number of Births	Number of Births (≥37 weeks gestation	Number of Term Baby Admissions to NNU	%
Dec 2024	129	113	5	3.8%
Jan 2025	128	109	7	5.5%
Feb 2025	122	108	12	9.8%
Mar 2025	142	127	15	10.5%
Apr 2025	139	127	10	7.1%

SGH neonatal unit had above-average ATAIN admissions. These admissions were potentially avoidable, as several were related to process issues identified around the timing of applications with local social services and babies were admitted while awaiting placement.

Review of 8 Potentially Avoidable Admissions (Q3)

- FASP Guidelines Followed however, congenital cardiac disease identified postnatally—could have been identified antenatally and referred to Leeds for delivery.
- Enhanced Maternity Care not followed which may have impacted the need for NNU admission.
- Clinically Well Babies Admitted that could have been nursed on Transitional Care (TC) instead of NICU.

Admission Trends

- Primary admission reason: Respiratory (17 babies across DPOW & SGH).
- Gestational age with highest admissions: 39 weeks
    - DPOW: 8 cases
    - SGH: 9 cases

Shared Learning and Clinical Governance Highlights

- Refer to Neonatal Care Pathways before admitting to NICU.

- Discuss with parents about NICU admission from TC; explore alternatives.
- Instrumental delivery concerns:
    - Consider practitioner experience and fetal position during procedure.
- New Neonatal Consultant Lead at SGH:
    - Expected to enhance support and engagement with ATAIN initiatives.

- Positive Outcome:
    - Zero low temperature admissions in Q3—second consecutive quarter of improvement.
    - *Congratulations to all teams involved!*
- Overall Clinical Care:
    - Aligns well with best practices and target standards.
    - Continued effort needed to ensure consistent compliance across all areas assessed.

Hull University Teaching Hospitals NHS Trust

% of term babies that required admission to the NNU HUTH				
Month	Number of Births	Number of Births (≥37 weeks gestation	Number of Term Baby Admissions to NNU	%
Dec 2024	385	364	11	2.8%
Jan 2025	378	345	25	6.6%
Feb 2025	324	289	12	3.7%
Mar 2025	384	354	18	4.7%
Apr 2025	339	315	19	5.6%

March ATAIN rate 4.7% all cases attributed to respiratory distress

- Continue to Datix all admissions and present fortnightly thematic review at MIRM meetings- no changes anticipated with MIS Year 7.
- Cases meeting MIRM criteria (ie low cord gases) receive full MDT review in MIRM.

Item 9: Service User Feedback

9.1 Hull Royal Infirmary Friends and Family Test – February 2025

For February 2025 a total of 80 responses were received as part of the Friends and Family Test for Maternity Services. 97% of the feedback was positive. 0 responses were received for neonates.

Maternity Services	
Ward/area	**Number of responses**
Midwifery Led Unit	2
Community Midwifery Team	2
Maple ward	1
Rowan Ward	65
Labour and Delivery Suite	8
Rainbow/bereavement Suite	2

Maternity Services - Trust wide		
Response option	**Number**	**Percentage**
Very good	71	89%
Good	4	5%
Neither good nor poor	1	1%
Poor	1	1%
Very poor	0	0%
Don't know	3	4%

MLU: "Superb service from the staff at the Fatima Allam centre. The ladies listened to exactly what we wanted with our birth and enabled us to have an incredible experience for the second time. The involvement of trainee midwives meant that we received even more support and we were able to learn from the experience too. We cannot thank the staff enough and will be forever grateful to them. We feel very fortunate to have this service available to us during such an important event".

Community Midwifery Team: "Clare my midwife really helped and cared for me throughout my pregnancy. She gave my husband and I care that felt personal and made us feel very comfortable and confident with her care".

Maple Ward: "Staff were all fantastic, walked us through each section of C-section and made us feel very relaxed. We were regular checking in and could tell we were very well looked after".

Rowan: "The staff in the hospital were lovely and very thoughtful but they were so stretched when it came to the night shift and it was apparent that the medication, tea and coffee everything is definitely on a cut back which is really sad. It would be helpful to take a more

proactive and common-sense approach to share staff between midwifery wards depending on the patient levels it would take the strain off and utilise the amazing staff there is".

Labour / Delivery Suite: "Staff were friendly, supportive and attentive. This is our second child at this hospital".

Rainbow/Bereavement Suite: "Excellent support throughout pregnancy, reassurance all the way through, any questions I had I got answers to, was tougher in our care and for my husband, we had a plan in place made by rainbow team which was tailored for our needs including our history to not trigger our loss, we could not have had the beautiful experience without this team they are truly amazing and caring! As a mother and father of an angel baby we were truly terrified throughout pregnancy and dreaded labour, this team went above and beyond and everything in place was upheld and they even visited me on the induction ward to check on me".

9.2 Northern Lincolnshire and Goole NHS Foundation Trust Friends and Family Test – February 2025

Neonatal Care

For February 2025 a total of 7 responses were received as part of the Friends and Family Test for NICU across the Trust. 100% of the feedback was positive.

NICU – Trust wide		
Response option	**Responses**	**Percentage**
Very good	7	100%
Good	0	0%
Neither good nor poor	0	0%
Poor	0	0%
Very poor	0	0%

Some of the comments received are detailed below:

NICU DPOW:

“All the staff have been absolutely amazing. We have never experienced premature birth or having a baby in NICU, they have all been so friendly and so caring towards me and my son”.

“Very helpful and friendly staff. Made us feel comfortable and provided the best possible care for baby”.

“All staff can't be faulted, all very supportive and informative of everything going on. Carol, Selina especially lovely all staff are thorough”.

NICU SGH:

“Spent over a week on the NICU ward with our newborn, and every single staff member is amazing! Every single staff member has gone above and beyond for not just our little boy but me and his dad. We will forever be grateful for them all. Real life earth angels!”.

Maternity Care

For February 2025 a total of 29 responses were received as part of the Friends and Family Test for Maternity Services across the Trust. 89.6% of the feedback was positive.

Maternity – Trust wide		
Response option	**Responses**	**Percentage**
Very good	22	76%
Good	4	14%
Neither good nor poor	1	3%
Poor	1	3%
Very poor	1	3%

Some of the comments received are detailed below:

Maternity DPOW:

“Midwives were lovely and answered all questions/concerns and they have helped to make postpartum a really positive experience”.

“All of the midwives were absolutely brilliant who have been to visit us at home. All very knowledgeable and I felt confident and comfortable in talking to them about any issues I’ve been having with breastfeeding etc”.

The poor comment relates the following comment:

“Some visits were good the midwives were lovely and answered all the questions I had to ask. Didn’t make me feel like a rubbish first time mum. Some midwives were horrible towards me felt like they didn’t want to visit myself or my child. Felt like they tried to make me feel like a rubbish first time mum. Also find it hard not having the same community midwife visit as I find it hard to talk about emotions plus explaining it to several midwives upon several visits is hard”.

Maternity Goole:
None received.

Maternity SGH:

“Everyone from the minute walked in has been fantastic. Every single member of staff have been fantastic, understanding and beyond grateful. Massive thank you to everyone that has helped us and looked after our twin boys”.

“Felt very looked after, no issue too small!! Thanks for making this experience a lot less scary!!!”

The very poor comment relates the following comment:

“The doctor that saw me for all but my last appointment had very poor bedside manner. Inconsiderate of my requests, speaking down to me, questioning my choices trying to convince me otherwise and also putting a lot of emphasis on bmi and not actually looking at my weight to how I’m built. I had to contact a solicitor and put a complaint in with my midwife for her to actually listen to my requests. She was trying to scare me into making different choices when I had done plenty research and spoken to different doctors at the trust I moved over from. The midwives were lovely there no issue with them”.

9.1 Hull Royal Infirmary Friends and Family Test – March 2025

For March 2025 a total of 111 responses were received as part of the Friends and Family Test for Maternity Services. 94% of the feedback was positive.

MLU: “My midwives were fantastic, both Helen and Phillipa made the experience so calm and enjoyable. Both very caring, explained everything thoroughly and made us feel very welcome and unjudged. They are a credit to the hospital and deserve the recognition and praise.”

Community Midwifery Team: “The community midwife team in Hull are incredible - I had a great experience with my first pregnancy and my second is just as amazing! I always say it is the best care I have ever received on the NHS and am sad after birth when I go back into the ‘normal’ system! The community midwife team listen so well and always take the time to make you feel like an individual and care about your needs.”

Maple Ward: “Staff very comforting and reassuring and very understanding when I was scared for my c section. They were patient and kind”.

Rowan: “Friendly and helpful. Felt very looked after Communicated well when I was going up to NICU. Prompt with medication required”

Delivery Suite: “Midwives and doctors were absolutely amazing, especially Ashleigh and Daisy our midwives. They made us feel calm and spoke us through everything. Daisy was so supportive and kind when our labour ended up in theatre and she really was the best”.

9.2 Northern Lincolnshire and Goole NHS Foundation Trust Friends and Family Test – March 2025

Neonatal Care

For March 2025 a total of 7 responses were received as part of the Friends and Family Test for NICU across the Trust. 86% of the feedback was positive.

NICU – Trust wide		
Response option	**Responses**	**Percentage**
Very good	6	86%
Good	0	0%
Neither good nor poor	0	0%
Poor	0	0%
Very poor	0	0%
Don't know	1	14%

Some of the comments received are detailed below:

NICU DPOW:
"Absolute 100% care for our baby and family so much compassion and love from staff. These nurses, doctors are angels in disguise! Thank you for bringing our boy back to health".
"All of the staff have been perfect. Nothing could be improved it's been spot on".
"Positive, supportive makes a team. Negativity - on occasions, lack of communication things not passed over when have plan in place, not being listened too when pointing out something, when in flat it's like you have disappeared no checks no wellbeing checks and with parents whether 1st time mum or have mental health may not be ok takes 2 minutes to open a door praise or a chat. Journey books - the odd nurse has no one wrote in it takes it to fill in when all should take 1 minute to just write something for parents".

NICU SGH: None received.

Maternity Care

For March 2025 a total of 54 responses were received as part of the Friends and Family Test for Maternity Services across the Trust.

100% of the feedback was positive.

Maternity – Trust wide		
Response option	**Responses**	**Percentage**
Very good	51	94%

Good	3	6%
Neither good nor poor	0	3%
Poor	0	3%
Very poor	0	3%

Maternity DPOW:
“Gave needed help and advice, arranged an appointment/checked up on other appointment that should've been made, positive actions taken regarding weight loss of my son. Friendly and helpful.”.

“All the midwives have been so lovely & supportive with each question, decision and planning. No question has seemed silly”.

“All staff were very helpful, knowledgeable and professional. All were more judgmental. Special mention to Zoe who went above and beyond to support me throughout my stay”.

Maternity SGH:
“Everyone has been amazing and offered support and help when needed. All the staff are amazing and lovely, a credit to the NHS”.

“Very friendly midwives who listen and you can tell genuinely care for you and baby”.

“Only concern I have is a pressure put on mothers regarding vaccines, personal opinion should not be over professionalism. How I was treated was appalling, there are others in the team that are fab”.

Item 10: Screening Key Performance Indicators (Quarter 3 - 2024/2025)

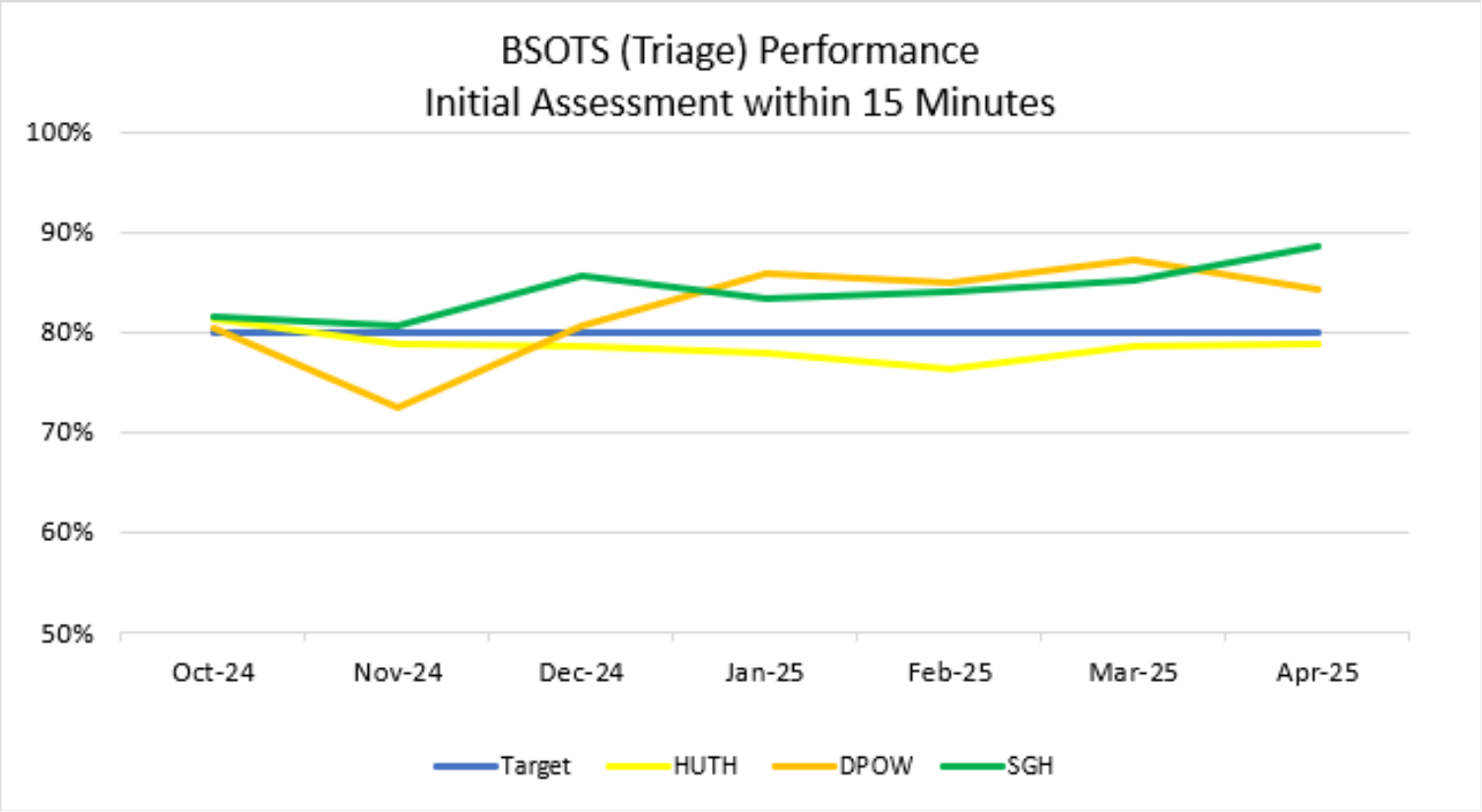
Hull University Teaching Hospitals

Indicator	Performance	Acceptable Threshold
ST2: Timeliness of antenatal screening	84.7%	≥50.0%
ST3: Completion of FOQ	100%	≥95.0%
NB2: Avoidable repeat NBS test	2.9%	<2.0%
ID1: HIV coverage	99.7%	≥95.0%
ID3: Hepatitis B coverage	99.7%	≥95.0%
D4: Syphilis coverage	99.7%	≥95.0%
ST1: Antenatal Screening coverage	99.6%	≥95.0%
FA3: Coverage T21/T18/T13 screening	2	Not set
FA2: Coverage fetal anomaly ultrasound	99.6%	≥90.0%
NIPT S01: Coverage NIPT	96.8%	Not set

Northern Lincolnshire and Goole NHS Trust

Indicator	Performance	Acceptable Threshold
ST2: Timeliness of antenatal screening	80.6%	≥50.0%
ST3: Completion of FOQ	97.8%	≥95.0%
NB2: Avoidable repeat NBS test	3.3%	<2.0%
ID1: HIV coverage	99.8%	≥95.0%
ID3: Hepatitis B coverage	99.8%	≥95.0%
D4: Syphilis coverage	99.8%	≥95.0%
ST1: Antenatal Screening coverage	99.8%	≥95.0%
FA3: Coverage T21/T18/T13 screening	No cases to follow up	Not set
FA2: Coverage fetal anomaly ultrasound	99.0%	≥90.0%
NIPT S01: Coverage NIPT	1000%	Not set

Item 11: BSOTS Performance



NHS Humber Health Partnership

Escalation and Assurance Report to Quality and Safety Committees-in-Common

Report from	Maternity & Neonatal Assurance Group
MNAG meeting date	15th May 2025
Report completed by	Yvonne McGrath, Group Director of Midwifery
Date submitted	16th May 2025

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert

Workplace Culture Concerns

- Persistent **incivility hotspots** at HUTH and staff-reported cultural issues at DPOW.
- Internationally Educated Midwives (IEMs) at NLAG raised concerns around integration and support, triggering listening events and contract review processes.

Equipment and Capacity Gaps

- Ongoing delays in replacing diathermy machines and insufficient caesarean section capacity at HUTH pose operational and clinical risks.

Clinical Incidents and Investigations

- Multiple moderate/severe incidents, including one maternal cardiac arrest, have required reviews, referrals to MNSI, and action planning.
- NLAG incident involving a diathermy burn also raised procedural concerns

Advise

Strengthen Workplace Culture & IEM Support

- Extend listening events and ensure actions are followed up with measurable outcomes.

Accelerate Digital Training and Data Quality Checks

- Improve training for midwives on electronic documentation systems.
- Utilise the ACE tool for documentation audits monthly.

Address Equipment and Infrastructure Delays

- Expedite procurement processes for diathermy machines and explore approaches to increase elective caesarean capacity.
- Implement interim measures to mitigate current surgical and procedural risks.

Continue Transparent Learning & Governance

- Ensure full dissemination of learning from MNSI and internal reviews.
- Maintain robust oversight of thematic reviews and rapid response learning panels.

Monitor ATAIN and Preterm Pathways

- Ensure compliance with updated IC criteria at SGH following the ODN review.
- Embed neonatal governance into core review cycles to reduce avoidable admissions.

Assure

CNST Year 6 Compliance

- Both HUTH and NLAG achieved 100% compliance (Blue rating) across all 10 CNST safety actions.

- Compliance with Duty of Candour remains at 100% across both trusts, with evidence of multilingual support and consistent documentation.

Service User Satisfaction

- **HUTH**: 94% positive feedback (March), including consistent praise for midwifery-led units and bereavement services.
- **NLAG**: March maternity feedback was 100% positive; neonatal feedback also strong (100% positive in February).

Quality Governance & Incident Review

- Robust internal governance: thematic reviews, AARs, MIRM reviews, and external reporting in place.
- Data validation at HUTH confirmed that concerns about outlier status for APGAR score were related to data quality and not clinical outcomes.

Training Compliance

- Both Trusts achieved >90% compliance in core training modules (fetal monitoring, PROMPT, neonatal resuscitation). Continued improvement needed in some staff groups, particularly anaesthetic staff.

New and Emerging risk identified

-

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 4

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

NHS Humber Health Partnership

Claims Scorecard April 2014 –June 2024 (90 claims)

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

Claims Breakdown Q4 24/25

Claims opened:

- Active cooling of baby delivered via Kiwi. Mother attended via A&E. No AN care received. Term admission to NICU. MNSI ref: MI-038708. Rejected by MNSI.

Existing claims: 34

Claims closed:

- Fatal claim & inquest, baby born in poor condition by rotational forceps due to long second stage and baby in OP position. Baby underwent active cooling for 72 hours. Bleeding in the brainstem/upper cervical spine persisted. Baby transferred to palliative care and died at 1 month of age. **Damages paid £22k**
- Alleged failure to perform further imaging which would have identified placental insufficiency resulting in earlier delivery, stillborn and psychological damage. **Damages paid £57k**
- Wrongful birth claim. Alleged failure to translate and review Claimant's Spanish records confirming she is gene carrier of genetic disorder, leading to missed opportunity to refer Claimant for diagnostic test at 15 weeks and have a medically induced termination. Claimant gave birth at 40 weeks and baby died shortly thereafter as she had the genetic disorder. **Damages paid £75k**

Incidents Q4 24/25

Top 5 incident by volume:

- Delay to treatment **(31)**
- Term NNU admissions **(30)**
- In-utero delay in IOL **(24)**
- Post partum haemorrhage (PPH) >1500mls **(24)**
- Readmission to hospital **(20)**

Number of incidents reported on DATIX for Obstetrics / Maternity: **438**

Complaints Q4 24/25

There have been 9 new complaints received relating to the following

- Treatment- outcome of treatment
- Treatment – outcome of surgery
- Treatment delayed
- Delay in procedure/investigation

Clinical Audits Registered Q4 24/25

No new audits registered in Q4. However, audits registered previously continue with data collection, for example for Saving Babies Lives Version 3 submissions.

Deep Dive Reviews Q4 24/25

Complete:

Management of Diabetes in Pregnancy - *Focusing on investigations throughout pregnancy e.g. GTT and HbA1C, service user demographics and outcomes.*

In progress:

Perinatal Optimisation – *focusing on the pathway from presentation to delivery to assess if optimisation measures have been taken. Supported by the LMNS.*

Learning Q4 24/25
• ATAIN decrease in admission rate • Cord gas SOP approved, increase in in obtaining and documenting seen in reviews • IUT for delays in continue to be reported on DATIX • Electronic SBAR use increased • PPH management

Themes Q4 24/25
• ATAIN sustained decrease in hypothermic admissions • CTG classifications and management – escalated to fetal monitoring team to review for learning and teaching • Delay in IOL and ARM >24hrs continue to be Datixed • BadgerNet documentation standards

Action Plan Q4 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	
MDT Induction of labour time out day to take place	January 2025	

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme (SA9) Quarter 4

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

NHS Humber Health Partnership

Claims Scorecard April 2014 –June 2024 (55 claims)

Top injuries by volume:
Fatality (16)
Unnecessary pain (15)
Additional / unnecessary operation(s) (13)
Stillborn (11)
Bladder damage (5)

Top injuries by value:
Brain damage (3)
Cerebral palsy (2)
Wrongful birth (1)
Bladder damage (3)
Fatality (9)

Top causes by volume:
Failure / delay in treatment (15)
Failure / delay in diagnosis (8)
Inadequate nursing care (3)
Operator error (3)
Intra-operative problems (3)

Top causes by value:
Failure / delay in treatment (2)
Intra-operative problems (1)
Other (1)
Fail in antenatal screening (1)

Claims Breakdown Q4 24/25

Claims opened:

- Alleged failure to review VTE score prior to prescribing anticoagulation medication and prescribed anticoagulation medication for an insufficient period of time resulting in pulmonary embolism.
- Alleged negligent management of twin delivery using forceps & ventouse resulting in 2nd degree tear and episiotomy. As a result, patient suffered 3 years PSLA and dyspareunia which required further corrective surgery.

Existing claims: 22

Claims closed:

- Caesarean section commenced using diathermy device whilst patient not fully under anaesthesia, resulting in pain and shock. **Damages paid – Nil**
- failing to consider claimant was suffering from an infection and failing to admit following report of seizure. **Damages paid – Nil**

Incidents Q4 24/25

Top 5 incidents by volume:

- Error /omission in health record **(17)**
- Below Safe Staffing Levels Following Escalation **(17)**
- Unexpected admission to NICU **(14)**
- Delay in treatment or procedure **(13)**
- Post partum haemorrhage (PPH) >1500mls **(12)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **415**

Complaints Q4 24/25

There have been 6 new complaints received relating to the following:

Category	Detail
Care needs not adequately met	Management of birth and birthing plan
	Concerns regarding treatment - antenatal, labour, delivery, postnatal
Delay or failure in treatment	Concerns regarding the care provided at HUTH resulting in emergency C-Section at NLaG
	Concerns regarding care before and during the birth of baby.
Attitude of staff - Midwife	Care provided following planned still-birth and lack of actions following
Birth Injury	care provided during a forceps delivery.

Clinical Audits Registered Q4 24/25

- Caesarean section category times
- Saving Babies' Lives, Elements 1 – 6
- Obstetric Anaesthetic Outpatient Reviews

Deep Dive Reviews Q4 24/25

In progress:
None registered in Q4.

Learning Q4 24/25
• Further training and support was given on the use of Badgernet • Continued use of Cherished Pathways • Training given to MSW about deviations of vital signs and urinalysis

Themes Q4 24/25
• The introduction of Badgernet has caused issues with documentation • Staffing levels - mitigated with escalation policy. No harm caused by staffing levels. • Deep Dive of Unexpected Admission to NICU being undertaken to identify any themes

Action Plan Q4 24/25	Not started / In progress / Complete	
Training for all MSWs to ensure competence of recognition of deviations of vital signs and urinalysis	June 2025	
Review of the Bereavement documentation on Badgernet to ensure all parts of the PMRT review are included within it in order to discontinue the paper pathways	June 2025	

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FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 7, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) HUTH Quarterly Report (Quarter 4 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

April 2025

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 MBRRACE-UK reporting requirements and PMRT support:

Type of death	Eligible for reporting to MBRRACE-UK	Supported by the PMRT
Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Stillbirths – the baby is delivered from 24+0 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Early neonatal deaths – death of a live born baby occurring before 7 completed days after birth	**Yes** From 20+0 weeks gestation or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Late neonatal deaths – death of a live born baby occurring between 7 and 28 completed days after birth	**Yes** From 20+0 weeks gestation of pregnancy or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Post-neonatal deaths – death of a live born baby (born at 20+0 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring after 29 or more completed days after birth.	**No** Notification supported if death is to be reviewed with the PMRT.	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available. Baby must have received neonatal care.
Surviving sibling(s) in a multiple pregnancy – any live born baby who lives beyond 28 days, as part of a multiple pregnancy resulting in at least one late fetal loss, stillbirth or neonatal death.	**Yes** Notification only. Surveillance not required.	**No**
Terminations of pregnancy – Any registered stillbirth (from 24+0 weeks' gestation) or neonatal death (from 20+0 weeks' gestation) resulting from a termination of pregnancy should be notified. However, completion of the initial notification is only required. Completion of the full surveillance form is not required, and these deaths will not be supported for review using the PMRT.	**Yes** Notification only. Surveillance not required.	**No**

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), c) and d) 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.	**75%**
d) An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT.	**50%**
e) 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 Seven (Appendix A)

There has been a total of 15 incidents reported to MBRRACE-UK via the PMRT that fall within the MIS year seven period (01 December 2024 onwards):

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
December 2024	3	3	0
Q4 (01 Jan – 31 Mar 25)	8	0	1
Q1 (01 Apr – 30 Jun 25)	-	-	-
Q2 (01 Jul – 30 Sept 25)	-	-	-
Q3 (01 Oct – 31 Dec 25)	-	-	-
Total	**11**	**3**	**1**

11 cases are eligible for review and full assessment against CNST standards. Of these, 100% were notified to MBRRACE within seven days. The remaining 3 notifications are due to MTOP or post-neonatal deaths (>28 days). The 1 baby that is not eligible is because the baby is still alive due to a twin pregnancy. 0 cases met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

From 1st December 2024, please note there are 4 cases registered with MBRRACE where the deaths occurred at other Trusts and HUTH contributed to the care. It is the responsibility of the other Trusts to collaboratively complete the PMRT review. These cases do not appear on HUTH MIS year seven case list but are included in the yearly case list.

3.2 Summary of all incidents reviewed through PMRT in Quarter 4 2024/25 (Appendix B)

There have been 10 incidents reviewed through the PMRT process in quarter 4, and reports have been published for 3 of these. When reviewing these cases, they are 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. It should be acknowledged that reporting relates to incidents that occurred earlier in the year 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 case 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.

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

- 1 case had no issues identified that would have had an impact on the outcome.
- 1 case had issues identified that would not have had an impact on the outcome.
- 1 case had issues that may have had a difference to the outcome.

3.3 CNST Compliance as per MIS Year 7 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 eligible incidents reported (n=3)

	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	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Dec 24	**96445**	Neonatal death	27+2	13.10.24	11.12.24	650g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
	96455	Antepartum stillbirth	38+3	13.12.24	13.12.24	2810g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 11/06/25)	Yes - LMNS
	96467	Neonatal death	37+1	13.06.24	15.12.24	3096g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
	96528	Neonatal death	26+2	02.08.24	09.12.24	890g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
	96596	Antepartum stillbirth	39+4	23.12.24	23.12.24	2860g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 23/06/25)	Not yet discussed at PMRT
	96662	Neonatal death	23+2	25.12.24	27.12.24	360G	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 27/06/25)	MNVP
	96397	MTOP	21+2	06.12.24	06.12.24	410g	HUTH	HUTH	HUTH	NA	No	NA	NA	NA	NA

	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	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q4 24/25	**96776**	Neonatal death	30+2	06.01.25	07.01.25	1500g	HUTH	LGI	LGI	LGI	No	Yes	Yes	LGI	Not yet discussed at PMRT
	97125	Neonatal death	22+1	22.01.25	29.01.25	520g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 29.07.25)	Not yet discussed at PMRT
	97208	Neonatal death	37+3	03.02.25	03.02.25	1455g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 03.08.25)	Not yet discussed at PMRT
	97361	Antepartum Stillbirth	33+6	17.02.25	17.02.25	2285g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 17.08.25)	Not yet discussed at PMRT
	97393	Neonatal death	22+3	01.02.25	19.02.2025	520g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 19.08.25)	Not yet discussed at PMRT
	97484	Neonatal death	22+6	26.02.25	26.02.25	444g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 26.08.25)	Not yet discussed at PMRT
	97613	Stillbirth	23+0	03.03.25	03.03.25	1090g	Unbooked	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 03.09.25)	Not yet discussed at PMRT
	97620	Neonatal death	? <28 days	06.02.25	04.03.25	680g	Calderdale	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 04.09.25)	Not yet discussed at PMRT

	97853	Antepartum stillbirth	29+6	20.03.25	13.02.25	1615g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 20.09.25)	Not yet discussed at PMRT

Appendix B – Summary of all incidents reviewed through PMRT and reports published in Q4 of 2024/2025

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?
95688 Stillbirth 26+4 weeks	Severe early growth restriction	B / B	1. The test used to screen for gestational diabetes does not follow national guidance 2. This mother met the national guideline criteria for screening for gestational diabetes, screening was organised, but the results were not available 3. This mother developed an indication fora GTT and a GTT was organised but there were no results available 4. This mother's progress in labour was not monitored on a partogram	1. Change to diabetes guideline to ensure the flow of referrals is robust and failsafe in place 2. Change to diabetes guideline to ensure the flow of referrals is robust and failsafe in place 3. Change to diabetes guideline to ensure the flow of referrals is robust and failsafe in place 4. A. Feedback given to member of staff regarding importance of documentation and reflection, B. To be included within topics of the week on all ward, C. To be included within the next PMRT newsletter, D. Email to all staff regarding importance of documentation	Yes
96177 Stillbirth 36+5	1a. Severe IUGR secondary to placental insufficiency	A / A	No issues identified. The woman was unaware of the pregnancy.	N/A	Yes
95480 Stillbirth 37+1	Unknown	C / C	MNSI investigation complete. Main discussion point was the missed opportunity to plan an elective delivery earlier than 37 weeks of pregnancy. The PMRT group acknowledge although care followed local and national plans, the ability to have acted sooner was not taken. The team were saddened to learn that the woman felt her ethnicity was an effecting factor following the delivery of their baby. The grading	The diabetic team were involved and present for the review of care and following this, additional resources (GDM health) which will help make professional review of blood glucose monitoring much easier. This has been escalated to the Director of Midwifery. As part of the MNSI action plan, the guideline will be reviewing this as NICE	No

			of the post-delivery care of a C was an agreed consensus and as a trust we have a zero-tolerance policy for any discrimination.	(2020) doesn't differentiate between existing and gestational diabetics and locally this may have been misidentified due to Saving Babies Lives V3 changes in scan pathway. Although this did not affect the outcome, it is acknowledged this requires review.	

The following reviews have been undertaken but the report has not been published yet, these will be included in the Q1 report:

- 96211
- 96662
- 95990
- 96445
- 96528
- 96455
- 97125

Grading of care

Stillbirth:

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 7 standards (01/12/24 – 30/11/25)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q2 Apr – Jun 25	Q3 Jul – Sep 25	Q3 Oct – Dec 25	Total
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	4/4 (100%)	8/8 (100%)	-	-	-	**12/12 (100%)**
Cases applicable for PMRT review are applicable to the following standards (n=11)							
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	3/3 (100%)	8/8 (100%)	-	-	-	**11/11 (100%)**
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	3/3 (100%)	8/8 (100%)	-	-	-	**11/11 (100%)**
Multi-disciplinary reviews should be published within six months of the death.	**75%**	3 in progress (on target for Jun 25 deadline)	8 in progress (on target for Jul-Sep 25 deadlines)	-	-	-	**On Target**
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT. (from 02/04/2025)	**50%**	N/A	Not yet discussed at PMRT.				
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted Jan 2025	Submitted Apr 2025	-	-	-	**100%**

Appendix D: Learning Points and Key Themes:

Key themes and/or learning identified from **Q4** cases PMRT or continued from previous quarterly reviews are as follows:

- Diabetes pathway/guideline requires updating
- Explore referral and management pathway for diabetes

Appendix E: Summary of Saving Babies' Lives Interventions of cases which have gone through PMRT:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/3 (0%)				0%
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/3 (0%)				0%
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.	0/3 (0%)				0%
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/3 (0%)				0%

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FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 7, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) NLAG Quarterly Report (Quarter 4 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

April 2025

Working in partnership:
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Northern Lincolnshire and Goole NHS Foundation Trust

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1.1 MBRRACE-UK reporting requirements and PMRT support:

Type of death	Eligible for reporting to MBRRACE-UK	Supported by the PMRT
Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Stillbirths – the baby is delivered from 24+0 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Early neonatal deaths – death of a live born baby occurring before 7 completed days after birth	**Yes** From 20+0 weeks gestation or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Late neonatal deaths – death of a live born baby occurring between 7 and 28 completed days after birth	**Yes** From 20+0 weeks gestation of pregnancy or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Post-neonatal deaths – death of a live born baby (born at 20+0 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring after 29 or more completed days after birth.	**No** Notification supported if death is to be reviewed with the PMRT.	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available. Baby must have received neonatal care.
Surviving sibling(s) in a multiple pregnancy – any live born baby who lives beyond 28 days, as part of a multiple pregnancy resulting in at least one late fetal loss, stillbirth or neonatal death.	**Yes** Notification only. Surveillance not required.	**No**
Terminations of pregnancy – Any registered stillbirth (from 24+0 weeks' gestation) or neonatal death (from 20+0 weeks' gestation) resulting from a termination of pregnancy should be notified. However, completion of the initial notification is only required. Completion of the full surveillance form is not required, and these deaths will not be supported for review using the PMRT.	**Yes** Notification only. Surveillance not required.	**No**

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.	**75%**
d) An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**50%**
e) 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 Seven (Appendix A)

There has been a total of 3 incidents reported to MBRRACE-UK via the PMRT that fall within the MIS year seven period (01 December 2024 onwards):

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
December 2024	1	0	0
Q4 (01 Jan – 31 Mar 25)	2	0	0
Q1 (01 Apr – 30 Jun 25)	-	-	-
Q2 (01 Jul – 30 Sept 25)	-	-	-
Q3 (01 Oct – 31 Dec 25)	-	-	-
Total	**3**	**0**	**0**

All 3 cases are eligible for review and full assessment against CNST standards. Of these, 100% were notified to MBRRACE within seven days.

2 cases met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI). Both cases have been reported accordingly.

3.2 Summary of all incidents reviewed through PMRT in Quarter 4 2024/25 (Appendix B)

There have been **5** 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 prior to the MIS year 7 timeframe.

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

- 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
- 3 cases had issues that may have had a difference to the outcome.

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

- 0 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
- 2 cases had issues identified that may have had a difference to the outcome

Grading of care of the baby from birth up to the death of the baby:

- 0 cases had no issues identified that would have had an impact on the outcome.
- 2 case had issues identified that would have had no impact on the outcome.

3.3 CNST Compliance as per MIS Year 7 Standards (Appendix C)

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 eligible incidents (for review) reported (n=3)

	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	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Dec 24	96717	Intrapartum stillbirth	38+3	31/12/24	31/12/24	3130g	SGH	SGH	SGH	Yes	Yes (consent declined by family)	Yes	Yes	Not yet published (deadline 30/06/25)	Not yet discussed at PMRT planned for May 2025

	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	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q4 24/25	97389	Antepartum stillbirth	28+1	19/02/25	15/02/25	1080g	SGH	SGH	SGH	Yes	No	Yes	Yes	Not yet published (deadline 19/08/25)	Not yet discussed at PMRT (planned for June/July)
	97175	Antepartum stillbirth	38+6	02/02/25	02/02/25	2336g	DPOW	DPOW	DPOW	Yes	Yes	Yes	Yes	Not yet published (deadline 02/08/25)	Not yet discussed at PMRT (planned for May/June)

Appendix B – Summary of all incidents reviewed through PMRT in Q4 of 2024/2025

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?
94853 Antepartum Stillbirth 24+6 weeks	Following the review which took into account 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 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 may have made a difference to the outcome for the mother	This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out 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 had pregnancy complications recognized as requiring specific birth planning advice but the advice wasn't given The parents consented to a full or limited post-mortem examination, but this was not carried out Although indicated this mother was not offered chromosome analysis for her baby It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home It is not possible to tell from the notes if the parents were provided	Reminder to be put on PMRT Newsletter that fundal height surveillance should be measured from 24 weeks. To be addressed with community managers that this is taken to the next managers meeting for dissemination to staff. Reminder to be put on PMRT newsletter that written information leaflet needs to be made available on BadgerNet Consultant to be informed and discussion to take place with consultant regarding plan of care. Due to delays in consent forms this resulted in parents changing their mind about the post mortem. Bereavement champion role to be revisited and support and structure given upon commencement of new bereavement midwife. Reminder to be put on PMRT Newsletter that all	Yes

			with written support information around emotional issues before they left hospital It is not possible to tell from the notes if the parents were provided with written information about practical issues following the death e.g. funeral options and benefits It is not possible to tell from the notes if when the parents went home they were given a named person in the hospital to contact if they had any questions Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons	postnatal investigations should be offered and documented. Reminder to be put on PMRT Newsletter to highlight that the bereavement discharge checklist if fully completed. Consultant to be informed and discussion to take place with consultant regarding plan of care.	
95343 Antepartum stillbirth 28+5 weeks	Due to limited PM the cause of death could be due to the placental findings. The placental examination revealed accelerated villous maturation, decidual arteriopathy, large infarction haematoma and a small remote retroplacental haematoma, these features are in keeping with maternal vascular malperfusion.	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 may have made a difference to the outcome for the mother	This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance Although indicated this mother was not offered a Kleihauer test Although indicated this mother was not offered further postnatal investigations for herself and/or her baby	Fetal Monitoring newsletter to be distributed highlighting the need to keep computerised CTG's on for 1 hour for accurate STV interpretation. Audit to be undertaken of a random selection over 1 week of 30 sets of notes cross site. Identification of where the process has failed and resolution for future management. Bereavement pathway checklist to be reviewed.	Yes

			It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available It is not possible to tell from the notes if the parents were told where their baby was being taken to and why when he/she was taken to the mortuary It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home It is not possible to tell from the notes if the parents were provided with written support information around emotional issues before they left hospital	Clarification required for staff to know whether to complete digital notes or paper cherished pathways for bereaved parents.	

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?
94938 Neonatal death 23+5 weeks	Extreme prematurity	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 baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	This mother's risk status during labour was assessed and it had changed but she was not managed appropriately In retrospect this mother's care should have been transferred to obstetric-led care during labour, but this need was not identified 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 they were indicated This mother was in preterm labour/threatened preterm labour but was not offered antibiotics when they were indicated This mother was in preterm labour/threatened preterm labour but was not offered magnesium sulphate for fetal neuroprotection when this was indicated The type of fetal monitoring used in the latent phase of labour was not appropriate	Staff education on assessment of risk. Discussions to be undertaken with individual staff members. Triage criteria to be highlighted. Staff education on optimisation of birth in extreme prematurity Supportive and reflective discussion with staff involved. Ongoing neonatal work regarding neonatal airway competencies. Further neonatal laryngoscope for this extreme prematurity gestation purchased. Staff education to complete the bereavement pathway. A provisional copy of a checklist for neonatal actions post resus (drug chart, de-brief, handover to neonatal ward team and documentation) has	Yes

			The fetal heart monitoring in the latent phase of labour was not carried out correctly The interpretation of the fetal heart rate monitoring in the latent phase of labour was not correct This mother's progress in labour was not monitored on a partogram The type of fetal monitoring used in established labour was not appropriate The fetal heart monitoring in established labour was not carried out correctly The interpretation of the fetal heart rate monitoring in established labour was not correct During resuscitation the baby required intubation but there were difficulties with the intubation Although indicated this mother was not offered chromosome analysis for her baby It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out The baby's death was not discussed with the coroner/procurator fiscal	been provided to Divisional Governance Lead. The medical examiner process has changed regarding coroner/medical examiner input regarding these cases as per national process.	

95943 Neonatal Death 24+0 weeks	Extreme Prematurity Evidence of chorioamnioitis on PM findings. Respiratory Distress syndrome	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 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 This mother has a history of preterm birth <34 weeks gestation and her antenatal care was not appropriate given this history During resuscitation of the baby fluids were required, but not all the correct fluids were given in the correct volume(s) 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 whether during the early bereavement period use of a cold cot was offered/available	Staff reminder to be placed on PMRT Newsletter Audit of pre-term birth prevention clinic notes Neonatal educator to ensure type of fluid and their volumes to be included on simulations. Lead paediatrician for this case to be made aware.	Yes
95387 Antepartum Stillbirth 37+6 weeks	Fetal vascular malperfusion secondary to VUE	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	It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home There is no evidence in the notes that this mother was asked about domestic abuse at booking At first presentation with reduced fetal movements this mother was not appropriately risk assessed This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance.	Scoping of the bereavement pathway to be completed on Badgernet To scope whether domestic abuse questioning can be a mandatory field on Badgernet Snap shot audit of Stillbirth Risk Assessments being completed when attending with RFM.	Yes

Appendix C – Summary of CNST Compliance as per MIS Year 7 standards (01/12/24 – 30/11/25)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q2 Apr – Jun 25	Q3 Jul – Sep 25	Q3 Oct – Dec 25	Total
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	1/1 (100%)	2/2 (100%)	-	-	-	**3/3 (100%)**
Cases applicable for PMRT review are applicable to the following standards (n=3)							
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	1/1 (100%)	2/2 (100%)	-	-	-	**3/3 (100%)**
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	1/1 (100%)	2/2 (100%)	-	-	-	**3/3 (100%)**
Multi-disciplinary reviews should be published within six months of the death.	**75%**	1 in progress (on target for Jun 25 deadline)	2 in progress (on target for Aug 25 deadlines)	-	-	-	**On Target**
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**50%**	Not yet discussed at PMRT	Not yet discussed at PMRT	-	-	-	**On Target**
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted Jan 2025	To be submitted Jun 2025	-	-	-	**100%**

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q4** cases PMRT or continued from previous quarterly reviews are as follows:

- All postnatal bloods and investigations not being taken.
- Management for reduced fetal movements not followed as per policy.
- Growth surveillance not carried out as per policy
- Written information not given antenatally regarding reduced fetal movements.
- Specific birth planning advice not given
- Post mortem not carried out due to confusion over consent forms
- Fetal monitoring not followed as per policy
- Bereavement checklist not fully completed
- Risk assessment not updated in the intrapartum period
- Pre-term birth optimisation not carried out as per policy.

The following key learning points from **Q4** PMRT reviews have been shared with staff via Safety Bulletins or PMRT Newsletter:

- All postnatal investigations required to gain full clinical picture
- Reduced fetal movements (RFM's) attendance after 26 weeks with risk factors to be referred for scan and CTG performed.
- Fundal height surveillance to be measured from 24 weeks
- Written information regarding fetal movements should be made available on Badgernet
- Bereavement checklist must be fully completed
- Questions surrounding domestic abuse to be asked at booking

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

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/5 (20%)				
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	3/5 (60%)				
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.	1/5 (20%)				
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	1/5 (20%)				

Scunthorpe ODN Action Tracker

These actions are aimed at addressing network feedback while ensuring that improvements in training, teamwork, and data review are effectively implemented. We will continue to engage with the network for further clarity on their mortality data conclusions.

Theme	Recommendations	Actions Required	Action Lead	Action complete by Date	Evidence Of Completion (sources of verification)	Update log	Change Stage*
Clinical Leadership	1. Substantiative appointment to Consultant with Specialist interest in Neonatal Medicine	1a. Convert the locum neonatal interest post to substantiative with a view to post holder commencing in the substantive post by April 2026	UM AM PG TB	31.12.25	1a. Appointment to permanent post	**10.04.2025** – Neonatal Workforce Paper – awaiting Cabinet/Executive outcome. Locum in post from 1st April 2025	
Airway Skills (Resources, Knowledge & Skills, Assessment)	2. Regular airway training for all medical staff to be implemented and sustainable delivery plan developed	2a. Airway skills training to be scheduled monthly at local level (SGH only). 2b. Joint sessions with SGH & HUTH to be scheduled at least annually. 2c. Difficult airway algorithm to be developed, agreed, ratified and embedded in practice 2d. Clinical incident reporting to be encouraged to ensure learning extracted from any adverse event and shared appropriately	AH	30.09.25	2a &2b. Attendance Log Data 2c. Ratified controlled document - audit as part of documentation audit/clinical reviews 2d. Clinical Incidents reviewed through weekly Incident Review Meeting schedule	10.04.25 – Workstream commenced	
	3. BAPM airway competency standards to be achieved and maintained	3a. Maintain a robust log of training - individual practitioners 3b. Maintain a robust log of procedures undertaken - individual practitioners, including Consultants. 3c. Intubation checklists to be completed in 100% of intubations and filed within the clinical records	AH LP	30.09.25	3a & 3b. Personal Training Logs 3c. Documentation& Clinical Review Audit data	10.04.25 – Workstream commenced	
	4. New airway equipment to be procured	4a. CMAC video laryngoscope already available. 4b. Consider purchase of Peak VN video laryngoscopes. 4c. Develop, deliver and evaluate a practical training session for the use of video laryngoscopes.	UM VH EJS	31.05.25	4b. Equipment procured, 4c. Training attendance logs	10.04.25 – Workstream commenced	
Team Work & Communication	5. Enhancing team working	5a. Neonatal In-SiM sessions conducted every two months (embedded) 5b. Share learning themes from In-SiM sessions, incidents/ clinical reviews. 5c. Embed the sharing of guideline updates to ensure changes are embedded in practice. 5d. Ensure nursing attendance and contribution at Neonatal M&M and Perinatal Meetings. 5e. Revise Terms of Reference to include mandatory Nurse/MDT attendance for quoracy at M&M. 5f. PMRT ToR to be reviewed and include documentation standards, presence of external	ES SJ LP LMNS Support	30.09.25	5a. Training attendance logs & In-SiM schedule 5b. Improved documentation compliance 5c. Shared Learning posters/newsletter/update 5d, 5e & 5f. ToR for meetings including M&M/ PMRT with quoracy.& external representation.		

		members, neonatal nurses/ consultants for 100% of Neonatal Cases. 5g. Neonatal nursing staff representatives to be rostered and released to attend the relevant meetings. 5h. Scope and plan to deliver a rotational working rota for all grades of medical staff across NLaG to improve flexibility in workforce resource utilisation and promote exposure to the whole range of neonatal cases required to maintain clinical skills and competence. 5i. Scope and plan to deliver a rotational working rota for all grades of nursing staff across NLaG & HUTH to improve flexibility in workforce resource utilisation and promote exposure to the whole range of neonatal cases required to maintain clinical skills and competence.	DB YM NJ AM UM VH CC DB EJS JC VB CC FM		5g. Roster and Meeting attendance logs 5h & 5i. Rotational Rosters		
Workforce	6. Address MDT workforce concerns	6a. Neonatal Nursing, AHP and Medical Workforce Review to be undertaken against BAPM Workforce Standards (BAPM 2021) 6b. Workforce Paper to be developed and presented to Cabinet for consideration and decision on required investment	DB YM AM	30.05.25	6a & 6b. Workforce Review Document	10.04.25 – Workforce Paper submitted to Cabinet – awaiting outcome	
Sustainable ROP Provision	7. ROP screening service	7a. Family Services Care Group and Head and Neck Care Group discussion & collaboration to develop and deliver a sustainable ROP provision for NLaG Neonatal Services. 7b. Pursue RETCAM purchase and if secured, deliver a training plan supported by an SOP. 7c. Scope and progress a proposed Hub and Spoke ROP service between HUTH & NLaG 7d. ROP Service fragility to be entered onto the risk register	PG DB AM LP Head and Neck Care Group Rep	31.12.25	7a. ROP Service Offer – SOP 7b. RETCAM embedded in practice 7c. Hub & Spoke Model Service Offer - SOP 7d. Risk register entry		
Benchmarking, Audit & Quality Improvement	8. Regular surveillance of Perinatal Optimisation. Formulation of a Quality Improvement Strategy. Benchmark local services against: National standards - GIRFT, NNAP, NICE, BAPM Regional - compliance with ODN guidelines & embedding learning from regional mortality	8a. Perinatal M&M Meeting attendance to be mandatory for all obstetric, maternity and neonatal staff. 8b. Meeting agenda and dashboard information to be reviewed and amended accordingly. 8c. Peri-prem forms to be completed by midwifery workforce and transferred with baby to the Neonatal Unit. 8d. Embed high quality antenatal counselling in threatened preterm labour delivered by Paediatric/ Neonatal teams. 8d. Neonatal QI Strategy to be developed and embedded as core business	UM AH CCh SJ EJS KT CB SJ	30.09.25 30.09.25	8a. Terms of Reference 8b. Meeting Agenda 8c. Documentation Audit & Clinical Reviews Document Control dashboard NNAP dashboard 8d. Neonatal Quality Strategy 8e. QI Project Plans		

	Local - Audit & QI	8e. QI projects to be identified, progressed and completed with a view to achieving sustainable change.					
	9. ATAIN data analysis and dissemination	9a. ATAIN lead clinician to attend 100% of meetings 9b. ATAIN lead clinician to produce and progress an action plan for surveillance in speciality governance meetings 9c. Lessons Learnt to be shared through strategies of disseminating learning 9d. Review dedicated time in Lead Clinician job plans to; • ensure consistent engagement • to ensure they lead on the cascade and embedding of the recommendations/challenges to practice within the wider obstetric team • To eliminate meetings being dependent on the availability of single representatives.	AH EJS KT UM AM UR YM	30.09.25 30.09.25	9a. ATAIN attendance log 9b & 9c. ATAIN learning lessons document 9d. Job Plans		
	10. NNAP-	10a. Develop a Business Case to support the recruitment of a Data Analyst to ensure accurate data input and analysis 10b. NNAP data to be reviewed monthly with clear communication of concerns or areas of risk. 10c. QI plans to be formulated to support and progress sustainable change	AH AM SJ	30.09.25	10a. Business Case 10b. Monthly NNAP Data Review Report 10c. QI Plans		
	11. Update & Embed Guidelines	11a. Ensure Compliance Monitoring and robust document control through speciality and Care Group Governance 11b. Develop a process that ensures timely review of documents, and promotes a collaborative approach across HUTH and NLAG to have shared guidance where feasible	VC	30.06.25	11a. Governance Minutes 11b. Meeting Terms of Reference and Document Control SOP		
Learning & Sharing Lessons	12. Neonatal M&M meeting	12a. Schedule Neonatal M&M meetings every other month with clear terms of reference and agenda which must include the discussion of at least two clinical cases along with key neonatal learning lessons. 12b. Lead Governance and neonatal clinicians to attend HUTH/ Sheffield Neonatal M&M Meetings to embed cross site learning. 12c. SMART Action plans from PMRT's to be monitored in Governance Meetings.	AH VC	30.09.25	12a, Meeting minutes, Terms of Reference and attendance logs 12b. Learning Lessons Poster/Newsletter 12c. Action Plans		
	13. Dissemination of learning lessons from the network	13a. To develop and embed a process that ensures Neonatal Network learning lessons, are on NHS Futures Platform are effectively and appropriately shared with medical, nursing and AHP teams.	AH SJ	30.09.25	13a. Learning lesson document		

	14. Neonatal Grand Round	14a. Implement and embed a weekly neonatal grand round with participation from all Consultants, to standardise ward rounds and enhance team cohesion. 14b. Review Consultant Job Plans to ensure time allocated	AM AH	30.06.25	14a. Grand round attendance log 14b. Job Plans		
Family Experience	15.Transitional care	15a. Agree that partners who wish to be resident on the Transitional Care Unit within the Maternity Ward are supported to do so. 15b. SOP for Resident Partners to be developed and embedded into practice 15b. Transitional Care Staffing Plans to be reviewed and amended to ensure Non-registred HCA's are overseen directly by Registered Nurses.	CB NJ YM DB SJ EJS	30.06.25	15a. SOP for Resident Partners TC Patient Feedback Safe care live ODN workforce tracker		
	16.Family Integrated Care/Service User Experience	16a. Standardise and embed the process for ensuring Parents are updated by the Consultant within 24 hours of admission to the Neonatal Unit. 16b. Promote, encourage and embed, parental involvement in ward rounds – considering virtual attendance options. 16c. monitor quality of interaction to ensure culture of shared decision-making is embedded. 16d.Encourage the promotion of early breast milk education and the provision of dedicated time within workplans to support the unit achieve the UNICEF BFI stage 2 accreditation. 16e. Improve the environment on the unit including refurbishment of breastfeeding room, milk storage and parent accommodation and within these plans we suggest that provision of cot side chairs should be reviewed along with storage facilities for families.	SJ AH SJ CD IFC E&F SJ EJS	30.06.25	16a.Badgernet Data 16a. Clinical Documentation Audit 16b.Badgernet Data 16c.Feedback 16d.Mandatory training 16d.Infant Feeding Audits 16e.Building work completed as per plan		
Nursing Staffing & Quality Roles	17.To substantively recruit into vacant Neonatal Governance Lead Nurse (Band 7) 18.To ensure existing Neonatal Clinical Nurse Educator posts are Band 7 in line with BAPM Workforce Standards (2021)	17a. Progress Job Description through job matching panel 17b. Commence& complete recruitment process 18a. Progress Job Description through job matching panel 18b. Commence HR process to uplift current post-holders	EJS EJS	30.06.25 30.06.25	17a. Approved JD 17b. Postholder commenced employment 18a. Approved JD 18b. Postholder commenced employment	**10.04.2025**: Awaiting final stage of job matching panel. Recruitment prepared and ready to commence on notification of panel outcome. N.B – job panel capacity has caused significant delays to these key posts being recruited to.	

Action Lead Name Key:

AM – Dr Aparna Manou – Neonatologist and Clinical Director

DB – Debbie Bray – Nurse Director

PG – Miss Preeti Gandhi – Chief of Service

UM – Dr Umapathee Majuran – Paediatrician and Clinical Lead

TB- Theresa Bowen – Senior General Manager

EJS – Emma Spicer - Matron

CB – Claire Brothwell] – Matron

KT – Kendra Thomas – Senior Sister - CDS

NJ – Natalie Jenkin – Interim Head of Midwifery/Governance Lead

YM – Yvonne McGrath – Group Director of Midwifery

AH – Dr Adeel Haq – Paediatrician with expertise/interest in Neonates

VC – Dr Vineeth Cheruvalli – Paediatrician and Lead Clinician Governance

SJ – Sarah Judd – Neonatal Unit Senior Sister/Manager

CCh – Miss Cho Cho – Obstetrican

UM – Miss Uma Rajesh – Clinical Director – O&G

VH – Dr Vijaya Hebbar – Paediatrician and Clinical Lead

CC – Caroline Corbett - Strategic HR Business Partner

JC – Paediatric & Neonatal Matron NLAG

FM – Neonatal Matron HUTH

CD – Charlotte Drinkall – Senior Staff Nurse – Neonatal Unit

IFC – Infant Feeding Co-ordinator

E&F – Estates & Facilities

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC (25) 088

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 June 2025**
Director Lead	**Helen Wright and Gill Ponder, Chairs of CIC**
Contact Officer / Author	**Helen Wright and Gill Ponder, Chairs of CIC**
Title of Report	Performance, Estates and Finance CIC Highlight 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 Tuesday 6 May and Tuesday 3 June 2025 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **The Boards in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	Thursday 12 June 2025
Report from:	Performance, Estates and Finance Committees in Common
Report from meeting(s) held on:	6 May 2025 and 3 June 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common (CIC) at their meeting(s) held on 6 May 2025 and 3 June 2025 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:

6 May 2025

- Group CQC Actions update
- Group Finance Report – Month 12
- Financial Plan 2025/26 including CIP Profile and Decision Timetable (including PMO Status update)
- Group Integrated Performance Report
- Deep Dive: Outpatient Transformation
- Procurement Improvement Plan/KPIs/Expired Contracts
- Bed Management – Command Centre and Electronic Bed Management System
- Contract Approval – Routine Radiology Reporting Services to include Out of Hours
- Estates, Facilities and Development update (to include the Green Plan)
- Cleaning Harmonisation
- Risk Level Recommendation

3 June 2025

- Board Assurance Framework
- Committees in Common Effectiveness
- Group Finance Report Month 1

- Group Performance Report
- Deep Dive Cancer
- Delivered Ready Prepared Meals contract
- Routine Radiology Reporting Services contract – Outstanding questions from last meeting
- Theatre Services at Castle Hill Catherisation Labs contract
- Bank and Agency Demand Solutions contracts
- Estates Facilities and Development Update and Review of High Level Risks
- The Green Plan

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:

CQC Actions

a) HUTH CQC Actions – the patient follow-up initiatives backlog had increased since the previous CQC inspection in 2022. This has been escalated to the Planned Care Board for further scrutiny and action.
b) The CIC discussed triangulation of the Group CQC actions and whether real-time information was being captured. Internal Audit to carry out a full review of all the outstanding actions and how these could be closed, noting the current trajectories and operational plans.

Finance

c) The Group Financial Plan 2025/26 including CIP Profile and Decision Timetable was presented in May. The bottom-line position remained unchanged from previous submissions and the Group would be re-profiling and ensuring the CIP is largely delivered recurrently due to productivity and efficiency focus. The PMO and EQIA governance was in place but digital capacity, cultural issues and the level of investment in transformation capability were still concerns.
d) Group Finance Report – The underlying position forecast for 2026/27 was £120m and this was significantly impacted by the non-recurrent level of CIP identified and delivered previously. However, at the May meeting, the CIC were reassured by the focus on financial sustainability, the PMO approach and progress made with the EQIA process.
e) The Group Finance risks relating to revenue and cash had been reviewed. The proposed risk level was 16 (4 x 4) which aligns to the Board Assurance Framework. It was expected that the risk would be reduced to the target of 9 (3 x 3) by the end of the year.

   The Month 1 position (£2.5m deficit) was presented at the June meeting and concerns were expressed about the use of technical adjustments in Month 1 to deliver a result only marginally off plan. The Committee agreed that the underlying result (without technical support) would be shared internally alongside the reported position. The scale of the challenge was clear and a series of oversight sessions were programmed with NHS England. A deep dive focusing on the CIP and efficiency would be undertaken in June 2025. The cultural and performance challenges were great and there was an opportunity to request targeted support from NHS England. Service Line Reporting and benchmarking information would be available in the future for review of any further potential opportunities.

The underlying CIP gap of £40.6m at the end of May had been sense checked and was the focus for 2025/26. This has reduced since plan submission but remains significant.

There were Capital opportunities from the Regional Teams to support the HRI ground floor programme, the bed management programme and a new referral system for the patch. This was in addition to the Capital funding for the EPR programme. The Regional Teams had been made aware that there may be slippage of EPR spend into the following year but until this is known, it was deemed appropriate to apply for the additional funding.

The cash position was positive in month 1 but further revenue support was unlikely, so careful planning was required.

The CIC agreed limited assurance due to the £40.6m Cost Improvement Programme gap and the cultural and behavioural challenges.

Performance

f) The CIC received a deep dive regarding Outpatient Transformation in May. Reasonable assurance was agreed due to clear Care Group ownership and Digital being a clear enabler. Main areas of focus were Advice and Refer, validation using AI, and cleansing of the waiting list. A need to review the programme fully to ensure there was no overlap in other areas was noted.
g) The need for a Bed Management System has been cited as a critical enabler in order to deliver the scale of efficiency and productivity improvement required. A business case will follow. The Committee supported this approach.
h) In month 1 a piece of work around RTT trajectories was being undertaken as the Group were not performing and there was no diagnostic resilience. Diagnostic trajectories were also being developed as was a short stay ward. A change model in ED was being worked through and patients were being moved out of AMU up to the wards. At week 5 of the process positive results relating to flow were beginning to show. The bed management system tool was required to optimise bed capacity using best practice. Referrals to CDCs are lower than expected and ICB and PLACE colleagues were working with Primary Care to rectify this.
i) The CIC gave limited assurance for performance as although there were plans in place, the Group was not achieving its performance targets and clear improvement trajectories were not yet in place. The challenges, pressures and the need to achieve improvements within the financial resources available were also recognised.
j) A Cancer Deep Dive was presented in June and the Group would not meet the FDS standards from June 2025. There were key challenges relating to service improvement and operational issues, including radiology recovery and weekly monitoring and escalation was in place. There were issues around capacity and funding for extra staffing as the cancer alliance funding had been reduced. NHS tiering meetings were in place and actions and revised trajectories were being reviewed and monitored.
There will be a clear plan for each tumour site to make sure each team is clear on what is required. The CiC were advised that it might be necessary to re-align priorities from RTT to Cancer to achieve the 5% improvement required.
The CIC gave limited assurance although recognised that more detailed plans were being developed to address the issues.

Procurement and Contracts

k) Group Procurement Improvement Plan – Significant assurance was received in May due to level of savings delivered overall, but there was a need to ensure that support was provided to ensure that planned savings in radiology were achieved.

l) Contract Approvals – Routine Radiology Reporting Services to include Out of Hours. The CIC did not approve the contract in May, as further information was required relating to in-house activity savings, confirmation of the contract value and approval requirements in line with the Group's scheme of delegation. Confirmation was received at the June meeting that the contract value was £3.5m which was within the CICs approval limits. The team had been exploring the opportunity for further roles and outsourcing and a review of radiologist productivity against the guidelines had been carried out to see what benefits could be achieved. An insourcing and outsourcing SOP had been developed and a positive recruitment campaign had completed. The CIC approved the contract.

m) The Group-wide delivered ready prepared meals contract was endorsed for Board approval. Subsequent discussions are taking place internally to reduce food waste and ensure the processes for preparation is efficient across the Group.

n) Bank and Agency Demand solutions – The most effective model had been developed and had been harmonised across the Group following a procurement exercise. The contract will be a fixed license and payroll cost, resulting in potential savings. The CIC endorsed the contract for Board approval.

Committee Effectiveness

o) The Effectiveness Review was presented and the actions provoked a discussion around future performance trajectories being presented. The overall effectiveness was positive and there were actions in place for any areas of concern.

Estates and Facilities

p) The Green Plan was presented and more information will follow regarding the journey to net zero. The Decarbonisation capital programme has delivered positive results to date. The Green Plan was endorsed by the CIC for Board approval.

q)The Estates risks were presented to the CIC. The Pit Car Park at SGH had been closed for refurbishment work. Cleaning, security and car parking contracts were being reviewed and harmonised across the Group. The North Bank catering was being reviewed as it continued to operate at a loss despite the changes made to date. There were a number of legacy issues relating to health and safety and legal regulations which were being addressed and the CIC recognised the challenges faced. The CIC gave significant assurance to this item.

4.0 Matters on which the committees have requested additional assurance:

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

a) Group Integrated Performance Report – Validation work had commenced and had delivered positive benefits in reducing the PTL. A key focus was on improving diagnostics to improve the overall performance and enable focus on the right patients within cancer. Clear plans and changes to the ways of working within ED and opportunities to optimise CDC performance were noted. Whilst the Committees acknowledged the many performance improvement plans in place across all operational areas, limited assurance was given due to performance not achieving planned levels. The Committees again requested clear trajectories to show when current performance would improve to be in line with the operational plan.

b) Managed theatre services at Castle Hill Catheterisation Labs – was not endorsed as there was more work to be carried out in relation to the Business Case. This would be re-presented in July 2025.

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

5.1 The BAF was presented at the 3 June 2025 meeting and there were no proposed changes to the Performance and Finance strategic risks. The performance risk had been revisited in detail but the risk score remained the same. The BAF would be refreshed following an Executive Session relating to the new strategic objectives.

The Committee requested confirmation that the controls cited as mitigations of the strategic risks are operating effectively.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

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

Helen Wright, Chair of the Committees in Common

Gill Ponder, Chair of the Committees in Common

3 June 2025

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 (25) 089

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 June 2025**
Director Lead	**Julie Beilby and Tony Curry, Chairs of CIC**
Contact Officer / Author	**Julie Beilby and Tony Curry, Chairs of CIC**
Title of Report	Workforce, Education and Culture CIC Highlight Report
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on Wednesday 30 April and Wednesday 28 May 2025 including those matters which the committees specifically wish to escalate to either or both Trust Boards. **The Boards 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

Report for meeting of the Trust Boards to be held on:	Thursday 12 May 2025
Report from:	Workforce, Education and Culture Committees in Common
Report from meeting(s) held on:	30 April and 28 May 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common (CIC) at their meeting(s) held on 30 April 2025 and 28 May, 2025 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

30 April 2025

- Group CQC Actions update Report
- HUTH/NLAG Freedom to Speak Up Q4 Reports
- Freedom to Speak up Group Strategy
- National Staff Survey – Actions update
- Occupational Health Annual Report
- Group Employee Relations Cases 2024/25
- Job Planning Annual Report
- Medical Workforce Strategy
- Equality Delivery System 2022
- Harmonisation of National and Local Mandatory Training across the Group
- Deep Dive, Pharmacy Workforce

28 May 2025

- Board Assurance Framework including Risk Register Report
- Mid-year Nurse Safer Staffing Review
- Workforce Integrated Performance Report
- Guardian of Safe Working Hours Quarterly Report HUTH

- Guardian of Safe Working Hours Quarterly Report NLAG
- Response to the Staff Assaults 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:

30 April 2025

a) Simon Nearney updated the CIC regarding the current position relating to the NLAG consultant extra-contractual payment rates. Discussions were ongoing and although there had been no immediate safety issues as on calls were being covered, some patients were waiting longer for procedures as a result.
b) The impact of not working additional hours was being reviewed weekly.
c) The CIC endorsed the Freedom to Speak Up Strategy and recommended approval to the Boards in Common.
d) The CIC approved the Medical Workforce Strategy.
e) The CIC received a Deep Dive into the Pharmacy Workforce and although lean, the service was being run as efficiently as possible.

28 May 2025

a) 25/25 national Pay Awards have been published. BMA are balloting their member on Industrial Action. Other trade unions may follow.
b) NLaG JLNC had agreed to recommend to Consultants to undertake additional hours. NLaG JLNC also agreed to have 'talks' with ACAS and the Group to try and break the deadlock.

4.0 Matters on which the committees have requested additional assurance:

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

30 April 2025

a) The CQC reports for HUTH and NLAG were presented and there had been no actions closed relating to workforce. Red rated actions for both organisations related to mandatory training in a number of areas but there were signs of improvement. The CIC gave reasonable assurance due to the continued work with the teams.
b) An update was provided relating to the National Staff Survey results and the Groups cultural transformation programme to improve staff engagement. There had been a number of Putting People First sessions (approximately 200 leaders so far had attended).Managers were being asked to provide three improvement actions at the different management levels so all staff could see and feel positive changes and a difference to the way we work and make decisions. The CIC gave reasonable assurance for this item.
c) The CIC received a comprehensive update relating to the nationally mandated statutory learning programme and highlighted that the Group was harmonising its approach. New starters can now transfer over any in date training and a Required Learning Group had been established to review any hotspot areas. The CIC gave reasonable assurance for this item.

28 May 2025

a) The CIC requested more detail regarding this year's national pay awards and the potential risks attached. The impact of the finances would be discussed through the Performance, Estates and Finance CIC.
b) Job planning and the shortage of medical assessors was referred from the Audit Risk and Assurance CIC. There were complications affecting the use of systems

for job planning by doctors due to licenses across the North and South bank. The LNCs are treated independently when reviewing the job planning framework and this is slowing the progress. An update was requested in 3 months' time.

c) HUTH Consultant Declarations. Numbers to be reviewed and work with the Deputy CMO to raise awareness to take place. A further update to be received at the Committees in Common.
d) The Safer Staffing report highlighted the harmonisation work across the Group and the need for triangulating data relating to lower staffing levels and any links to patient harm. The South Bank establishment risk rating had been reduced due to the positive staffing levels. The CIC gave a reasonable assurance level for the South Bank headcount. However, staffing levels and fill rates on the North Bank were under review due to establishment shortfalls. The CIC gave limited assurance for the North Bank. The CIC found it difficult to come up with a singular Group assessment. The CIC also expressed concern as to whether the actions in place would address the issues.
e) The Guardian of Safe Working Reports were received for HUTH and NLAG. The HUTH report was given reasonable assurance, due to the management processes in place. The NLAG report raised concerns regarding Junior Doctors dissatisfaction and patient safety and this resulted in limited assurance. The CIC agreed that the Group Chief Medical Officer would discuss the issues with Anwer Queshi and report any outcomes back to the CIC at the next meeting.
f) Staff Assaults report – Group wide Safer Staffing Committee had been established. There were a number of actions being put into place which included de-escalation training, active health and wellbeing response packages and police engagement. Patient accountability and staff rights were being reviewed. Staff on staff incidents events would be reviewed and discussed at a future meeting.

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

4.2 The Board Assurance Framework was presented to the Committees in Common.

The BAF report has evolved in format. The strategic objectives, once in place will inform the BAF. There were no proposed changes to the Workforce BAF Risk score or the risk appetite.

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.

Julie Beilby, Chair of the Committees in Common

Tony Curry, Chair of the Committees in Common

30 April 2025 and 28 May 2025

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(25)090

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	12th June 2025
Director Lead	Simon Nearney, Chief People Officer
Contact Officer/Author	NLAG – Liz Houchin, Freedom to Speak Up Guardian HUTH – Fran Moverley, Freedom to Speak Up Guardian
Title of the Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 4) incorporating Annual report**
Executive Summary	Each report provides the Q4 and annual report 2024-25 for NLAG and HUTH respectively. Each report gives an update including an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by each Freedom to Speak Up Guardian.
Background Information and/or Supporting Document(s) (if applicable)	Not applicable
Prior Approval Process	Both NLAG and HUTH reports have been submitted to the Workforce, Education and Culture Committee in Common on 30th April 2025
Financial implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 4 Report January to March 2025 & Annual Report 2024-2025

Liz Houchin
12th June 2025

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 4 2024/2025
& Annual Report 2024/2025

1. Executive Summary

1.1 This paper provides an update regarding the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Freedom to Speak Up Guardian (FTSUG) activity during quarter 4 (Q4) of the 2024/2025 reporting year. The report also gives an annual update for 2024/2025. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Group Priorities

2.1 This paper satisfies the Group Strategic Objectives of ‘Our People – we will look after the health and wellbeing of our people’ and ‘Quality & Safety – we will keep our patients safe and reduce avoidable harm’.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at NLAG in place that allow staff to raise concerns, including, but not limited to:

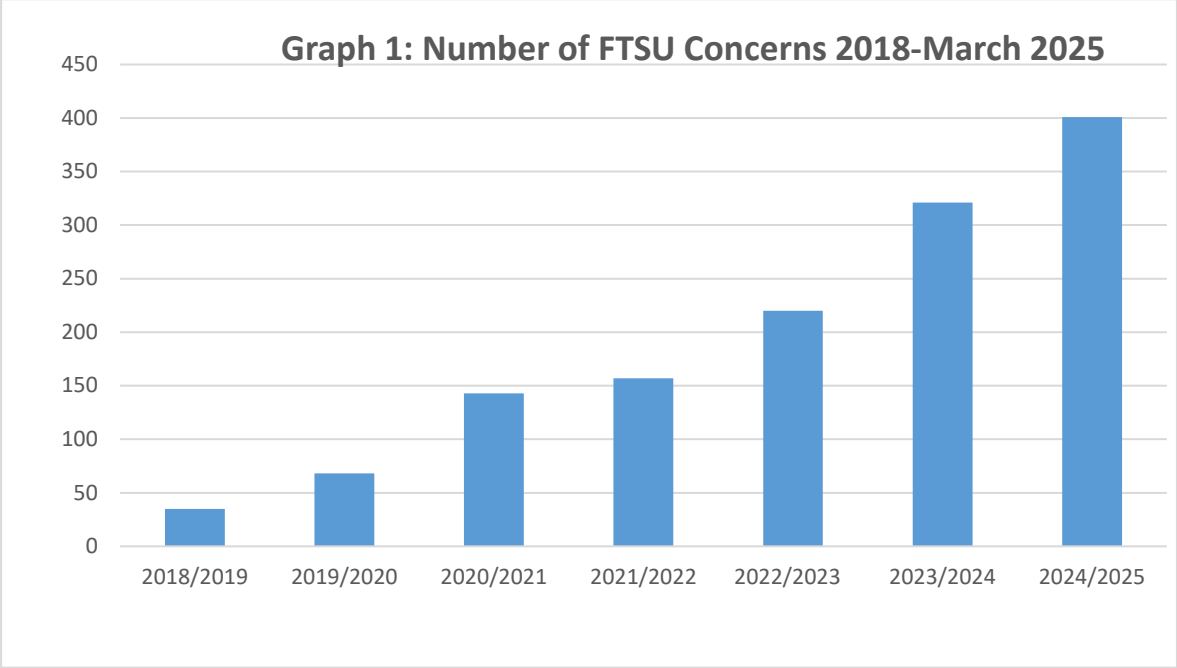
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (DCP126)
- Grievance Policy (DCP084)

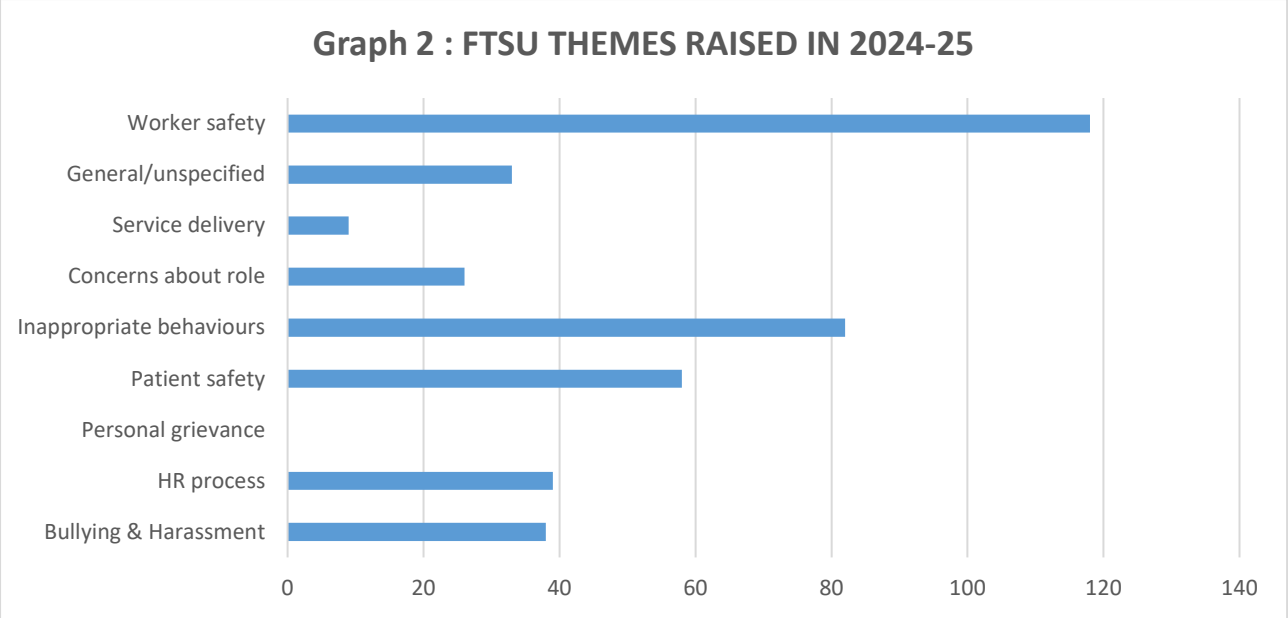
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

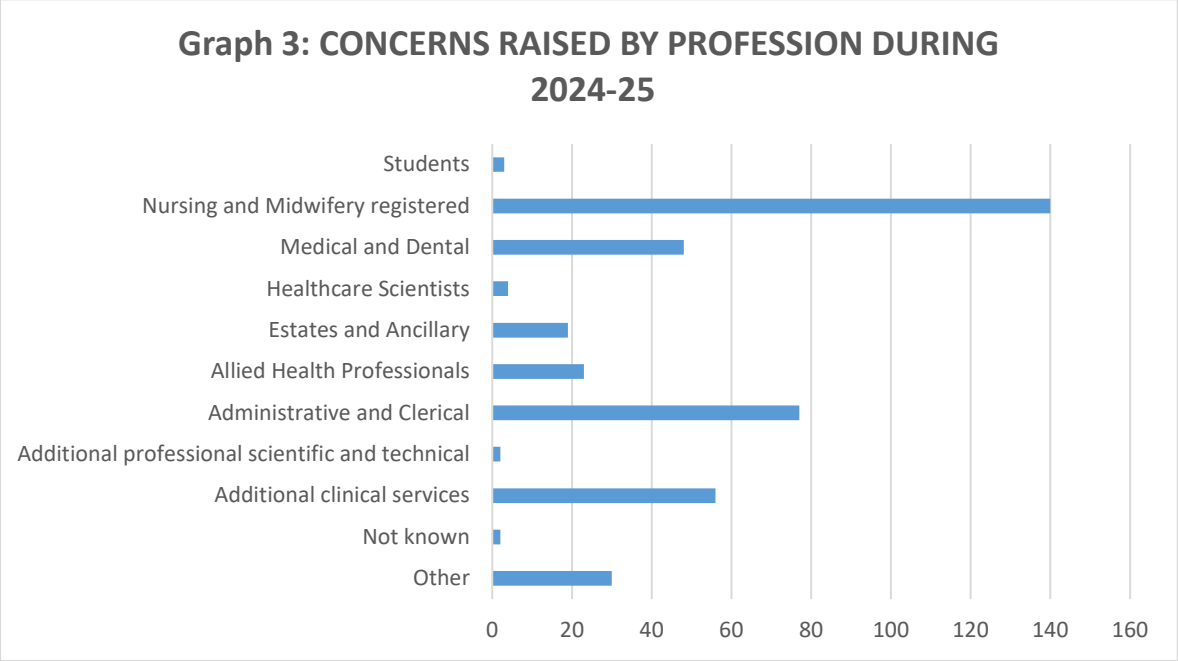
4. FTSU concerns raised during 1st January to 31st March 2024 (Q4) and Annual data for year ending March 2024 – data, comments and assessment.

4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 The following graphs show the number of FTSU concerns by year up to March 2025, the themes and the professions who contacted the FTSUG during 2024-25 (reporting year is April 2024-March 2025).




Graph 2 : FTSU THEMES RAISED IN 2024-25
Worker safety
General/unspecified
Service delivery
Concerns about role
Inappropriate behaviours
Patient safety
Personal grievance
HR process
Bullying & Harassment
0
20
40
60
80
100
120
140


Graph 3: CONCERNS RAISED BY PROFESSION DURING 2024-25
Students
Nursing and Midwifery registered
Medical and Dental
Healthcare Scientists
Estates and Ancillary
Allied Health Professionals
Administrative and Clerical
Additional professional scientific and technical
Additional clinical services
Not known
Other
0
20
40
60
80
100
120
140
160

4.3 In Q4 2024-25, 128 concerns were received. This included a group of 25 and 10 concerns (raised individually) relating to the same issue.

Q4 had the highest quarterly figure for 2024-25. 16% were closed on the same day after giving advice or signposting.

- 4 concerns were raised anonymously in Q4, all through the Staff App.
- Most colleagues asked for their name to be kept confidential initially, although some did consent to give their details later on in the process.
- In Q4 the top themes were worker safety, patient safety and inappropriate behaviours.
- Analysis of the theme 'inappropriate behaviours' for Q4 shows that the majority were 'colleague on colleague'.
- Analysis of the theme 'bullying & harassment' for Q4 highlights that the majority of colleagues who used this term were raising a concern about a manager.

Analysis of 2024-25 data:

In 2024-25, 401 concerns were raised with the FTSUG, this is a 20% raise on the previous year and is the seventh consecutive year that the number of colleagues contacting the Guardian has risen.

18 concerns (4%) were raised anonymously, which is below the national average of 9.5%.

Two colleagues (0.5%) reported that they had been subjected to detriment or disadvantageous treatment as a result of raising a concern, which is below the national average of 4%. Both were reviewed by the NED for FTSU in line with Trust process.

The top themes reported for 2024-25 were worker safety (29%), inappropriate behaviours (20%) and patient safety (14%).

Nationally in 2023-24, the top themes were worker safety, inappropriate behaviours and bullying & harassment (2024-25 national data not available at time of writing report).

Nurses and Midwives were the highest professional group that raised concerns with the FTSUG, this mirrors the national picture.
The diversity of different professions across all care groups contacting the FTSU Guardian is an indicator of increased awareness of the role amongst colleagues in the Trust and the value and importance of having an effective communications plan.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed.

4.6 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

For the year 2023-24	Feedback received	Would you speak up again? Yes
2024-2025	37	36 Yes, 1 maybe

Data analysis of the completed evaluation forms indicate colleagues aged between 18-70 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British, Black or Black British and White backgrounds and 'other' accessed the FTSUG during 2024-25.

Within the feedback received, the following are extracts of qualitative feedback received:

Liz was really helpful- although the concern isn't fully resolved yet I felt it was taken seriously and escalated appropriately, and we are well on the way to sorting things out, and having Liz involved initially gives us confidence to know that we can go back to Liz if needed.

Liz was extremely supportive of me and understanding while talking to me about my issues

Everything discussed was addressed, thank you

4.7 Case Study

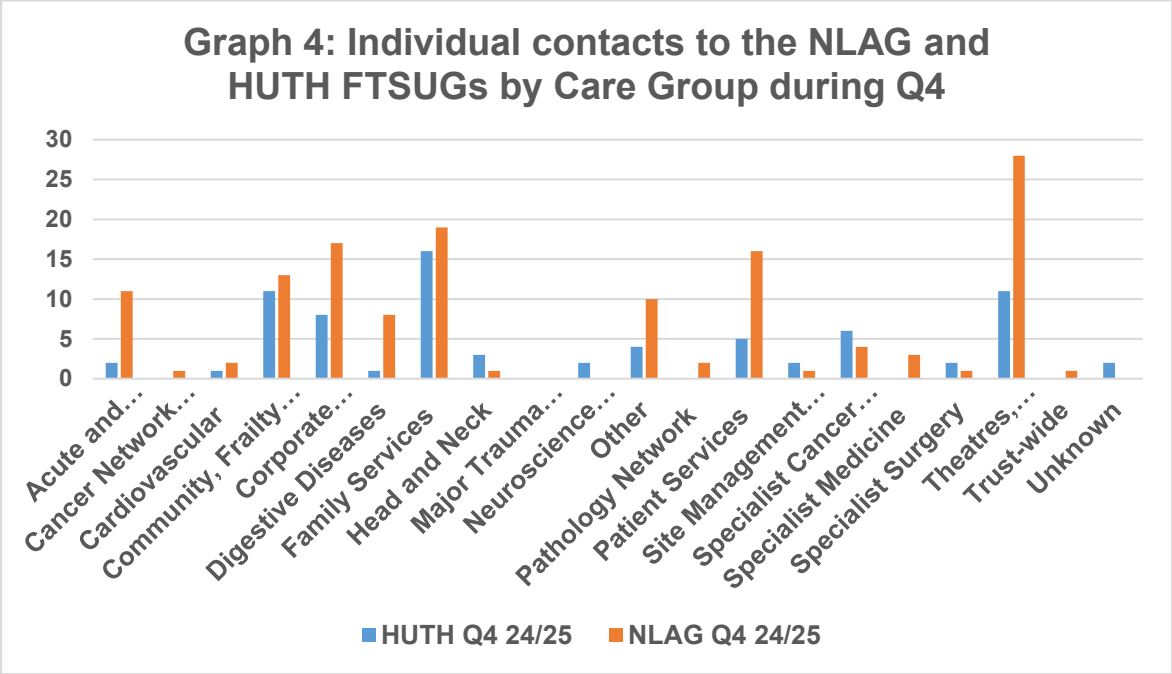
The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

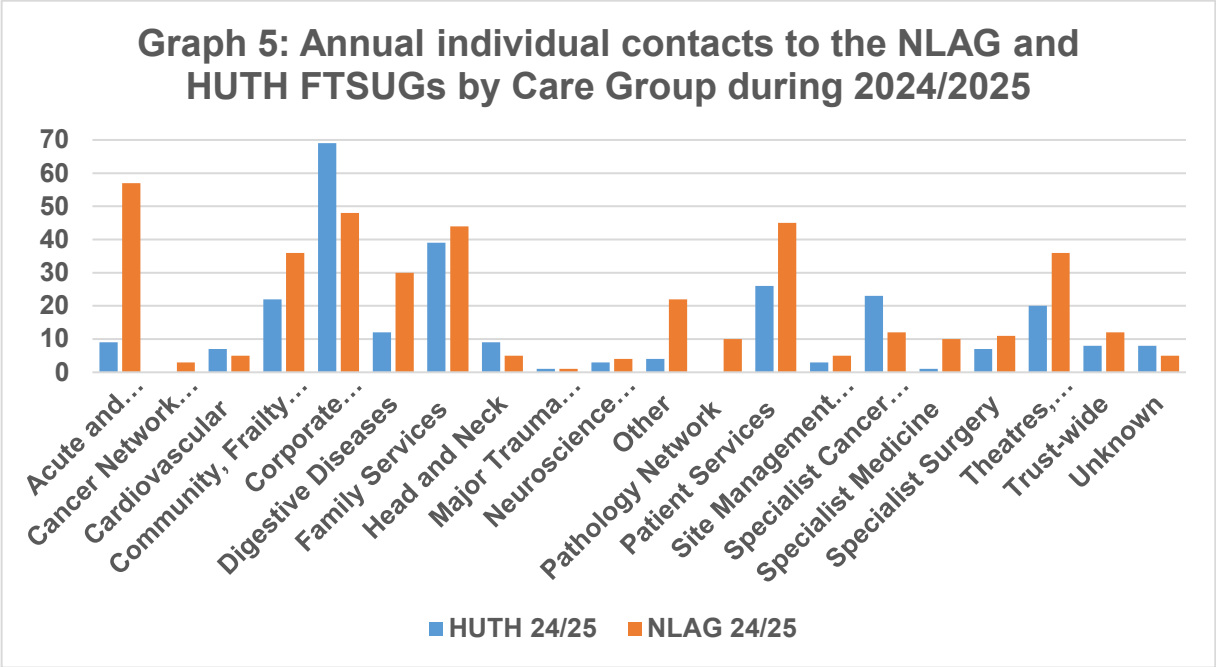
The FTSUG received a recent concern from a non-clinical member of staff who was concerned they didn't know who to ring after witnessing a clinical incident recently in a hospital corridor. When they went back to their office, they found their colleagues didn't know the clinical emergency number either. They wondered if a reminder about the numbers could be advertised on the group's communication channels.

Liz contacted the communications team, and they published the numbers on Bridget, in the Weekly all staff email and on the staff Facebook group. The concern was also used a Freedom to Speak up You said, We listened, We did and shared across the group communication channels for awareness.

4.8 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined during Q4.
Graph 5 provides the annual overview of concerns raised by sovereign organization.





5. FTSUG activities and proactive work during Q4

5.1 A high level summary of the activities are detailed below:

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Drop in/Walk round at both SGH and DPOW with Director of Nursing (Team North)
- Attendance at all Trust inductions
- Champions network meeting
- Joint working with Guardian of Safe Working – canteen drop-ins
- Joint presentation with HUTH FTSUG and GMC Regional Advisor to Medics

5.2 Future plans:

- Launch FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- FTSU concerns included in Power BI information
- Attendance at all relevant meetings
- Facilitate Board Self Reflection (planned for May 2025)
- Development of Action Plan with Boards and ongoing work to deliver against it.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG attends, where possible, the Yorkshire and the Humber and North East regional meetings to discuss best practice and contribute to active discussions. During Q4 the FTSUG attended meetings that discussed new national guidance, supported other FTSUGs with specific scenarios and shared good practice.

6.2 National update

The National Guardian Office have released the national Q3 figures, which show in 15% increase in number of concerns raised compared with the same period last year. The top themes reported nationally were inappropriate behaviours (40%) and worker safety (38%) which is in line with NLaG figures.

The FTSUG attended the national conference virtually in March 2025, with the theme of ‘changing organisational culture’ This provided the FTSUG with the opportunity to listen to keynote speakers and participate in breakout groups to discussing overcoming barriers to speaking up. Several of the Speak Up Champions were also able to attend the conference virtually to expand their knowledge and understanding.

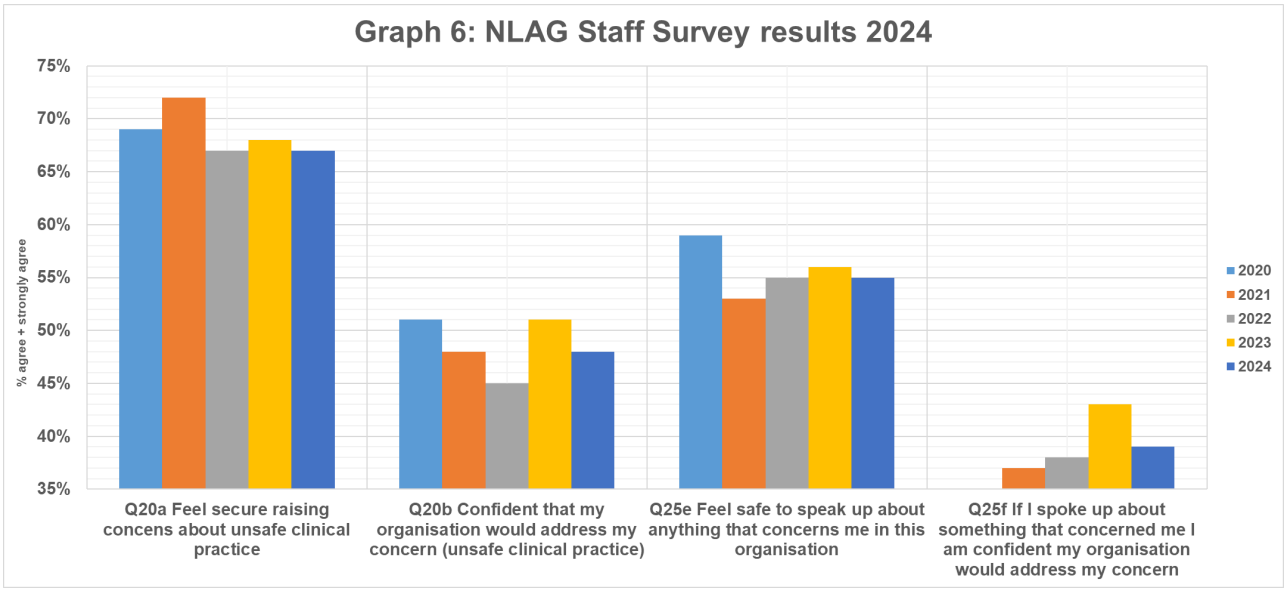
It is understood that the outcome of the Dash Review is due to be published shortly in Q1 2025/2026. The Dash Review has focused on a review of six NHS bodies, including the National Guardian Office.

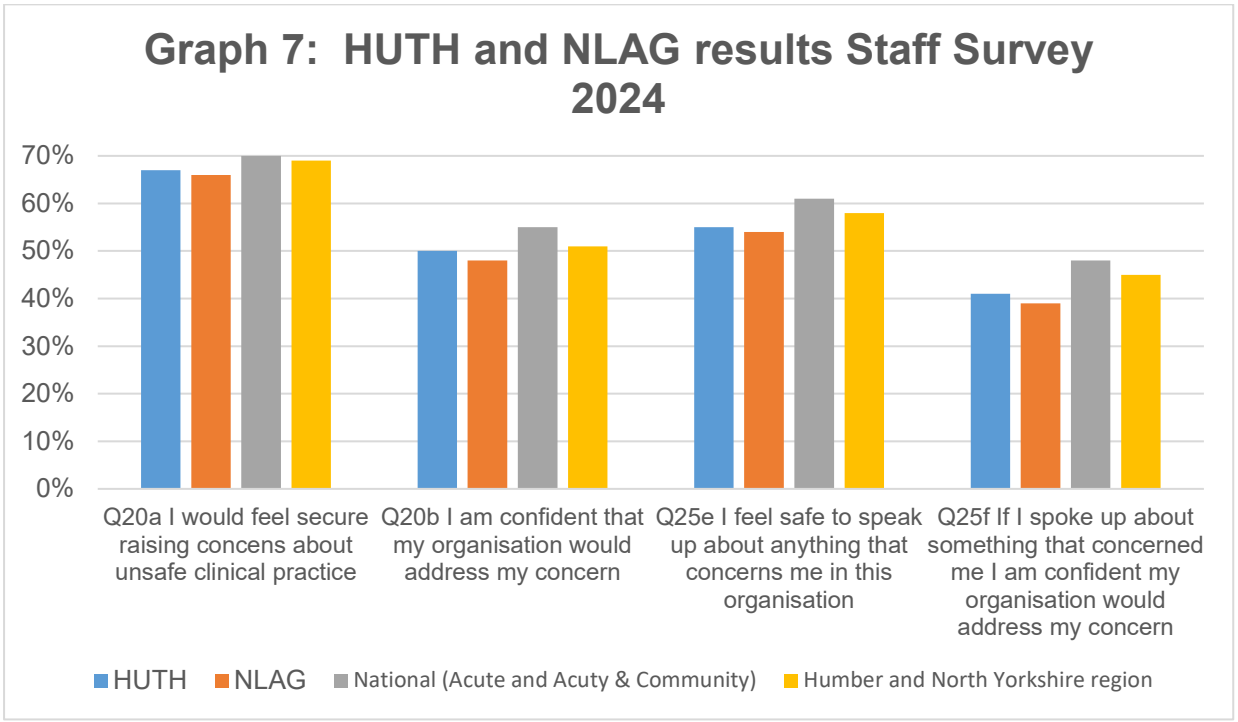
6.3 Staff Survey Results and FTSU

The NHS Staff Survey provides a crucial insight into what and how colleagues feel about the organisation. In relation to the FTSU questions in the staff survey, the 2024 results show a decline from the previous year, and all results are below the national average for Acute and Community Trusts as shown in Graph 6. The biggest decline relates to staff being confident that the organisation will act on concerns both clinical or anything else. This is something that follows the national trend.

The NGO highlight the need for leaders to move beyond encouraging staff to speak up, they must also demonstrate that speaking up leads to meaningful change. They cite that a speak up culture without action risks creating disillusionment, distrust and disengagement and is something that the Trust will need to be mindful of.

Graph 7 shows the Group position benchmarked with national and regional data.


Graph 6: NLAG Staff Survey results 2024
75%
70%
65%
60%
55%
50%
45%
40%
35%
% agree + strongly agree
Q20a Feel secure raising concens about unsafe clinical practice
Q20b Confident that my organisation would address my concern (unsafe clinical practice)
Q25e Feel safe to speak up about anything that concerns me in this organisation
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern
2020
2021
2022
2023
2024


Graph 7: HUTH and NLAG results Staff Survey 2024
70%
60%
50%
40%
30%
20%
10%
0%
Q20a I would feel secure raising concens about unsafe clinical practice
Q20b I am confident that my organisation would address my concern
Q25e I feel safe to speak up about anything that concerns me in this organisation
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern
HUTH
NLAG
National (Acute and Acuty & Community)
Humber and North Yorkshire region

7. Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objectives of 'Our People – we will look after the health and wellbeing of our people' and 'Quality & Safety – we will keep our patients safe and reduce avoidable harm'.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Liz Houchin
16th April 2025

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

Development areas to address in the next 6-12 months	Target date	Action owner	Progress Update
1. Board development session to get all Board members to agree a vision for Speaking Up (including role modelling values of the organisation) and to commit to it	June 2025	HRD/Vice Chair	Board development session scheduled for May 2025
2. Discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course	June 2025	HRD/Vice Chair	Will form part of the board development session in 2024/25
3. Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme) – Review FTSU input after 12 months delivery	January 2025	OD/FTSU Guardian	All leaders undertaking the leadership development course complete 'listen up' training. Leadership training being looked at for the Group
4. Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board- review in 6 months	March 2025	HRD/CIO	FTSU information to be included in Power BI
5. Update and Communicate new policy to staff			Action Completed
6. Develop ways of measuring the effectiveness of the communications strategy for FTSU	March 2025	FTSU Guardian/Comms	Bi-monthly meetings held with Comms - ongoing

7 Ensure FTSU information on local induction check list	March 2023	FTSU Guardian/People Directorate	FTSU listed on Induction Checklist for New Starter (DCM716) Action Completed
8 Further work needed on how we can encourage managers including targeted support through cultural transformation work to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale.	March 2025	OD/HRD	FTSU information included in the Manager's monthly email Further work needed as part of leadership development for the Group

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian
Quarter 4 Report
January 2025 to March 2025
and
Annual Report
April 2024 to March 2025

Fran Moverley
12th June 2025

Hull University Teaching Hospitals NHS Trust
Freedom to Speak Up Guardian Report
Quarter 4 and Annual Report 2024/2025

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during 1st January 2025 to 31st March 2025 quarter four (Q4) and the annual report of the 2024/2025 reporting year. The paper includes the details of relevant regional and national updates for comparison and context. An overview of Group working within the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the "Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current HUTH Strategic Objectives of 'Our People', 'We will look after the health and wellbeing of our people', 'Quality & Safety' and 'We will keep our patients safe and reduce avoidable harm'.

2.2 The report aims to provide assurance to the Board on promoting a 'speaking up' culture at HUTH for staff.

2.3 Freedom to speak up is directly linked to the CQC Well-led quality statement *'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at HUTH in place that allow staff to raise concerns, including, but not limited to:

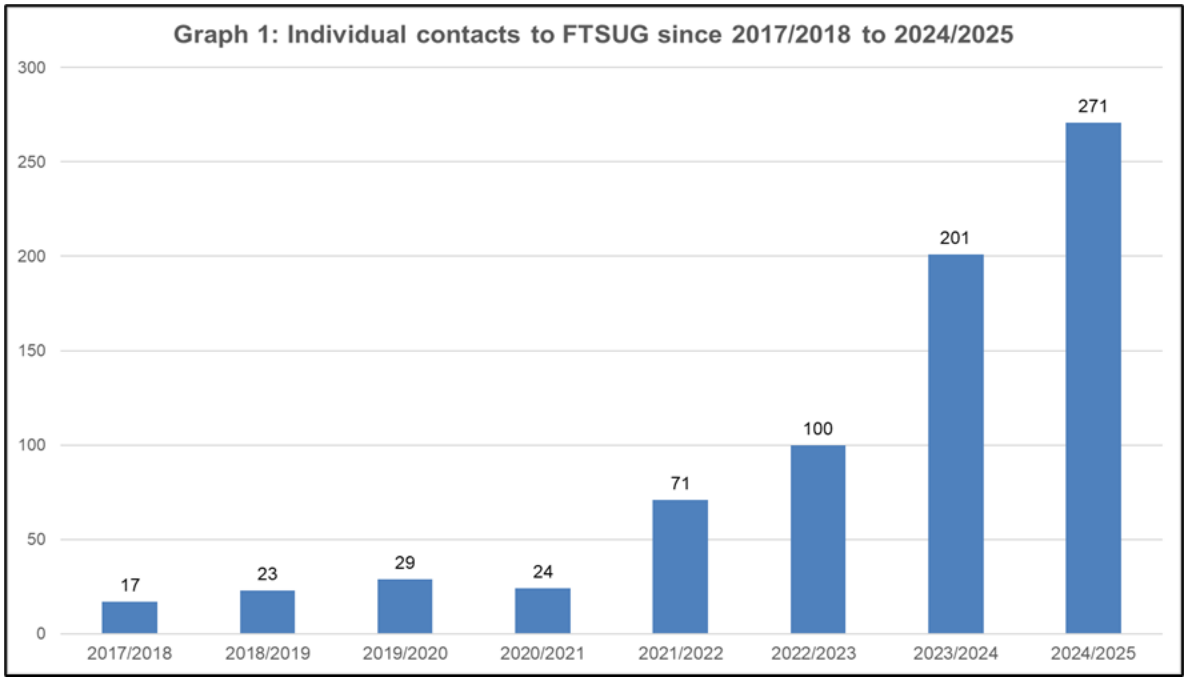
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)

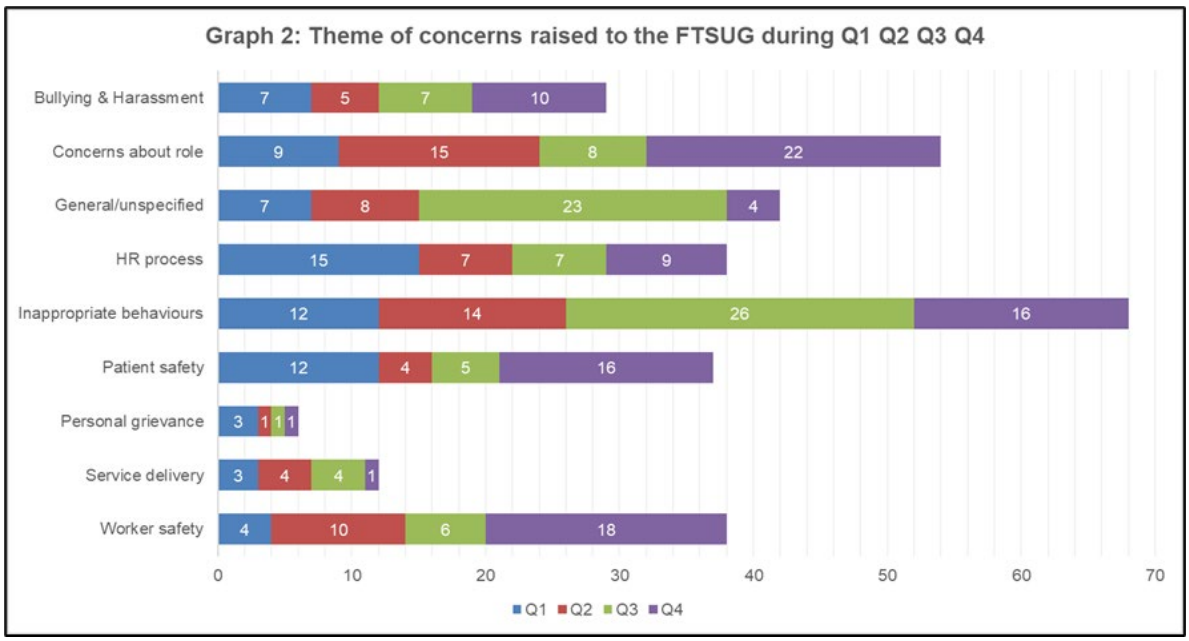
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st January 2025 to 31st March 2025 (Q4) and the annual reporting year (1st April 2024 to 31st March 2025) – data, comments and assessment

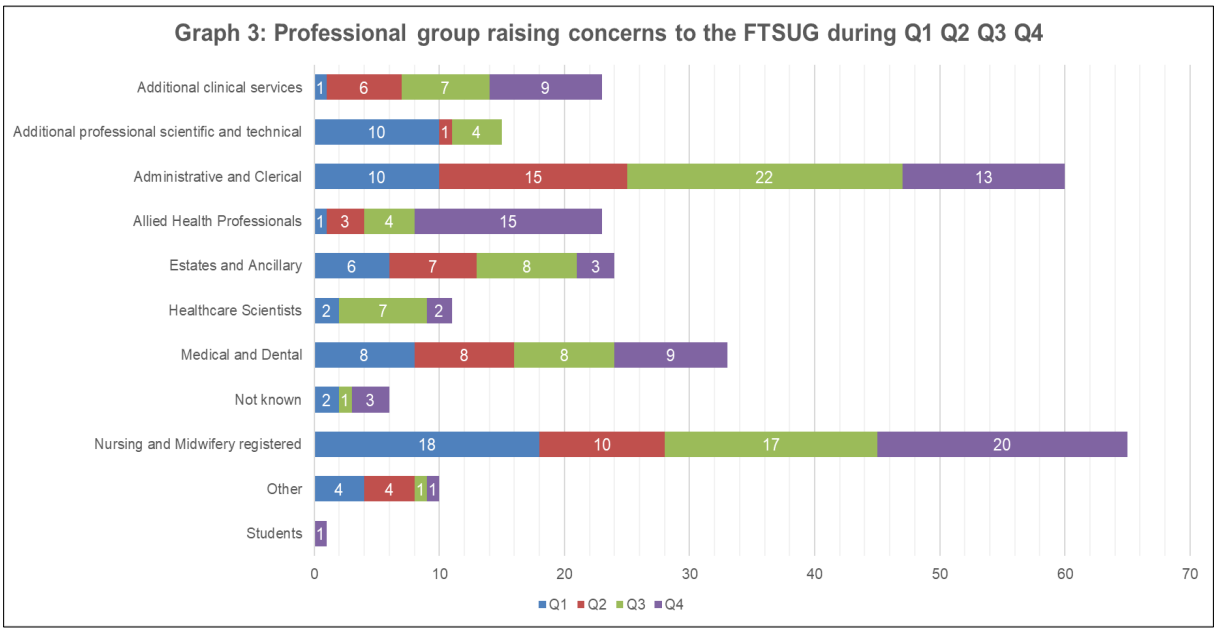
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1, 2 and 3 below summarise Q4 and the annual data:





NB. Please note some concerns may have more than one theme



4.3 Observation and comments during Q4:

- 76 concerns were received to the FTSUG. This was a slight decrease from Q3 2023/2024 (79).
- Three concerns were raised anonymously (where the FTSUG did not know the identity of the individual). Two of the concerns were regarding poor behaviours from others within a team and where the staff members did not feel comfortable identifying themselves for fear of negative impact. In one case the FTSUG was able to gain the name of the department and consent to escalate their anonymous concerns to the Matron of the area. For the two other anonymous concerns, guidance was given to the individuals on how to raise their concerns themselves.
- There was a further increase in the number of individuals requesting to be anonymous throughout the speaking up process (where the FTSUG knew the identity of the individuals but did not have consent to release their identities). This represented 30% (23) of the individuals approaching the FTSUG.
- 67% (51) of concerns were relevant to an individual's line manager; either where the line manager could assist in the resolution or the concern being directly about the line manager, of which 78% (40) of individuals had already spoken up to their line manager, before approaching the FTSUG.
- During Q4 the most popular reasons for staff approaching the FTSUG, were due to concerns with an element of:
    - The individual's role (22)
    - Worker safety (18)
    - Patient safety (16) and inappropriate behaviours (16)
- Previously during Q3 the concerns with an element of inappropriate behaviours had increased; however, this has now reduced during Q4. Concerns related to an individual's roles (examples include concerns about requesting reasonable adjustments, contractual concerns, changes to roles and duties and management practices) and those featuring concerns about patient safety and worker safety (the majority related to psychological safety and wellbeing) increased during Q4.

- Nursing and Midwifery staff (20) and those in Administrative and Clerical roles (13) continue to be in the top three most common professional groups to raise concerns. For the first time, Allied Health Professionals are within the top three (15).
- During Q4 no staff members reported being subject to direct detriment because of speaking up. However, several staff members reported to the FTSUG that they felt they suspected that behaviours were starting to change towards them.

4.4 Observation and comments for the annual 2025/2026 data:

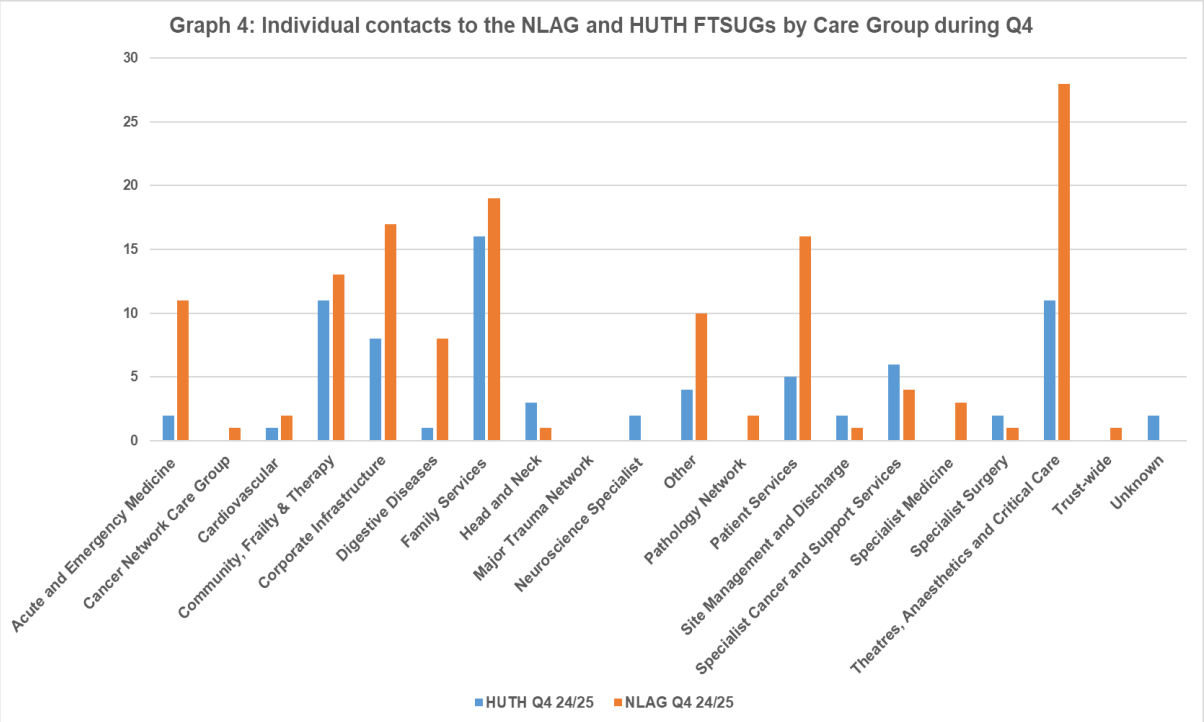
- 271 concerns in total were raised to the FTSUG (Graph 1), representing a 35% increase since the 2023/2024 reporting year and the highest recorded for the Trust since the FTSUG role was implemented.
- During 2024/2025 2% (6) individuals contacted the FTSUG anonymously. The level of anonymous reporting is often seen as an indicator of a transparent and open culture and whilst it is not yet possible to compare this with the national average of anonymous concerns raised to all FTSUGs in England; the Trust is below the national average in 2023/2024 of 9.5%.
- During 2024/2025, the FTSUG began collecting information regarding whether the individual requested to be anonymous throughout the speaking up process (where the FTSUG knew the names of the individuals but did not have consent to release their identities). This represented 21% (58) of individuals raising a concern with the FTSUG. Many staff have welcomed the ability for the FTSUG to escalate their concerns anonymously as a way of overcoming a barrier to speaking up and feeling psychologically safe.
- 55% (149) of concerns were relevant to an individual's line manager; of which 75% (112) of individuals had already spoken up to their line manager, before approaching the FTSUG. This is positive that the majority of staff attempt to resolve their query first, before speaking to the FTSUG.
- Annually, the most popular reasons for staff approaching the FTSUG, were due to concerns with an element of:
    - Inappropriate behaviours (68)
    - Concerns about the individual's role (54)
    - General concerns/queries (42)
- There was an increase in the number of concerns reported against every theme during 2024/2025 since 2023/2024 (NB – personal grievance is a new theme introduced as part of the alignment with the NLaG FTSUG). The highest increase were concerns with an element of inappropriate behaviours from 21 (2023/2024) to 68 concerns (2024/2025).
- Positively there was an increase in the number of concerns raised by nearly every professional group from 2023/2024. Nursing and Midwifery reduced by 12%; however it is noted that this professional group remained the highest reporting group for the second consecutive year - please also see the Staff Survey comments in section 6 of this report. Healthcare Scientists also saw a reduction, however only by one individual (8% reduction) less than the previous year.

- During 2024/2025 1.4% (four) staff members reporting concerns to the FTSUG stated they had been subjected to detriment or disadvantageous treatment during the speaking up process. This is lower than the national average – where detriment for speaking up was indicated in 4% of cases during both 2023/2024 and 2022/2023. Two of these cases were escalated to a member of the Board, a third case was escalated to the HR team and in the fourth case, the staff member themselves escalated the situation to their senior manager. In addition, several staff also continued to express fear of the potential for negative 'backlash' if they spoke up. In May 2025 the Board are reviewing the NHS England Self-reflection documentation, and this will provide the opportunity to review the statements regarding addressing detriment.
- Throughout the year in the event an individual has consented for the FTSUG to assist in escalating concerns; the FTSUG has been received positively with senior leadership, managers and the HR teams wanting to assist the individual in resolving the concerns.

4.5 Care Groups – concerns combined

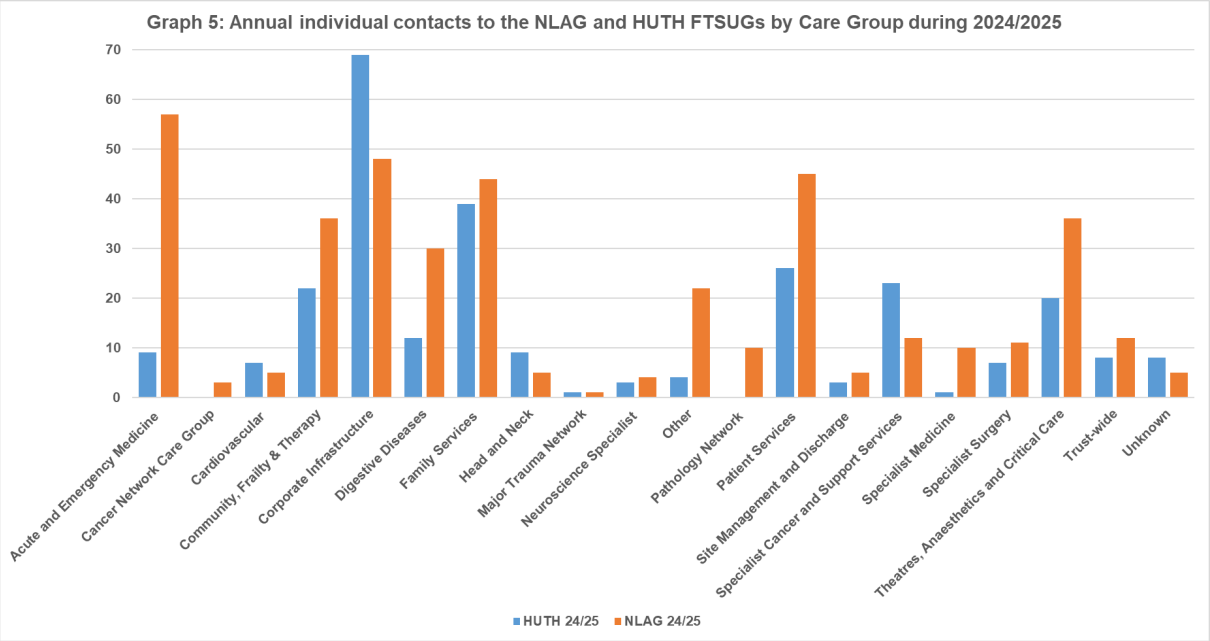
The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.

During Q4 at HUTH, the highest number of concerns were received regarding departments within the following Care Groups: Family Services, followed by Community, Frailty and Therapy and Theatres, Anaesthetics and Critical Care jointly.



Graph 5 below provides an annual overview of the concerns received during 2024/2025. Combined, the highest number of concerns were received by both FTSUGs were the Corporate infrastructure (117) followed by Family Services

(83) and Patient Services (71).



Both Graph 4 and Graph 5 have been sent to each of the Care Group Triumvirates and Corporate Directors, to assist in triangulating the information received by the FTSUGs and to provide themes of the cases.

5. Feedback on speaking up

5.1 FTSU Guardian and Speaking Up Feedback/Evaluation:

In July 2024 the FTSUG introduced a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience. Whilst there hasn't yet been the benefit of collecting survey responses over a full year, 35 responses were received to date. The survey is split into two parts – firstly the key results related to the staff member's experience of the FTSUG included:

	Very easy	Fairly easy	Not easy	Difficult
How easy was it to make contact with the FTSUG?	80% (28)	20% (7)	0%	0%
	Excellent	**Good**	**Fair**	**Poor**
How was your experience of the FTSUG?	83% (29)	17% (6)	0%	0%
	Yes	**No**	**Not sure**	
Did you feel supported when speaking up to the FTSUG?	97% (34)	0%	3% (1)	
Given your experience, would you speak up again to the FTSUG?*	94% (33)	0%	6% (2)	
Did you feel your concerns were listened to and taken seriously?	94% (32)	0%	6% (2)	
	Highly likely	**Likely**	**Unlikely**	**Highly unlikely**
How likely are you to recommend to a work colleague to contact the FTSUG?	77% (27)	20% (7)	3% (1)	0

Comments and observations:

- Positively 100% staff members completing the survey found it either very easy or fairly easy to contact the FTSUG, and 100% found their experience of the FTSUG to be excellent or good. The majority of staff (97%) felt supported by the FTSUG.
- *The National Guardian Office guidance only requires one mandatory question to be included in the survey – '*Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'.* At HUTH, 94% answered yes to this question. For the two respondents who answered 'unsure' – one stated that whilst they would *'certainly recommend'* the FTSUG, they did not feel they had an adequate response from management when raising their concern. The second respondent stated 'unsure' commented the FTSUG was approachable but found the wider system at the Trust was complex and difficult to get a resolution to their concern.

Why the individual would speak up again to the FTSUG, included the FTSUG:

- Had empathy and showed genuine concern for the individual's wellbeing.
- Was approachable, an active listener and provided valuable guidance and signposted individuals to the appropriate resources where needed.
- Created an environment where the staff felt comfortable raising issues and staff felt supported and respected throughout. Flexible communications options (face to face, teams, telephone etc) were offered which were valued.
- Many respondents commented on being reassured having the FTSUG to speak with and the confidence that they would receive a response.
- An example of feedback included: *"I felt really comfortable and safe explaining my concerns and issues to her [FTSUG]. She was really good at explaining her role, and what support mechanisms she can help put in place. It was really reassuring having a safe space to openly talk about what I was going through".*

What went well with speaking up, included the FTSUG:

- Provided support and reassurance, and validation of the concerns.
- Responded quickly, provided the appropriate updates and communications to the individuals effectively.
- Confidentiality was maintained, and as a result the individuals felt comfortable sharing their concerns.
- Examples of feedback included: *"Fran is accessible, very knowledgeable, approachable and easy to talk to"* and *"I felt that I had done the right thing is speaking up and Fran helped me to look at the bigger picture".*

What could be improved about speaking up to the FTSUG included:

- Many respondents stated nothing could be improved.
- Other ideas included:
    - *"I think it would be a great idea if we could hold monthly sessions to chat about experiences or issues that we often feel there is no one to support us with, I would like Fran to speak at our [staff group name] meeting next time"*
    - *"There should be an online reporting service where complaints can*

be put in and appropriate actions taken".

- *"A formal final response would have been useful as to what could be answered and what couldn't"*

The second part of the surveys asked questions about the staff member's experience of speaking up to the wider Trust (for example to a line manager, senior manager, HR team etc):

	Yes	No	Not sure	I chose not to raise my concern	Not sure
Did you feel your concern was treated confidentially?	69% (24)	3% (1)	20% (7)	9% (3)	
Did you feel your concerns were listened to and taken seriously?	66% (23)	17% (6)	9% (3)	9% (3)	
Given your experience, would you speak up again?	77% (27)	6% (2)	17% (6)		
Has your concern been addressed?	29% (10)	14% (5)	26% (9)	11% (4)	20% (7)

Comments and observations:

- The National Guardian Office mandatory question was also asked in respect of the individual's experience of speaking up to the wider Trust – *'Give your experience, would you speak up again?'.* In comparison, this was slightly lower with 77% confirming they would.
- Furthermore, 66% of staff felt their concern had been listened to and taken seriously by the wider Trust, in comparison with the FTSUG (94%).
- More concerningly, only 29% of respondents to the survey felt their concern had been fully addressed by the wider Trust.

What went well with speaking up, included that the wider Trust:

- Addressed issues and actions were put in place – examples were provided about the success with contacting a department manager.
- Staff felt listened to and supported.
- Resolving the concern was supported using the Trust policies and procedures.
- Examples of feedback included: *"Manager whose area of responsibility it was also responded promptly and effectively"* and *"DATIX complaint addressed seriously".*

What could be improved about speaking up to the wider Trust included:

- Three respondents stated that nothing could be improved.
- In one case the Trust engaged only after the FTSUG intervened.
- Individuals were disappointed not to receive feedback after raising concerns or the concerns weren't dealt with. There were comments regarding concerns about favoritism when concerns were dealt with.
- Two individuals referenced not feeling they had been treated in a compassionate way, including when having a disability.
- Two individuals suggested an online reporting system for complaints under HR policies.
- One respondent had been told not to discuss their concerns with anyone – therefore a higher level of understanding and transparency would be

beneficial.
- Several respondents spoke of the emotional impact of speaking up and the anxiety and stress this can cause.
- Examples of feedback included: *"My issue still is not resolved despite my frequent attempts to get it sorted"* and *"Problems still get dismissed and managers are reluctant to address any problems in their area".*

Other results from the survey:
- The most popular way staff found out about the FTSUG role was jointly Bridget and having previously contacted the FTSUG. The former likely reflects the increased support from the Communications Team.
- Respondents were able to provide their protected characteristics:
    - Respondents were from all age ranges; the most popular age was 56 to 65 years (31%)
    - 20% of respondents declared a health problem or disability that limited (a little and a lot) day to day activities
    - 17% of respondents were from ethnic minority backgrounds.
    - 83% stated they were female (including trans women).
    - The majority of respondents (91%) stated their sexual orientation is straight.
    - 46% of respondents stated they were Christian, and 46% stated they had no religion.

Suggested actions from the survey:
- Ensure the online reporting form to report concerns to the FTSUG is live for staff to access during Q1 of the 2025/2026 reporting year.
- Discuss the options of reporting under the HR policies and processes with the HR Team during Q1.
- Provide the key themes from the survey, including the importance of feeding back to managers, as part of the communications plan.
- Attend the specific departmental meeting as requested and plan regular drop ins throughout the year to give opportunities for staff.
- Where appropriate, provide a final written response to the concerns raised.
- Continue sending the option to complete a feedback survey to those who speak up to further to build on the data and the results.
- Include a question regarding detriment and/or any negative impact of speaking up, to triangulate with the data already captured from staff members.

5.2 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, learning for the Trust, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience. The below case study demonstrates an example of the learning from a staff member raising concerns to the FTSUG:

The HUTH freedom to speak up guardian (FTSUG) was contacted by a staff member who has a medical condition which meant their role would need to be adjusted. The staff member was keen to work with their department to discuss the alternative duties they could perform, but did not feel supported by their

management, who were resistant to engage in discussions about any possible reasonable adjustments. The staff member was upset and contacted the FTSUG to discuss further. The FTSUG provided support to the staff member, who escalated their concerns to a senior manager and received an immediate response to their contact, listened to the issues and took action. The concern has now been resolved, and the staff member's role has been adjusted to meet their needs, as well as to meet the needs of the duties available within the department. The FTSUG also signposted the staff member to the Staff Disability Network as a way to receive peer support for their ongoing condition.

There is clear learning from this experience in that an initial informal conversation with the staff member would have allowed for an open and supportive discussion about the staff member's role and empathy that many staff do have underlying medical conditions that require consideration. Timely management of the situation and improved communication would have avoided any undue stress and upset for the staff member. Once escalated, the staff member received a really positive response from their senior manager who provided them with the reassurance they needed at a difficult time.

The staff member commented: "I really want there to be learning from my experience and for it not to happen again to another staff member. I was exhausted by the situation and it was making me unwell. When I was honest with my management that I needed to discuss my role, it just needed to be a chat over a coffee. I am a hard worker and open to taking on any other duties that I know are available in the department for me to do. It should never have required me to involve the senior manager or Fran, as the FTSUG to resolve. The response from my senior manager was excellent, they listened and offered that timely support. I also cannot thank Fran enough for our discussion, she made a huge difference to how I've been feeling lately and the support the FTSUG offers in invaluable'.

6. FTSUG activities and proactive work

6.1 FTSUG activities and proactive work during Q4

A high level summary of the FTSUG activities are detailed below:

- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan (Appendix 1). Action 8 and Action 9 are now closed. It is proposed that Action 13 is transferred to the new action plan following the repeat of the Board Self-Reflection on 8th May 2025. Action 16 is planned for completion on final ratification of the FTSU Strategy at the Boards-in-Common meeting on 16th June 2025.
- The HUTH FTSUG was asked by NHS Resolution to be a keynote speaker at a Board-level Just Culture event, presenting to Trusts across Yorkshire and the Humber. The presentation was positively received, and thanks were received from NHS Resolution Directors after the event: *"As a key speaker we truly valued your insights and contribution to the pilot workshop".*

- The HUTH FTSUG was subsequently invited to present at the Yorkshire Improvement Academy Just Culture Network meeting to promote FTSU and discuss the barriers to speaking up.
- Commenced joint drop-in sessions with the Director of Nursing (North bank) to encourage staff to speak up about their concerns. Drop-in sessions were offered at Hull Royal Infirmary and the date at Castle Hill Hospital will be rearranged for Q1.
- Presented in partnership with the GMC Regional Advisor and the NLaG FTSUG at the 'Professional behaviours and Patient Safety' training session for doctors.
- Presented the first draft of the Group Speak Up Strategy to the Workforce Transformation Group to commence the ratification process.
- Continued work to create Group FTSU content on Bridget.
- Promotional stalls at the Resident Doctor Trust induction days to speak to new starters and to promote the FTSUG role.
- A further two new Speak Up Champions were trained, one Champion returned to the Network after rotating back to train at HUTH – therefore increasing the total number of Champions to 40.
- Led the Speak Up Champion Network peer support and development quarterly meeting, including responding to Champion feedback to increase knowledge of the zero tolerance to discrimination reporting tools by having the Equality, Diversity and Inclusion Lead as the guest speaker.
- Commenced participation in the new Stay and Thrive working group, with a focus on internationally educated staff.
- Presented to the new first year and third year Radiography students from Hull University and Leeds University, to provide an introduction to the FTSUG role and ways to speak up at HUTH.
- Meeting with the North and South Site teams to discuss themes and areas of concern.
- Support provided to the refreshed departmental incivility reporting tools circle groups.
- Provided a joint presentation with the NLaG FTSUG to the Group Health and Wellbeing Ambassadors to promote the FTSUG role and highlight signposting to the FTSUG roles.
- The FTSUG completed the training to become a Domestic Abuse Champion in order to support this initiative and to better support staff.
- Provided support to three other FTSUGs at other Trusts who are forming a Group structure; to share the learning gained from the NHS Humber Health Partnership.
- Introductory meeting with the new Co-Chairs of the LGBTQIA+ Staff Network to discuss partnership working and support for the Network.

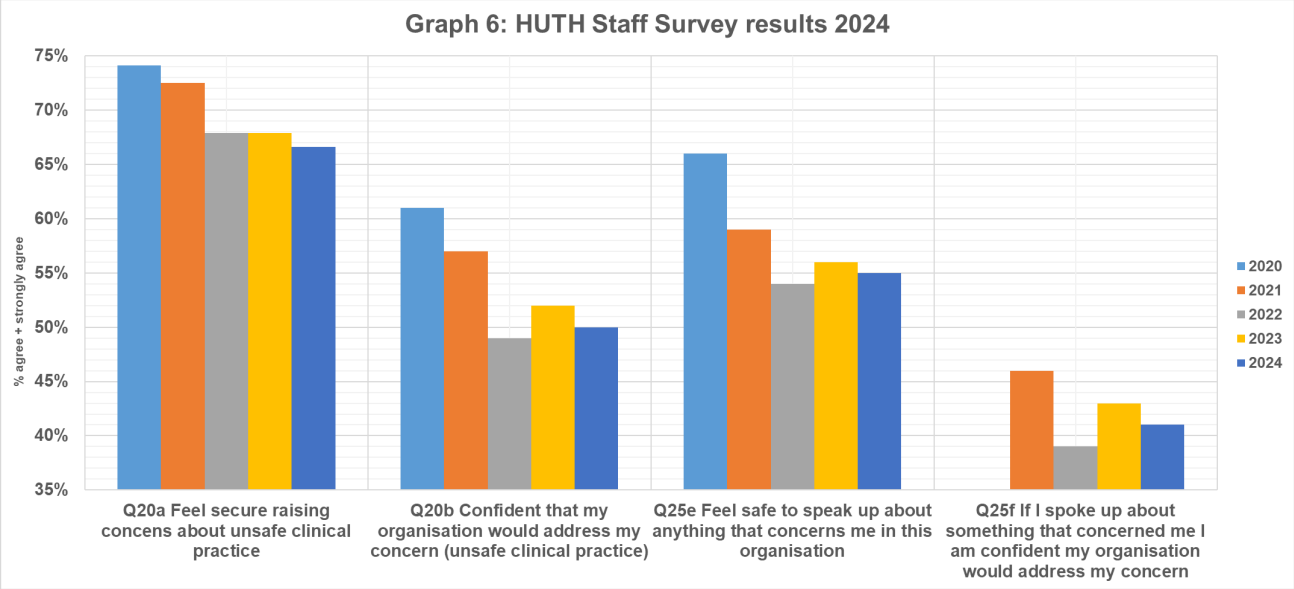
6.2 Future plans:

- Continue the consultation and ratification for the Group Speak Up Strategy. Meeting with the Chairs of the JNCC and LNC and planned attendance at the Workforce Committee and the Group Workforce, Education and Culture Committees-in-Common.
- Facilitating the repeat NHS England Self-reflection and improvement tool at a Board Development day.

7. Staff Survey results 2024

The 2024 Staff Survey included four questions that relate to staff feeling secure about speaking up and the confidence that their concerns will be addressed. Graph 6 below provides the 2024 results for the Trust in comparison to the results since 2020; the results are based on the percentage of staff answering 'strongly agree' and 'agree' to each question.

The Trust scores show a slight decrease from 2023. The scores for Questions 20a and 25e regarding staff feeling safe to speak up, reduced by 1% each. The scores for Questions 20b and 25f related to staff feeling confident that the organisation would address their concerns, reduced by 2% each.



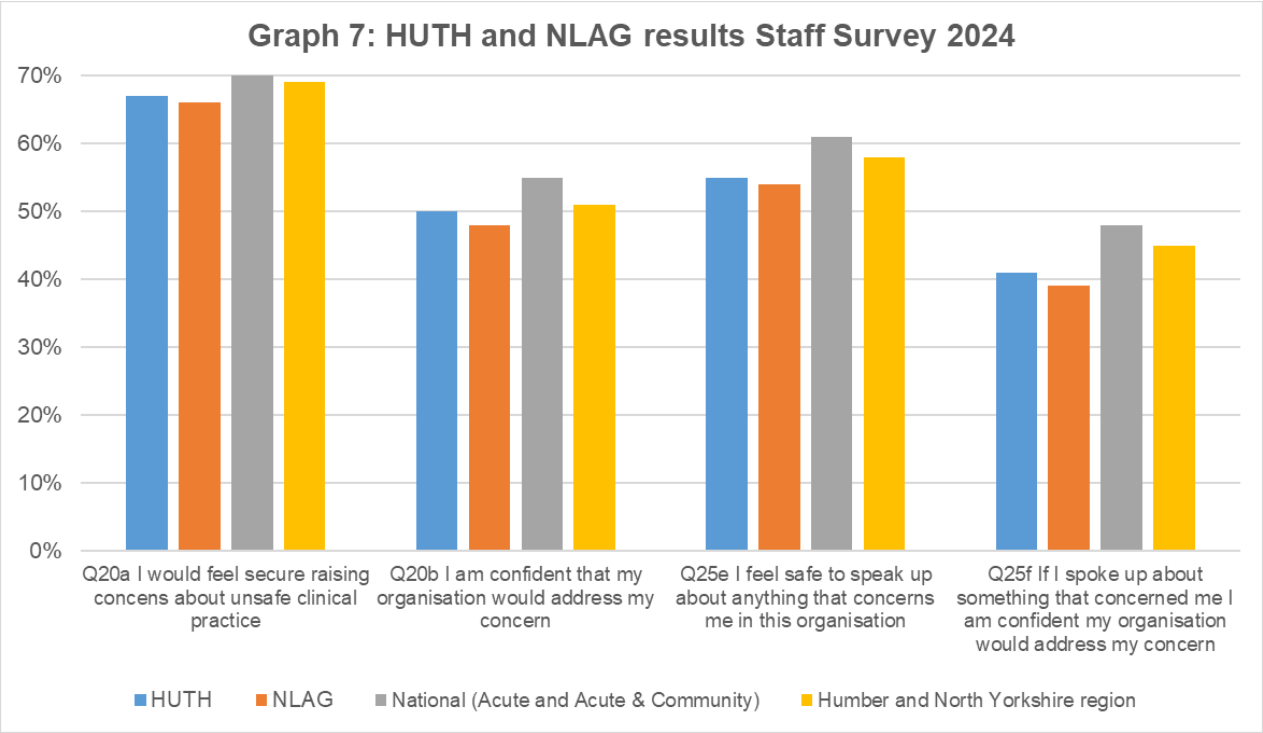
There are many potential barriers to speaking up, including having one or more protected characteristics. The Staff Survey provides a wide range of metrics, including the following two examples:

- Staff with a long term health condition or illnesses scored lower to all four questions. For example, 63.59% of staff with a health condition/illness felt safe to raise a concern about unsafe clinical practice (Q20a); as opposed to 67.95% of staff without any illnesses. Only 33.11% of staff with a health condition felt their concern would be addressed (Q25f); in comparison to 43.02% of staff without any illnesses.
- 67.56% of white staff are more likely to feel safe to raise unsafe clinical practice (Q20a); in comparison to staff from all other ethnic groups (64.71%). Whereas staff from all other ethnic groups scored higher for questions 20b, 25e and 25f. For example, staff from all other ethnic groups (55.12%) are more likely than white staff (49.32%) to feel that the organisation would address this concern they raised (Q20b).

When reviewing the staff survey data by professional group; Nursing and Midwifery staff are the most likely to feel safe to raise concerns about unsafe clinical practice (Q20a 53.45%) and raise all other concerns (Q25e 56.85%). This data correlates with Nursing and Midwifery staff being the most likely to

approach the FTSUG to raise their concerns.

Graph 7 shows the comparison to NLaG, the national average (acute and acute & community) and the regional average (Humber and North Yorkshire); HUTH scores slightly higher than NLaG for each of the questions. Both Trusts within the Group are below the national average and regional average; albeit closer to the regional average.



8. Regional and National Information and Data

8.1 Regional update

The FTSUG attends, where possible, the Yorkshire, Humber and North East regional meetings to discuss best practice and contribute to active discussions. During Q4 the FTSUG attended meetings that discussed new national guidance, supported other FTSUGs with specific scenarios and shared good practice.

8.2 National update

At the time of this report, the National Guardian Office had not yet released the national Q3 figures of the concerns raised to all FTSUGs.

The FTSUG attended the National Guardian Office conference virtually in March 2025, with the theme of ‘changing organisational culture’ This provided the FTSUG with the opportunity to listen to keynote speakers and participate in breakout groups to discussing overcoming barriers to speaking up. Several of the Speak Up Champions were also able to attend the conference virtually to expand their knowledge and understanding.

It is understood that the outcome of the Dash Review is due to be published shortly in Q1 2025/2026. The Dash Review has focused on a review of six NHS bodies, including the National Guardian Office.

9. Conclusions

9.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up.

9.2 The FTSUG has been active in building partnerships and the communications support during 2024/2025 has been important in continuing to raise the profile of the role.

9.3 The Group arrangements for FTSU have worked well, with the HUTH and NLaG FTSUGs developing consistent processes and being recognised nationally as good practice.

9.4 The Speak Up Champion Network continues to build and plays an important role in signposting to the FTSUG and raising awareness in local areas.

10. Recommendations

10.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

10.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Appendix 1: NHSE Board Self-Reflection Planning Tool – Development Actions Update

ACTIONS IN PROGRESS			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 13: Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8.	31/12/24	FTSUG	**Action in progress – propose to transfer** • FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports. • January 2024 – initial discussion with NLAG FTSUG to discuss best practice and different ideas for triangulation. • March 2024 commenced reviewing 2023 staff survey results in relation to the four speaking up questions. Trust-wide results communicated to each Health Group in the governance briefing reports. • Ongoing discussions with the Workforce Intelligence team to provide data to Care Group triumvirates, in conjunction with other relevant workforce data. At 16/07/24: • BI spreadsheet in development with assistance from the Workforce Intelligence team, to develop reporting data for Care Groups. At 01/12/24: • FTSUG continues to be a member of the zero tolerance to discrimination and departmental incivility circle groups, to aid triangulation. • HUTH FTSUG and NLAG FTSUG have co-created a Group-wide graph using speaking up data to assist in triangulating data across the Care Groups. • HUTH FTSUG and NLAG FTSUG have commenced meeting with the South site triumvirates to discuss speaking up data and aid the triumvirates in triangulating key data. At 02/02/25: • Commenced discussions with the Group Director of Learning & Organisational Development to consider expanding the triangulation of data, including potentially a Group wide Circle Group and a Cultural Dashboard on Power BI. **At 01/06/25:** • **Board Self-Reflection process was repeated on 08/05/25.** • **Proposed that this action is moved across to the new action plan.**

Action 16: Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/12/24	FTSUG	**Action in progress** • Initial work underway to develop a draft strategy; including reviewing other Trust's strategies. • January 2024 – discussed with NLAG FTSUG to propose a joint Group. NLAG current strategy due for renewal August 2024. • In February 2024 the Board agreed to the creation of a joint Group FTSU strategy. NLAG and HUTH FTSUGs have commenced the early stages of developing a strategy. Development day planned in June 2024. At 16/07/24: • HUTH and NLAG FTSUGs have commenced the early planning of a Group wide strategy. Awaiting publication of the Group Strategy and National Guardian Office Strategy. At 01/12/24: • Version 1 of the draft strategy has been written and is currently being reviewed, in preparation for identifying stakeholders and circulating the strategy for comment, ahead of ratification. At 02/02/25: • Draft Strategy presented to People Directorate Senior Leadership Team for comment. • Draft Strategy circulated to Equality, Diversity and Inclusion Lead, Staff Network Chairs and Co-Chairs and FTSU Non-Executive Director for comment. • Commencing the ratification process in February – initially presenting to the Workforce Committee for approval. **At 01/06/2025:** • **Strategy ratified/approved by the Workforce Transformation Group and Workforce Education and Culture Committees-in-Common.** • **Strategy will be presented for final approval at the public Board on 16.06.25. and if approved, the action will be closed.**

ACTIONS COMPLETED			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 1: Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead	**Action completed** • Repeat self-assessment of the Board self-reflection will be scheduled no longer than two years from the previous assessment (February 2023). Executive Lead committed to ensuring this has been completed.
Action 2: Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG	**Action completed** • 6 further Speak Up Champions recruited and trained during March, April, May, June and July 2023. • List of local Speak Up Champions continually updated on staff intranet Pattie and bimonthly network meetings for all Champions providing peer support and development are in place. • Private workspace on Pattie set up for Champions to provide a central resource for key updates and resources. • Recruitment to being a Speak Up Champion continues to be promoted at local induction events e.g. internationally educated nurses, junior doctors. • At 29.01.24. 24 active Speak Up Champions trained and further 4 are booked on training. At 03/06/24: • The Speak Up Champion Network has been expanded. Currently 27 Speak Up Champions trained, with 13 further places booked on training in July 2024 and September 2024.
Action 3: Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/12/24	FTSUG	**Action completed** • Bimonthly training dates booked until end of 2023. • Bimonthly training dates for 2024 are in place. • The Speak Up Champion Network has been expanded to 27 trained Speak Up Champions. Trust-wide email sent April 2024 promoting the training. Further 14 places booked on training in July 2024 and September 2024. Additional training date in November 2024 planned and advertised. • Speak Up Champions have been mapped per Care Group and there are minor gaps with some Care Groups with no Champions. FM to discuss with senior management to recruit as widely as possible across the Trust. At 16/07/24: • The total number of Speak Up Champions trained is 34; with further 8 trainees booked for training in September and November 2024.

			At 01/12/24: • Number of trained Champions increased to X. X booked on training. • Review professional groups. • 2025 dates booked and communicated. • Speak Up month webinar drop in session • Celebration event and November meeting
Action 4: Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.	**Action completed** • New national speak up policy has been personalised and circulated to stakeholders. The Workforce Transformation Committee on 20th July 2023 was cancelled – currently seeking ratification through email approval to progress the policy. • Joint drop in session with the York and Scarborough NHS Teaching Hospitals NHS Trust held for SHYPS staff took place 27th July 2023. Further dates will be scheduled to provide further opportunities to speaking up. • The new Group CEO circulated communications in reflection of the recent national media coverage into the conviction of a neonatal nurse and the importance of speaking up in the NHS. • Joint drop in session with the FTSUG and Chief Nurse scheduled for 31st August 2023. • Attendance planned to provide a market stall to raise awareness of speaking up at the Staff Disability Network conference in October 2023. • Repeated communications and bulletins from the Group CEO promoting a speaking up culture at HUTH and the FTSUG role. • During speak up awareness month in October 2023, a timetable of activities was promoted across the Trust including joint drop in sessions and walk arounds with the Interim Chief Nurse and FTSUG. • Ad hoc communications e.g. Daily Update linked to speaking up, circulated Trust-wide. • Future - 2024 Communications Plan to be developed, where possible in conjunction with the NLAG FTSUG.
Action 5: Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any	30/09/24	FTSUG	**Action completed** • Question about whether the individual had experienced positive behaviours when speaking up considered and included in the feedback survey. • Question about referral route and awareness of the FTSUG role included in the feedback survey. • Free text box included in the survey to include permission to share stories of speaking up. • Final amendments to the feedback survey to be made – Digital Communications team confirmed in work plan.

improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances. • A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.			• Questions related to protected characteristics approved by Equality, Diversity and Inclusion Committee 18.01.24. Final checks in progress and feedback survey will commence. • Delay in survey due to further changes required (as per the National Guardian Office change in guidance), currently with the Communications Team to progress using Encapsulate to satisfy data protection requirements. Aim to launch the survey in Q2. At 16/07/24: • Feedback survey completed and live. FTSUG has commenced circulating links to staff who have spoken up since April 2024. • Questions included asking about how well the staff member felt listened to, supported and whether their concern was resolved. National mandatory question included. • FTSUG to report on results at the next Board meeting. At 01/12/24: • Feedback survey live and in place • Feedback included from Q2 Board and WEC reports • Propose annual review • Using free text quotes in comms to promote and encourage speaking up
Action 6: Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	30/11/24	Group Director of Learning & Organisational Development	**Action completed** • Initial discussion held between Head of Organisational Development and FTSUG to discuss incorporating existing Health Education England e-learning into line manager development. • PACT embedded into all of the leadership programmes and how to speak up. Programmes will be reviewed with the move to the group leadership model but speaking up with remain with any new/revamped programmed. • January 2024 - Head of Learning and Organisational Development confirmed looking at opportunities to include speaking up content in future leadership training. Requested an extension to the target date. • FTSUG met with OD Facilitator to discuss including a bespoke speaking up module within the new Inclusion Academy. • Bitesized programmes are due to begin again in end of June 2024 and full programmed activity will begin end of October 2024 – FTUG content will be included. At 01/12/24: • New leadership bite sized courses were launched by the Organisational Development team, and all staff members are able to book on. The courses include Professional and Civility Training (PACT). • Action now closed

Action 7: Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an "internal consultant" to bring expertise into bespoke work design.	30/11/24	Group Director of Learning & Organisational Development	**Action completed** • The Maternity reporting tool is now live and Cardiology is currently in progress. • FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised. • Cardiology incivility reporting tool launched on 10th November 2023. • FTSUG continues to be involved in the monthly circle groups. At 01/12/24: • Maternity incivility tool has been relaunched; including direct staff communications via a maternity tea trolley. The tool is part of business as usual. • Action closed.
Action 8: Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	30/11/24	Group Director of Learning & Organisational Development	**Action completed** • Initial discussion held between Head of Organisational Development and FTSUG to discuss what indicators and data could be appropriately used for a Trust wide group. • This action needs further thought as more reporting tools are made live. Zero tolerance to ableism launched October 2023 in addition to the existing zero tolerance to racism. • LGBTQ+ framework and circle group are due to go live February 2024. • Group Director of Learning and Organisational Development have identified a potential support/supervision need for staff network leadership teams – informal meeting to discuss further the scope of this work in February 2024. • Head of OD (South) now in post and has EDI and Cultural Transformation as part of their portfolio. Target date of 31st August 2024 for roll out of Zero Tolerance tools Group-wide. **A**t 02/02/25: All zero tolerance tools now launched Group wide. At 01/12/24: • The Circle Groups for zero tolerance to racism and LGBTQIA+ discrimination have been extended to Group wide. • Zero tolerance to ableism to be launched Group wide at the end of December. Group Director of Learning & Organisational Development looking to implement a zero tolerance tool quarterly report to include soft intelligence and themes for learning. At 02/02/25: In progress and needs to remain open. **At 01/06/2025:** • **It is reflected that this action has altered since its inclusion in the improvement plan.** • **The cultural dashboard linked to engagement and the staff survey**

			has been delivered and is now live on Power BI to enable Care Groups and departments to triangulate their data. • **A full review of the Circle Group approach is taking place.**
Action 9: Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	30/11/24	Group Director of Learning & Organisational Development	**Action completed** • PACT "Professionalism and Civility Training" launched from late August 2023 onwards, alongside a marketing campaign to allow us to reflect on how "Bad Behaviour Doesn't Work – Time to Change". At 02/02/25: Close off as moving to a Group approach as part of the People Strategy Delivery programme once signed off. • PACT has been delivered to approximately 150 leaders and is currently on hold for a group roll out as needed. PACT is also delivered in the new format to all new starters and this includes a FTSUG contacts and how to report concerns. At 02/02/25: Close off • Currently on hold subject to the Group leadership structure. • New Values and Staff Charter now in place. Head of OD (South) has been tasked with creating the following Group Programme: o Civility and Respect Campaign refresh and relaunch (bad behavior doesn't work) o Required Learning for Leaders inc PACT o "What's it like to be managed by me?" and "What's it like to work with me?" style content o Cultural Ambassadors (NLAG have currently and scoping out group roll out) o Cultural Dashboard – People metrics triangulated to give an overall picture of culture in a care group or department At 01/12/24: • As above, the bite sized leadership courses, including PACT training are now live and bookable across the Group. • The new staff behaviours charter to be rolled out; this will include workshops for leaders/teams and train the trainer. Managers will be trained to subsequently deliver workshops for values and behaviours and lead a conversation with their teams. At 02/02/25: • Values training is being piloted in January/February/March ready for roll out in April. In addition 20 Band 7 and above Executive led briefing sessions will be held on "putting people first" to be clear on our expectations of all line managers and leaders. **At 01/06/25:** • **Values training is now in place and offered across the Group following the pilot.** • **The Putting People First sessions are in place for managers.**

Action 10: Implementation of the new NHS England speaking up policy. To include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.	31/12/23	FTSUG	**Action completed** • National policy transferred into HUTH template and personalised. • Policy could not be ratified due to Workforce Transformation Committee on 20th July 2023 being cancelled. Approval sought via email approval. • Approval via email confirmed. Policy now published live on Pattie (reference CP451).
Action 11: Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG	**Action completed** • Draft policy sent to internal stakeholders for information/comment. Including Executive Lead, Director of Workforce, Head of Workforce, Head of HR, Disability Staff Network Chair, BAME Staff Network Chair, LGBTQ+ Staff Network Chair, JNCC Chair, LNC Chair, Equality Diversity & Inclusion Trust Lead.
Action 12: Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.	31/05/23	FTSUG	**Action completed** • Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training.
Action 13: Review the self-reflection and planning tool outputs from at least two other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.	31/12/23	FTSUG	**Action completed** • Self-reflection and planning tool reviewed and shared with NLAG FTSUG. • HUTH FTSUG has contacted other FTSUGs working in similar sized acute Trust's across the region to discuss sharing. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • HUTH results compared to NLAG. Copies of improvement plans requested from two other acute NHS trusts for comparison. • Contact made with Mid Yorkshire Teaching NHS Trust and Group (Kettering General Hospital and Northampton General Hospital). At 03/06/24: • Reviewed the self-reflection and improvement tool from Cambridge Community Trust, previously rated as the highest in the FTSU Index.
Action 15: Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.	31/03/23	FTSUG	**Action completed** • Ongoing feedback requested as appropriate

Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner	Progress update
1. Share speak up arrangements with other Trusts. To include: recruitment and ring fenced time for the role, locally agreed absence arrangements, creation of the speak up champions network, involvement with other services across the Trust and being an ally of each staff network.	30/09/23	FTSUG	**Action completed** • Self-reflection and planning tool reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • FTSUGs at three other Trust's across the region have requested observing the training the HUTH FTSUG provides to Speak Up Champions to gather best practice ideas. • HUTH FTSUG to present training videos produced at the Trust by the FTSUG at the next regional FTSUG meeting due to interest from other Trusts. • Additional update at 16/07/24: FTSUG being approached by FTSUGs at other trusts with requests to discuss the Group arrangements with NLAG. HUTH and NLAG FTSUGs involved in national discussions regarding the arrangements.

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(25)091

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	12th June 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	NLAG – Liz Houchin, Freedom to Speak Up Guardian HUTH – Fran Moverley, Freedom to Speak Up Guardian
Title of the Report	**Group Freedom to Speak Up Strategy**
Executive Summary	The document sets out the strategy for Freedom to Speak Up across the Group, and provides the national and local context, alongside an action plan to achieve the long-term objectives set out in the strategy. Final approval is sought from the Group Boards-in-Common.
Background Information and/or Supporting Document(s) (if applicable)	Not applicable
Prior Approval Process	Feedback has been sought from a number of key stakeholders, including the People Directorate Senior Leadership Team, Staff Network Chairs, Equality, Diversity and Inclusion teams and the respective HUTH and NLaG JNCC and LNC Chairs. The strategy has previously been presented and approved at the Workforce Transformation Group (27th February 2025) and Workforce Education and Culture Committees-in-Common (30th April 2025). NB – the document will be formatted into the Group Strategy template on approval.
Financial implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	✓Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Group Freedom to Speak Up Strategy 2025 – 2028

When this document is viewed as a paper copy, it is the reader's responsibility to ensure that it is the most current version

Contents

1. Introduction

This document sets out the NHS Humber Health Partnership (the 'Group') strategy for Freedom to Speak Up, the national and local context and the action plan to achieve the long-term objectives.

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) have historically been two separate organisations working either side of the river Humber on the east coast. A Group partnership between the two organisations formed on 1st April 2024.

Our ambition and vision at the Group: for all workers to be confident to raise their workplace concerns; these are listened to and acted upon. Concerns are treated seriously, and colleagues are supported in line with the Group values: compassion, honesty, teamwork and respect. This is in line with the Group People Strategy key objective of: Our People Feel Proud To Work Here and the organisational vision: United by Compassion, Driving for Excellence.

This strategy aims to create a culture in teams and at the wider Group level that is psychologically safe, meaning that workers are free to raise their concerns and suggest improvement ideas without fear of detriment or negative reprisals. Ideally, workers would feel safe and are encouraged to raise their concerns within their teams and management structures or choose to use another safe route for speaking up.

Workers and teams who feel psychologically safe, and who are able to 'speak up', provide better outcomes for patients and organisations. The Group employs a diverse range of staff and hosts many students and trainees in different professional disciplines. Individuals with one or more protected characteristics and those early in their careers can face increased barriers to speaking up, and this strategy complements the Group Strategy and the NHS People Promise in committing to create a culture that values well-being, inclusivity and professional development, where 'we each have a voice that counts'.

For the purposes of this strategy, the term 'workers' will be used throughout and will be inclusive of permanent and temporary staff members, bank staff, students, trainees, and volunteers. This strategy applies to all individuals working at the Group in these roles.

2. Background

2.1. National context

The national report into Mid Staffordshire NHS Trust was published in 2015 and conducted by Sir Robert Francis, QC. The Francis report provided a number of recommendations to improve open and honest cultures to ensure patient safety concerns could be raised effectively and resolved.

The report made a recommendation for the creation of the Freedom to Speak Up Guardian (FTSUG) role. Since 2017, it has been a requirement of every NHS Trust

in England to have a FTSUG in place to support workers to speak up about concerns in the workplace.

The report also led to the creation of the National Guardian Office (NGO) who, alongside NHS England and Improvement (NHSEI), set the national guidance that FTSUGs and Trusts follow. The Care Quality Commission (CQC) assess speaking up cultures as part of their inspection processes under the well-led domain and the quality statement *'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.*

In 2024 the NGO has refreshed its national strategy and set six strategic objectives; including developing additional support and guidance for organisational leaders and using insight to drive recommendations including challenging organisations to improve.

2.2. Local context

The formation of the Group structure enabled partnership working between NLAG and HUTH, but the Trusts have maintained their separate sovereignties and their responsibilities for FTSU.

NLAG and HUTH continue to have separate FTSUGs to support the staff at each respective Trust. The FTSUGs roles are well embedded and have continued to be strengthened by the move to a Group model. The FTSUGs have aligned their governance and line management, including now sharing a single Executive Sponsor and line manager within the People directorate.

3. Linked documents

This document should be read in conjunction with the documents listed below:

NHS People Promise NHS England » Our NHS People Promise

Group People Strategy: copy on Bridget

Group Strategic Framework [insert link when published]

Both Trusts have adopted the national mandated policy written by NHSEI and will be reviewed as and when this is updated:

NLAG: Freedom to Speak Up Policy for the NHS (DCP126)

HUTH: Freedom to Speak Up Policy for the NHS (CP451)

In addition, HUTH has the following policy: Raising Concerns at Work (whistleblowing) Policy (CP169)

4. Long-term objectives

This strategy sets out three broad long-term objectives that will support an open and transparent culture, where speaking up is encouraged, valued and learning is shared across the Group.

The three objectives are:

Objective 1: Staff know how to speak up, are confident to raise their concerns and feel safe to do so

Objective 2: Managers and leaders encourage, listen and act upon the concerns that are raised by those who speak up

Objective 3: The Group use speaking up as an opportunity to learn and improve and promote good practice across the wider NHS system.

5. Action plan

The action plan details the actions, measures and outcomes required to achieve the long-term objectives of the strategy. In order to achieve success, the responsibility for creating a ‘speak up’ culture is group wide and sits with everyone.

Appendix 1 shows those roles which have designated enhanced roles including the FTSU Guardians and Board members.

It is important to note that the action plan will be reviewed on an annual basis to ensure it is still relevant, achievable and to review progress.

Objective 1: Staff know how to speak up, are confident to raise their concerns and feel safe to do so		
Action:	**Measure/outcomes:**	**Who is responsible:**
1.1 Ongoing Group communications plan to promote speaking up and the FTSUGs	Evidence of rolling communications using different forms of media to reach as many workers across the Group as possible. Evidence of ongoing promotion from senior leaders encouraging speaking up and the ways staff can speak up.	FTSUGs Communications Team Senior leaders
1.2 Develop Group Freedom to Speak Up content on the new Group intranet Bridget	Pages are accessible, relevant and up to date. Content is engaging and communicates clearly the role of the FTSUGs and the value of speaking up.	FTSUGs Communications Team
1.3 Staff reporting discrimination are supported through the Group wide zero tolerance to discrimination frameworks. We make speaking up for workers as easy as possible through their preferred method of raising concerns.	Roll out of the zero tolerance frameworks across the Group, including sexual safety. Ongoing evidence of the Circle Groups meeting to discuss and progress the concerns raised. Where possible, heat maps of areas are produced and FTSUGs are involved in triangulating the information.	Equality Diversity and Inclusion Teams Organisational Development FTSUGs
1.4 Line managers communicate to their teams how to speak up and that speaking up is welcomed.	Line managers include information on ways to speak up in their local inductions. Evidence line managers are supporting workers to become local Speak Up Champions. Completion of Listen Up e-learning module by workers with line management responsibilities. Results to Staff Survey question “I would feel secure raising concerns about unsafe clinical practice” will increase above the national average of 70%. Results to Staff Survey question “I would feel safe to speak up about anything that concerns me in the organisation” will increase above the national average of 60%.	Line managers Senior leaders

	Group People Strategy work – ambition that teams live by Group values and behavioural standards and feel empowered to speak up and raise concerns.	
1.5 Inclusion of the FTSUGs in the Group Induction	All new starters at the Group will receive a Group-wide induction presentation from the relevant local FTSUG.	FTSUGs Education and Learning Team
1.6 Improved awareness of Speak Up Champion Networks and Champions are embedded across the Care Groups and Corporate Directorates.	Continual recruitment of Speak Up Champions across all Care Groups and Corporate Infrastructure. All active Speak Up Champions are trained by the FTSUG to the standards set by the National Guardian Office and relevant to the local context. Evidence of regular communications and inclusion in the FTSU Communications Plan.	FTSUGs Care Group Triumvirates Communications Team
1.7 Development of strong and effective internal partnership working across all support functions who enable speaking up. Including but not limited to FTSUGs, Guardian of Safe Working Hours, Trade Unions, Professional Bodies and Human Resources.	Evidence of key partnership working across the Group. Consideration of external partnership working i.e. with regulators.	FTSUGs Guardian Safe Working Hours Trade Unions Professional Bodies Human Resources team
1.8 The Group is committed to creating a positive staff experience where staff are confident and feel psychologically safe to raise their concerns.	Reduction in workers reporting concerns anonymously to the FTSUG. By 2028 fully anonymous concerns will be less than 10% of total number of concerns. Staff will experience a reduction in incidents of bullying and harassment – Staff Survey. Results to the Staff Survey question: “The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?” will increase above the national average of 6.7%. Results to Staff Survey question “I would feel secure raising concerns about unsafe clinical practice” will increase above the national average of 70%. Results to Staff Survey question “I would feel safe to speak up about anything that concerns me in the organisation” will increase above the national average of 60%.	Line managers Senior leaders

	This will enable workers to see the positive outcomes of those who have spoken up and will encourage an open and honest culture where staff feel safe to raise concerns and speaking up is welcomed by all managers. Inclusion of an additional measure within the quarterly pulse survey to monitor staff feedback. Evidenced through delivery of year 1 People Strategy objectives (culture and engagement).	

Objective 2: Managers and leaders encourage, listen and act upon the concerns that are raised by those who speak up		
2.1 Senior leaders are knowledgeable about Freedom to Speak Up through reflection and training.	Achieve score of 5 in the Freedom to Speak Up – A Reflection and Planning Tool when repeated. All members of the Executive and Non-Executive Board have completed the 'Follow Up' training in the last three years.	Executive Team and FTSUG NEDs
2.2 Line managers are knowledgeable about Freedom to Speak Up and the importance of role modelling behaviours and creating psychologically safe environments. In line with the Group People Strategy 'we will ensure our leaders and managers are compassionate and inclusive, creating a psychologically safe culture that encourages innovation and risk-taking without fear' and 'we will focus on creating a psychologically safe environment where staff feel confident to speak up through developing our leaders' skillset and mindset'.	Completion of Listen Up e-learning module by workers with line management responsibilities. Line managers have access to leadership development to develop the skills and knowledge needed to role model positive behaviours. Inclusion of freedom to speak up e-learning modules within bite sized and wider leadership programmes. Results to Staff Survey question "I am confident my organisation will address my concern about unsafe clinical practice" will increase above the national average of 55%. Results to Staff Survey question "If I spoke up about something that concerns me I am confident my organisation would address my concern" will increase above the national average of 48%. By 2028 all leadership and line manager training programmes will include training on speaking up, listening to workers and creating psychologically safe teams.	Education and Learning Team

2.3 Senior leaders and line managers identify barriers to speaking up, and where possible, work is undertaken to make it as easy as possible to speak up.	Engaging with the Staff Networks at NLAG and HUTH to promote speaking up and ensure everyone knows we have a voice. Senior leaders and line managers are aware of their obligations under the Equality Act 2010. The Group Board-in-Common review and complete the Board Self-reflection tool to create an improvement plan to overcome barriers to speaking up. Staff survey results indicate that our staff members with protected characteristics are treated fairly at the organisation, feel safe to raise concerns and their concerns are addressed. The gap in the staff survey results for staff members with and without protected characteristics is reduced, and all results meet or exceed the national average for each question. Questions will include those related to discrimination, being treated fairly for raising an error, near miss and incident, safely raising clinical and other concerns and how those concerns were addressed.	Senior Leaders Line Managers Executives
2.4 Senior leaders and line managers ensure that workers do not suffer any negative impact, disadvantageous or demeaning treatment of behaviours as a result of a speaking up.	By 2028, workers reporting detriment for speaking up will be less than 4% of total number of concerns (4% is the national average reported to the National Guardian Office). Evidence of clear communications from senior leaders and line managers that any negative impact to speaking up; will not be tolerated. Senior leaders and line managers take action if they become aware of any negative impact to a worker speaking up.	Senior Leaders Line Managers Executives
2.5 Senior leaders and line managers take concerns seriously and act upon the information provided.	Results to Staff Survey question “If I spoke up about something that concerns me I am confident my organisation would address my concern” will increase above the national average of 48%. Group People Strategy and Group Strategic Framework – ‘we will tackle discrimination head-on and ensure all our people are living out our values compassion, honesty, teamwork and respect.	Senior Leaders Line Managers Executives
2.6 Senior leaders and line managers feedback (where appropriate) to workers the outcome of the concerns they have raised to provide assurance and to evidence that speaking up makes a difference.	Results of the FTSUG feedback survey indicate that workers are kept informed and receive feedback about the concerns they have raised.	Senior Leaders Line Managers Executives FTSUGs

	Results to Staff Survey question “I am confident my organisation will address my concern about unsafe clinical practice” will increase above the national average of 55%. Results to Staff Survey question “If I spoke up about something that concerns me I am confident my organisation would address my concern” will increase above the national average of 48%.	

Objective 3: The Group use speaking up as an opportunity to learn and improve and promote good practice across the wider NHS system.		
3.1 The Group will act upon the feedback and learning gained from cases (speaking up, HR, incidents, patient safety investigations), ensuring changes are made where possible to optimise the learning. We can demonstrate positive examples of change from speaking up. For example, this may include changes to line manager training, systems and processes.	The Group can evidence where changes have been implemented as a result of workers feeling safe to speak up and raise their concerns and improvement ideas. Presentation of case studies to committees and other forums.	Executives Senior Leaders Line managers FTSUGs Education and Learning Team Human Resources Quality Governance
3.2 Where appropriate, learning, outcomes and changes made as a result of cases are communicated across the Group.	Minimum one communication per month sharing learning and positive outcomes from workers speaking up, for example ‘You said, We did’. Key learning is included directly to line managers.	Communications Team FTSUGs Line managers
3.3 Creation of Group wide Business Intelligence dashboard to enable senior leaders to have access to high level FTSU information to triangulate themes.	Senior Leaders have access to FTSU data on Power BI in order to triangulate with other metrics i.e. employee relation cases, sickness, incidents. Care Group Triumvirates and other managers use FTSU data to build a wider representation of their own departments, in conjunction with other performance metrics including HR data, absence, turnover, disciplinaries, patient safety data and patient experience information. Data is used and triangulated at Group level Circle Groups to ensure FTSU information is not viewed in isolation and is triangulated with other metrics.	Senior Leaders Business Intelligence Team FTSUGs
3.4 Completion of NHSE Board Self-Assessment by Boards–In-Common.	Self-assessment is repeated and evidence of improvement and strengths plan developed and communicated at subsequent board meetings.	Executives NEDs
3.5 Group FTSUGs to continue to share knowledge and good practice across the wider NHS system.	FTSUGs to identify opportunities to share knowledge and learning. Continue to support other NHS organisations in establishing effective partnership working.	FTSUGs

6. Performance monitoring

The Freedom to Speak Up Strategy will be monitored in a number of ways, including:

- An annual progress report and review of the strategy to Workforce, Education and Culture Committees in Common.
- Relevant information included in quarterly reports to the Workforce, Education and Culture Committees in Common and Group Boards in Common.
- Relevant sections of the Group People Strategy performance monitoring.

7. Review

This strategy will be reviewed on an annual basis and reported to the Workforce Education and Cultures Committees-in-Common. The report will look at the outcome measures, achievements to date and where possible, compare with benchmark data gained from the NHS Staff Survey questions.

The review will also provide any additional actions or measures are required to fulfil the strategic objectives.

8. Equality Impact Assessment

Completed

9. References

CQC well-led statement: Freedom to speak up - Care Quality Commission

NHS England Board Self-reflection and improvement tool: https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_iii_Freedom-to-speak-up-a-reflection-and-planning-tool.docx

National Guardian Office annual report 2023/2024: Speaking Up Data - National Guardian's Office

10. Document control

Strategy Reference No.	**TB**
Director Lead:	Simon Nearney, Chief People Officer
Strategy Author:	Elizabeth Houchin, FTSUG (NLaG) Frances Moverley, FTSUG (HUTH)
First Version Issued:	TBC
Latest Version Issued:	TBC
Review Date:	TBC

Approved By:	
Endorsed By:	People Directorate Senior Leadership Team
Ratified By:	Feedback and comments sought from: People Directorate Senior Leadership Team NLaG FTSU Non-Executive Sponsor HUTH FTSU Non-Executive Sponsor Group Director and Group Deputy Director of Communications and Engagement NLAG JNCC Chair HUTH JNCC Chair NLAG LNC Chair HUTH LNC Chair Group Committees: Workforce Transformation Committee – 27th February 2025 Workforce Education and Culture Committees in Common – 30th April 2025 Group Boards-in-Common - TBC

CHANGE RECORD

Date	Author	Nature of Change	Version
December 2024	E. Houchin F. Moverley	New strategy	1.0

Appendix 1 – roles and responsibilities

Enhanced Roles and Responsibilities

Group Chief Executive and Group Chairman

The Chief Executive is responsible for appointing the FTSU Guardians and regularly meeting with them. They are also ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their Trust. The Chief Executive and Chair are responsible for ensuring both organisations' Annual Reports contains information about FTSU and confirms that the Group is engaged with both the regional Guardian network and the National Guardian's Office.

Executive Director responsible for FTSU

- Ensuring they are aware of latest guidance from the National Guardian's Office
- Overseeing the creation of the FTSU vision and strategy
- Ensuring the FTSU Guardian role has been implemented, supported and has adequate cover for planned and unplanned absence
- Ensuring that a sample of speaking up cases have been quality assured
- Conducting an annual review of the strategy, policy and process
- Ensuring the learning derived from speaking up issues is embedded in the Trust's services
- Ensuring allegations of detriment are promptly and fairly investigated and acted on
- Providing the Board with a variety of assurance about the effectiveness of the Trust's strategy, policy and process and performance

Group Chief People Officer and Group Director of Learning and Organisational Development

- Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the Trust
- Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively

Non-Executive Director responsible for FTSU

- Ensuring they are aware of latest guidance from National Guardian's Office
- Holding the Chief Executive, Executive FTSU lead and the Board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the Board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continuous improvement
- Role-modelling expected trust values
- To be an alternative source of advice and support for the FTSU Guardian
- Overseeing speaking up concerns regarding Board members in conjunction with the Senior Independent Director

Group Medical Director

- Ensuring that the FTSU Guardian has appropriate support and advice on patient safety issues
- Ensuring that effective and as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up

- Ensuring learning is put into practice within the Teams and Departments they oversee

Group Chief Nurse

- Ensuring that the FTSU Guardian has appropriate support and advice on safeguarding issues
- Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- Ensuring learning is put into practice within the Teams and Departments they oversee

FTSU Guardians

As NHS Humber Health Partnership is a group and Northern Lincolnshire and Goole NHS Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) are separate sovereign organisations, each organisation will appoint a FTSU Guardian working for one organisation only. FTSU Guardians will adopt the following principals:

- The FTSU Guardian will be responsible for handling concerns relating to employees of their respective organisation only
- FTSUGs will not share details of individual cases with each other to ensure that confidentiality and trust in the role in not impacted
- Management and governance will be aligned to a single Executive Sponsor and line manager.

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(25)092

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	12th June 2025
Director Lead	Simon Nearney / Ivan McConnell
Contact Officer/Author	Mano Jamieson / Karl Portz / Lucy Vere / Jackie Railton
Title of the Report	NHS Equality Delivery System (EDS) 2022 Submission
Executive Summary	The purpose of the report is to inform the committee of the detail of the assessment that was carried out to conduct the Hull University Teaching Hospitals NHS Trust's & Northern Lincolnshire & Goole NHS Foundation Trust's EDS 2022 for 2024/25. The EDS 2022 in this report covers three Domains. Domain 2 (Workforce Health & Wellbeing) and Domain 3 (Inclusive Leadership) are for consideration by WECC. Although not directly a workforce issue, Domain 1 (Commissioned or Provided Services) is also included as this contributes to the overall scoring (see Score Rating below and NLaG /HUTH scores for 2024 and 2025) and is still the responsibility of the Executive and Non-Executive Directors and the Chairman and Chief Executive Officer. To meet national reporting deadlines once approved by WECC this report will be published in draft format on both Trust websites until such time as full Board approval is received.

EDS 22 Score Rating Framework

Undeveloped activity	Those who score **under 8, Undeveloped**
Developing activity	Those who score **between 8 and 21, Developing**
Achieving activity	Those who score **between 22 and 32, Achieving**
Excelling activity	Those who score **33, Excelling**

Domain Scores

2024

NLaG: Domain One = 7-8, Domain Two= 4, Domain Three= 3

Total Score = 15 (Developing)

	HUTH Domain One = 7-8, Domain Two = 7, Domain Three = 4 Total Score = 18 (Developing) **2025** NLaG: Domain One = 8, Domain Two = 5, Domain Three = 5 Total Score = 18 (Developing) HUTH Domain One = 8, Domain Two = 8, Domain Three= 5 Toral Score = 21 (Developing) The Group EDI Team (People Directorate) has incorporated the key actions from EDS22 into their priorities. They also ensure close alignment with other statutory reporting requirements such as WRES, WDES, and gender pay gap reporting, along with their subsequent action plans. The ratings have not significantly improved since 2023/24 at both HUTH and NLaG. One of the key challenges is addressing the wide range of health and wellbeing support expected by EDS22. While we have some good provisions, they do not meet the breadth expected by EDS22 ratings. Regarding the inclusive leadership element, after coming together as a group, we now have clearer plans that need to be executed. We expect that successfully implementing these actions in domain three will enable us to increase our ratings next year. **Recommendations** • The committee should note these results and the actions laid out for domains 2 and 3. • Domain 1 should also be considered, but questions regarding actions and next steps should be directed to other relevant committees and the strategy and planning team.
Background Information and/or Supporting Document(s) (if applicable)	The EDS 2022 is the nationally mandated return that is to be published on all NHS Trusts websites and outlines what each organisation is doing to deliver its Public Sector Equality Duty
Prior Approval Process	None
Financial implication(s) (if applicable)	None identified at this stage.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The return highlights what an NHS Trust is doing to promote EDI within the organization and how it is addressing health inequalities in the population that it serves. There is a significant challenge across all three domains if we want to increase our ratings and the subsequent positive impact. The whole purpose of this process is to help organisations ensure they have great working environments free of discrimination.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

HUTH & NLaG Equality Delivery System 2022 Report 2024/25
Trust Boards in Common
Thursday 12th June 2025

1. Background

The Equality Delivery System (EDS) was launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

In November 2012 there was a review of EDS and, a refreshed EDS – known as EDS2 – was made available in November 2013.

A further review has taken place, and a new EDS has launched. Officially the numbering system is being dropped but it is likely that this will, colloquially, be known as EDS2022 going forward. All NHS providers are required to implement the EDS, having been part of the NHS Standard Contract from since April 2015 (SC13.5 Equity of Access, Equality and Non-Discrimination). In addition, NHS Commissioning systems are required to demonstrate 'robust implementation' of the EDS as set out in the Oversight Framework.

2. EDS 2022

The current EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

The EDS comprises eleven outcomes spread across three Domains, which are:

1) Commissioned or provided services

2) Workforce health and well-being

3) Inclusive leadership.

The outcomes are evaluated, scored and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement.

The scoring system is significantly different to that used in EDS2

3. Leadership

One Board, Governing Body member, senior or system leader for each organisation or partnership of organisations, should be identified as the EDS Champion who will act as the senior responsible officer, keep developments aligned and on track, and who will be held to account.

The abovementioned Champion should keep in routine contact with the relevant EDI team(s) to follow the EDS process and ensure that issues and concerns are heard and shared at Board and Committee levels promptly.

The overall responsibility for the EDS lies with the Executive Board within each organisation. This responsibility may be discharged to the EDI team/Senior Responsible Officer within the organisation, but board members retain overall responsibility.

4. Domain details

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service
1B: Individual patients (service user's) health needs are met
1C: When patients (service users) use the service, they are free from harm
1D: Patients (service users) report positive experiences of the service

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source
2D: Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

5. Annual Reporting requirement.

EDS reviews should be carried out annually with the result of the review published on organisation websites by 28th February (or the following working day). Any justification for late publication must be provided and signed off at Board level. Our plans have been uploaded on time in draft format ready for final approval. Please see these on the EDS22 template in Appendix 1.

Our EDI leads in both HUTH and NLAG lead the review process with relevant stakeholders and ensure the action plans are laid out. The strategy and planning team lead on the patient services element of EDS22 ratings and action plans.

EDS activity should be included in the reporting of the specific duties of the PSED in January of each year. This should include:

- The carrying out of the EDS reviews,
- recommendations, improvement plans and early impacts of the implementation of those plans
- results and progress from previous years' plans.

6. Conclusion and recommendations

The Group EDI Team (People Directorate) has incorporated the key actions from EDS22 into their priorities. They also ensure close alignment with other statutory reporting requirements such as WRES, WDES, and gender pay gap reporting, along with their subsequent action plans.

The ratings have not significantly improved since 2023/24 at both HUTH and NLaG. One of the significant challenges is addressing the wide range of health and wellbeing support expected by EDS22. While we have some good provisions, they do not meet the breadth expected by EDS22 ratings.
Regarding the inclusive leadership element, after coming together as a group, we now have clearer plans that need to be executed. We expect that successfully implementing these actions in domain three will enable us to increase our ratings next year.

Recommendations

- The committee should note these results, and the actions laid out for domains 2 and 3.
- Domain 1 should also be considered, but questions regarding actions and next steps should be directed to other relevant committees and the strategy and planning team.

[End]

(Please see next page for **Appendix 1)**

Classification: Official

Publication approval reference: PAR1262

NHS England

NHS Equality Delivery System 2022

EDS Reporting Template

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**Northern Lincolnshire and Goole NHS Foundation Trust**	**Organisation Board Sponsor/Lead**
			Simon Nearney/ Ivan McConnell
Name of Integrated Care System			

EDS Lead	Jackie Railton/Karl Portz		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	February / March 2025		**Individual organisation**	
			Partnership* (two or more organisations)	Northern Lincolnshire and Goole NHS Foundation Trust; Hull University Teaching Hospitals NHS Trust
			Integrated Care System-wide*	

Date completed	20/03/2022	**Month and year published**	March 2025
Date authorised		**Revision date**	

Completed actions from previous year		
Action/activity		**Related equality objectives**
Tobacco Cessation Service	Annual review of anonymised data by protected characteristic. **Data from September 2024 to January 2025 shows that 455 patients have been assessed by the Tobacco Cessation Service, made up of 327 female and 128 male patients. It is suggested that this difference between genders is due to the Smoking In Pregnancy Pathway (SIPP) being an opt out referral pathway.** **Historically, the initial assessment on this pathway would be carried out remotely, and included a question on ethnicity, resulting in approximately 30% of patients recorded as 'unknown'. This has been the focus of a service improvement effort, which has subsequently seen the level of patients with unknown ethnicity decrease to approximately 12% (based on September 2024 to January 2025 data). It is anticipated that the utilisation of Badgernet will also contribute towards improvements in data quality.** **Data from September 2024 to January 2025 shows that the majority of referrals came from patients in the 30% most deprived deciles (Indices of Multiple Deprivation).**	Patients (service users) have required levels of access to the service.
Antenatal Services	Extend the publicising of antenatal events to enable people to attend and self-refer in person. **Antenatal events are publicised via the hospital website, social media and Mumbler (website), which includes the**	Patients (service users) have required levels of access to the service.

	dates of each event for the year, and can be accessed via QR code attached to all publicity. **Banners and other publicity for the events are displayed in the hospital, as well as family hubs and midwifery clinics.** **The parent education midwife has visited local midwifery bases and community team meetings to explain the antenatal offer to midwives directly.** **Publicity documents are now displayed in a number of different languages, to improve accessibility.** **Push notifications about these events are also sent via Badger Notes.**	
	Consider utilisation of paper-based referrals where online is not an option. **Patients are now able to self-refer to the service via email or telephone, as well as via the online form.**	Patients (service users) have required levels of access to the service.
	Undertake a data review of antenatal unplanned attendances and the date/ time of attendance. **A review has been undertaken and has identified that 24/7 telephone triage and triage assessment is required. A staffing review has been undertaken to identify requirements, and the necessary increased staffing has been funded.**	When patients (service users) use the service, they are free from harm
	Maternity service, Healthwatch, and Maternity Voice Partnership to collaborate in engagement activities. **Maternity and Neonatal Voice Partnership (MNVP) has been involved in the development of services and guidelines, Quality improvement, and attending Trust meetings.** **Learning from PALS and Complaints - utilized in development of teaching programmes and feedback to Maternity Services.**	Patients (service users) report positive experiences of the service

	Review staff face to face and virtual interactions with service users, including information leaflets/ online information to ensure awareness of choice. **Antenatal sessions include an explanation of birthing facilities available, and the relevant criteria and information that may influence patient's decisions on where to give birth. A video including this information has also been created. Videos of four different birthing rooms have been created by the Parent Education Midwife, and are widely circulated to give patients and their families an insight into the available environments. It has also been requested that these are added to the Trust's external website, to supplement an existing video from the Local Maternity and Neonatal System (LMNS).**	Patients (service users) report positive experiences of the service
AAA (Abdominal Aortic Aneurysm) Screening Service	Recruitment to vacant posts and completion of training to enable increase in screening capacity. **Approval to recruit to these posts was delayed, but interviews are scheduled to be held week commencing 20th January.**	Patients (service users) have required levels of access to the service
	Re-establish contacts with the traveller community to ensure that potential patients are aware of the service. **Screening processes have continued to be in place for eligible patients within the traveller community, but meetings have been held with a number of staff across Primary Care and the ICB that are working on health inclusion/ improving access to health services for vulnerable groups.**	Patients (service users) have required levels of access to the service
	Participate in Public Health AAA Screening Survey 2024 and utilise survey results to inform service improvement.	Patients (service users) report positive experiences of the service

	Data collection for the survey was carried out 1st – 31st August 2024, and the report was finalised in November 2024. The results of the survey showed that the vast majority of patients (97-100%) were very satisfied with the service, including: • **Screening time** • **Screening day** • **Screening venue** • **Explanation of test** • **Explanation of result** • **Overall screening experience** **A 10-point action plan has been developed for completion ahead of the next survey, which is scheduled for September 2025.**	

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services
Chemotherapy Delivery

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Hours of operation at NLaG currently differ between the two sites, due to a difference in activity levels:
		  ○ Grimsby Diana Princess of Wales (DPoW) currently operates Monday-Friday
		  ○ Scunthorpe General Hospital (SGH) currently operates Tuesday – Friday
		• Both services operate during standard office hours, and are closed on evenings, weekends and bank holidays
		• No issues with appointment times, or demand for out-of-hours care have been noted via patient feedback received.
		• This service is provided by HUTH clinicians providing outreach via a Hub and Spoke model, enabling patients to receive treatment closer to home.
		• Lloyds Pharmacy Clinical Homecare also provide a Chemotherapy Treatment service 2 days per week, enabling some patients to access this care via an alternative off site clinic location in Scunthorpe
			2	Vicky Kenney; Karen Smith

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		• The service utilises information provided by Macmillan Cancer Support (https://www.macmillan.org.uk/cancer-information-and-support) for patient information, which can also be accessed in a range of alternative languages and formats (https://www.macmillan.org.uk/cancer-information-and-support/get-help/translations-and-other-formats) ○ It is noted that it is difficult to get specific drug information in alternative formats • Interpretation services are available for patients within the service, provided by Language Line. MacMillan Cancer Support is also able to provide translations and interpretation services, where required.		
	1B: Individual patients (service users) health needs are met	• Information was shared on the adjustments made to enable pregnant patients to receive their required treatment, in line with their specific health needs and circumstances. • Information was also shared in relation to a patient with Learning Disabilities that is currently receiving treatment, along with the adjustments required in	2	Vicky Kenney; Karen Smith

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		order to enable this patient to receive treatment. • Information was shared on the adjustments required for a patient with a mental health diagnosis and collaborative working between the psychiatrist, mental health nurses and the oncology team to enable the patient to be treated safely in line with their specific health needs and circumstances.		
	1C: When patients (service users) use the service, they are free from harm	• Patient incident data for the previous 12 months in Oncology shows that a total of 13 patient incidents have been reported for Clinical Oncology. • Of the 13 incidents reported, 12 were recorded as having resulted in no harm. • The 1 incident with a reported level of patient harm was reported as 'low harm', and was an extravasation incident. • It was noted that there is no difference in patient safety incident occurrence between those with or without protected characteristics.	2	Vicky Kenney; Karen Smith
	1D: Patients (service users) report positive experiences of the service	• Information from the Cancer Patient Experience Survey (CPES) was shared, with Q41.2 and Q42.2 being particularly relevant to Chemotherapy.	2	Vicky Kenney; Karen Smith

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		• Results for these questions showed an improvement from 2023 to 2024		
Domain 1: Commissioned or provided services overall rating			8	

Domain 1: Commissioned or provided services

Targeted Lung Health Check (TLHC)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Invitations to the TLHC are based on lists of eligible patients, as identified by GPs • Eligible patients are those aged 55-74 that are current or previous smokers • A Local leaflet is available, which is sent via post to every invited patient • The leaflet is readily available in Easy Read format, with other formats being available on request from the HNY Cancer Alliance • Easy Read letters are currently going through the approval process • Patients invited to TLHC receive multiple letters, as well as telephone contact if the patient does not respond • Patient's communication support needs can be accommodated at initial contact, provided this information is received from GP records • Further work is being carried out at a senior level within the organisation to identify, record, and make reasonable	1	Debra Dyble/ Paul Gledhill

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		adjustments for patients with Learning Disabilities • Initial assessments are typically held via telephone, but can be held in-person, as required. • Assessments can be supported by interpretation, and patients can bring family members/ carers if required. Further adjustments (e.g. longer appointment times) can also be made by the service, as requested. • Scans are provided at a number of community locations across the area, facilitating equity and ease of access. • Work has been carried out with the Forge project (www.theforgeproject.co.uk/) to engage with and provide the service to homeless patients. Further work will be carried to cater to this cohort of patients in 2025 • No issues have been identified in terms of patient access to the scanning facilities • Roll out of the LHC programme is still in its early stages on the South Bank, with further expansion needed in North East Lincolnshire (pockets of LHC activity currently).		

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
	1B: Individual patients (service users) health needs are met	• Appointments are offered during weekdays, evenings and weekends, to improve accessibility for patients • Patients' health needs are identified via the TLHC assessment, and those that require a low-dose CT scan are subsequently provided with one • Data from the LHC service across the Humber showed that 4.1% of patients identified for a low dose CT scan (156 of 3805) were ultimately found to have Lung Cancer • Data also showed that 73% of those receiving a low dose CT scan had at least one incidental finding, such as Coronary Calcification, Emphysema, or other suspected cancers. As such, patients were being alerted to health needs that they were unaware of, enabling further diagnostics and treatment to be provided at an early stage	3	Debra Dyble/ Paul Gledhill
	1C: When patients (service users) use the service, they are free from harm	• The TLHC service involves a patient assessment, followed by a Low-dose CT scan for applicable patients. The purpose of this is to identify potential health issues (including, but not limited to, cancer) at an early stage, to facilitate further investigation and treatment.	2	Debra Dyble/ Paul Gledhill

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		• The nature of this service means that patient harm is incredibly unlikely. • Established governance processes are followed in the event of any incident, and regular meetings are held with the CT equipment provider		
	1D: Patients (service users) report positive experiences of the service	• A video has been produced with local patients sharing their experience of the service • A feedback process is in place within the TLHC, which can be accessed via both a printed form or QR code	1	Debra Dyble/ Paul Gledhill
Domain 1: Commissioned or provided services overall rating			7	

Domain 1: Commissioned or provided services
Virtual Ward: North and North East Lincolnshire

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• The service is provided to adult patients only (ie over 18 years) including the elderly and frail patients.
		• The Standard Operating Procedure (SOP) for the Virtual Ward was shared, which set out the following information:
		  ○ Patient eligibility criteria
		  ○ The services provided
		• The SOP has not yet been formally approved, but is due for discussion imminently.
		• All patients are now onboarded for digital elements of the service
		• Staff are able to provide 1-to-1 training in the use of the relevant equipment where necessary
		• Patients are asked to submit observations during a 2 hour window, and will be contacted wherever these are not received.
		• Patients receive a reminder, and are able to submit data via email, text message or telephone call
			2	Ros Dougan/ Tracy Means/ Garry Cowling

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		• Where patients are unable to take their own observations, or are unable to submit data, this can be done by community staff visiting on a daily basis • Interpretation services are available via language line, if required. • The service noted that they had had no previous experience with a requirement for British Sign Language, but suggested that communication would be possible via face-to-face contacts • Patient Information Leaflets are available in standard formats, and alternative formats can be provided on request • It was noted that different elements of the service require varying levels of care to be provided to patients. As such, the capacity is often flexed to accommodate as many patients as possible. • Where changes are made to a patient's medication, mechanisms are in place to ensure that this can be dispensed by a local pharmacy, for collection by the patient or their relative/ carer. Where this is not possible, medication can be delivered via taxi. • Patients are able to access support and assistance 24/7 via either the		

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		Community Urgent Response Team (CURT) or Clinical Assessment Service (CAS), as required.		
	1B: Individual patients (service users) health needs are met	• The service noted that improvements have been made over the last 6 months to better accommodate patient need. • This has included work with diagnostic services, which has resulted in patients on the Virtual Ward now being able to access diagnostic tests within 24 hours, whereas these were previously being provided in similar timescales to other outpatients (i.e. 6 weeks) • Access to out of hours staffing and advice was also noted as a key element of ensuring that patient needs are met	2	Ros Dougan/ Tracy Means/ Garry Cowling
	1C: When patients (service users) use the service, they are free from harm	• No active risks are currently recorded on the service risk register • A total of 7 incidents have been reported so far during 2024 • However, all of these are reported as causing 'no harm' to patients • Discussion was held on whether the Virtual Ward Service would be aware if patients were struggling with mobility, etc. whilst submitting observations and data.	3	Ros Dougan/ Tracy Means/ Garry Cowling

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
		• It was noted that mobility issues would be flagged at the initial onboarding of the patient to the virtual ward service, which could then be managed accordingly: ○ Requirements to access short term care; unscheduled care therapists; equipment loans; etc. are all documented in the patient record, and are facilitated via the shared management structure responsible for these areas		
	1D: Patients (service users) report positive experiences of the service	• Data on Patient Complaints was shared, which showed just 1 complaint since May 2022. • Data gathered from the Friends and Family Test carried out in October 2024 was presented: ○ This data showed a response rate of 18.7% for the month ○ All respondents (17) rated the Virtual Ward service as 'Very Good'	2	Ros Dougan/ Tracy Means/ Garry Cowling
Domain 1: Commissioned or provided services overall rating			9	

Domain 2: Workforce health and well-being (NLaG)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• We have offerings in relation to general health for staff including: Health and Wellbeing Ambassadors, wellbeing programme/conversations, coaches, mentors and cultural ambassadors in some areas. • Occupational Health can refer for counselling and staff can self-refer via Employee Assistance and CIC. • We have a menopause peer to peer support group. • We have an Equality, Diversity and Inclusion Steering Group. • Stress risk assessments are available for staff if required. • Mental Health First Aiders in some areas • During the year we promote a number Health Awareness Campaigns to support a variety of health conditions. • We have adopted Trauma, Risk Incident Management (TRiM)	2	Karl Portz Equality, Diversity and Inclusion Lead

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	•We have recently signed up to a sexual harassment charter. •We promote a just and learning culture. •We challenge poor behaviour and to give staff the support to achieve this we provide Unconscious Bias training. •Introduced Zero Tolerance to Racism and Zero Tolerance to LGBTQIA+ Discrimination frameworks and Zero Tolerance to Ableism but these still need embedding.	1	Karl Portz Equality, Diversity and Inclusion Lead
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	•The Freedom to Speak up Guardian has frequent contact with staff and has established a network of Champions in some areas and attends numerous committee meetings. •All Staff Networks are set up but still need to be more accessible to staff and grow in their membership. •Trade unions are also influential in providing impartial support to staff and a Trade Union Partnership is in place. •Also, support is available from Occupational Health and through CIC. •An HR helpline is in place and staff can access HR team support. •Established pastoral support nursing team within the Nursing Directorate.	2	Karl Portz Equality, Diversity and Inclusion Lead

	2D: Staff recommend the organisation as a place to work and receive treatment	Taken from the most recent staff survey, 52.9% of staff recommend the Trust as a place to work. This as increased from 44.8% the previous year. 52% are happy with the care provided for a friend or relative which as increased from 45% the previous year.	1	Karl Portz Equality, Diversity and Inclusion Lead
Domain 2: Workforce health and well-being overall rating			5	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	•The Trust Board have received a development session on Equality, Diversity and Inclusion which included the subject of Health Inequalities •An independent Equality Diversity and Inclusion Steering Group has recently been formed. The EDI Steering Group is jointly chaired by the Group Chief Nurse and Director of Strategy •We have the Tailored Adjustment Form to support staff with long term conditions and disabilities and also a disability policy is in place. •We have a number of staff equality networks and recently each network as been appointed an executive lead/sponsor.	2	Lucy Vere Director of Learning & Organisational Development

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Equality, Diversity and Inclusion Steering Group is now established in the Board governance process. Workforce Education & Culture Committee (WECC) consider all EDI related papers. The Trust has an Equality Impact Assessment policy and framework to ensure Policies, Procedures and Functions identify and address equality and health inequalities.	1	Lucy Vere Director of Learning & Organisational Development
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board	2	Lucy Vere Director of Learning & Organisational Development
Domain 3: Inclusive leadership overall rating			5	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):**

Domain 2: Workforce health and well-being (HUTH)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• We have mature offerings in relation to General Health for staff, Coaches, Mentors, Mediators. • Dedicated psychologists for Staff Support in ED, ICU • OH can refer for counselling and Staff can self-refer • EDI can refer directly for counselling for people with protected characteristics when required • Staff can also directly receive support by accessing the groupwide Confidentail Care Employee Assistance Programme • We have embedded Trauma Risk Incident Management • Staff have access to the Tobacco Dependence Treatment Team • We have an Equality, Diversity and Inclusion Steering Group. • During the year we promote a number Health Awareness Campaigns to support a variety of health conditions.	2	Lucy Vere Director of Learning & Organisational Development
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• We have the Staff Conflict Resolution & Professionalism Policy and the Zero Tolerance to Racism Framework & Reporting tool to Support staff and tackle issues with colleagues and patients, The fact that the Staff Survey scores for BAME staff haven't deteriorated at the same rate as other scores suggests that it has had some impact. • The Trust launched a Period Dignity with discreet support, for topics such as menopause, domestic violence & women's health. • Established in 2024 Domestic Abuse Champions. • We have launched Zero Tolerance to Ableism framework and have also launched Zero Tolerance to LGBTQ+ Discrimination February 2024	2	Mano Jamieson Equality, Diversity & Inclusion Manager

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• The Freedom to Speak up Guardian has more frequent contact with staff and has established a network of Champions and attends numerous committee meetings and is also now Full Time dedicated to the role. The Freedom to Speak Up Guardian now has access to a Communications Officer, to assist in raising awareness across the Trust of the role, across a number of communication channels. The number of concerns being raised to the Freedom to Speak Up Guardian has risen year on year, indicating that staff are increasingly aware of the role and comfortable with raising their concerns. The Trust operates a Speak Up Champion Network, with local volunteers promoting speaking up and signposting their colleagues to the Guardian role. • All Staff Networks are active and provide support with all network chairs actively involved in representing individuals and promoting their wellbeing • Staffside are also influential in providing impartial support to staff • Also support is available from Occupational Health, Psychological Counselling services, Coaching networks and Mentoring networks • We have independent support groups led by some ethnic minority staff • The nursing directorate has an established pastoral support team	3	Mano Jamieson Equality, Diversity & Inclusion Manager
	2D: Staff recommend the organisation as a place to work and receive treatment	• Taken from the most recent staff survey, 48% of staff recommend the Trust as a place to work and 52% are happy with the care provided for a friend or relative.	1	Myles Howell Director of Communications
Domain 2: Workforce health and well-being overall rating			8	

Domain 3: Inclusive leadership (HUTH)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• A Board Development session was held on the subject of Inclusivity • EDI Steering Group now a Group Wide board and chaired by Group CNO And Director of Strategy • Trust has a policy of being Anti-Racist. • Staff Networks now have dedicated Exec and Non Exec sponsors who attend network meetings • The Chair, Chief Executive Officer and other Group Execs and Non Execs regularly attend the Group Staff Network Conferences and engage with the agenda holding follow up meetings where appropriate	2	Lucy Vere Director of Learning & Organisational Development
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	The Group Wide EDI Steering Group has been established in the Board governance process. Workforce Education & Culture Committee (WECC) consider all EDI related papers	1	Jackie Railton Deputy Director, Strategy & Planning Lucy Vere Director of Learning & Organisational Development

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Gender Pay Gap, WRES, WDES, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board.	2	Mano Jamieson Equality, Diversity & Inclusion Manager
Domain 3: Inclusive leadership overall rating			5	

EDS Organisation Rating (overall rating): 18 (NLaG) – Developing 21 (HUTH) – Developing
Organisation name(s): Northern Lincolnshire & Goole NHS Foundation Trust Hull University NHS Teaching Trust
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
EDS Sponsor	**Authorisation date**

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Targeted Lung Health Check: • Continue/ extend work to capture eligible patients with the homeless and prison populations • To begin work to capture local Traveller populations, in collaboration with the Cancer Alliance • To gather more data on the delivery of the TLHC in the North and North East Lincolnshire areas Virtual Ward: • To provide increased service coverage	Targeted Lung Health Check: • To work with the Forge Project to carry out another cycle of work targeting homeless patients • To continue working with local prison services, to ensure that eligible patients within the prison population are able to access TLHC. • To discuss further with the local Cancer Alliance and begin planning to capture local Traveller populations in 2025. • To continue the deployment of the TLHC in these areas, collecting further data and evidence on how the service is provided Virtual Ward: • To continue working with system partners to extend step-up care from GPs to a 7-day service in the future.	December 2025 December 2025 December 2025 December 2025 December 2025

Domain	Outcome	Objective	Action	Completion date
	1B: Individual patients (service users) health needs are met	Targeted Lung Health Check: • To ensure that patient's specific needs are documented within the EPR, to ensure that these can be acted upon on first contact. • To gather examples of good practice, for use as a training aid and evidence bank for future reviews. Chemotherapy Delivery: • To gather examples of good practice, for use as a training aid and evidence bank for future reviews. Virtual Ward: • To further develop the service to provide care in line with patient's individual needs	Targeted Lung Health Check: • To review the availability of flagging for LD patients within the EPR. • To ensure that examples of excellent patient care/ where staff make adjustments for individual patient needs are recorded. Chemotherapy Delivery: • To discuss with unit managers how best to ensure that appropriate examples are captured and recorded for future reference. Virtual Ward: • To continue work with the Transitional Lead Nurse in relation to care plans for patients with Learning Disabilities, and providing education on the care plans	March 2025 December 2025 December 2025 July 2025

Domain	Outcome	Objective	Action	Completion date
	1C: When patients (service users) use the service, they are free from harm			

	1D: Patients (service users) report positive experiences of the service	Targeted Lung Health Check: • To collect and respond to patient feedback in a more structured manner • To ensure that evidence is retained, to show that patient feedback is utilised for the improvement of services • To provide further opportunities for patient experience to be provided Chemotherapy Delivery: • To gather increased levels of Friends and Family Test data. • To gather more detailed patient feedback • To use the results of the recent Humber Coast and Vale audit on SACT to inform future service developments	Targeted Lung Health Check: • To develop and implement a process to ensure the regular collection and review of patient feedback • To ensure that patient feedback is retained and reported on • To explore the potential for collecting patient experience data via the TLHC website. This would include an explanation of the purpose behind the data collection, to encourage more patients to participate. Chemotherapy Delivery: • To work with Patient Experience to ensure that accurate Friends and Family Test data can be captured and reported. • To arrange and carry out a more focused patient survey, to ensure that appropriate data is gathered. • To obtain and review the results of the most recent HCV audit, when available	December 2025 December 2025 July 2025 April 2025 December 2025 April 2025

Domain	Outcome	Objective	Action	Completion date
		Virtual Ward: • To gather more patient feedback, in order to influence future service developments • To review existing patient experience data, for any potential learning opportunities	Virtual Ward: • To discuss with patient experience/ incident reporting to see if it would be possible to introduce a system for reporting positive feedback/ examples of good practice ('Greatix') • To review physical copies of previously received feedback, as there were noted issues with FFT reporting due to data collection being within the short stay ward	December 2025 April 2025

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To identify what support is needed for each condition and scope out what capacity is needed to offer the level of support required.	To complete capacity and demand exercise for each condition To prioritise interventions using the Health and Wellbeing MDT to identify and allocate resources Roll out or promote interventions identified To roll out the Health and Wellbeing framework – including to training staff in health coaching	March 2026

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To reduce number of staff reporting experiences of abuse, harassment, bullying & physical violence in the staff survey	To introduce and embed a number of Zero Tolerance to discrimination frameworks and reporting tools focussing on Race, Disability and LGBTQ+, To create clear roles and responsibilities for line managers in protecting their staff form harm including supporting them to upskill and increase their confidence in dealing with challenging situations To roll out the Inclusivity Academy including our in house more in depth EDI mandatory training model for the whole group.	April 2025 May 2025 June 2025

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To ensure that a full range of support is available that enables staff to speak up, get support and get their issue resolved without having a permanent impact on their work life and health.	To fully review current routes of advice and ensure that they are fully accessible. To fully maximise the Freedom to Speak Up Guardian Services including the network of FTSU Champions with a focus on EDI related complaints. To further embed and support our Network Chairs and Vice Chairs to offer support and advice including creating a regular supervision and support sessions for them led by the FTSUG and the Director of Learning and OD. To encourage our staff from protected characteristics to join a union to allow them access to external and impartial support.	June 2025 June 2025 April 2025 April 2025

	2D: Staff recommend the organisation as a place to work and receive treatment	Develop a values led culture that ensures all staff feel valued, welcome and creates a safe working environment, which ultimately translates into better and safer patient care.	Create a strong leadership development and people management approach that is compassionate and inclusive through a wide range of interventions: • Development programmes • Bespoke work with teams • Coaching and mentoring • Clear metrics and feedback to managers on their progress Create and rollout a group wide Professionalism and Civility Programme (PACT) to ensure all staff understand what is expected of them in creating a healthy work culture.	December 2025

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To embed Equality, Diversity and Inclusion, and Health Inequalities into the personal performance objectives for our Band 9 and VSM leaders	Include Care Group measures on EDI, staff survey scores in accountability to Trust Board along with Action Plans for improvement All relevant managers have EDI and Health Inequality objectives built into their appraisals. Care Group and Director Level WRES/WDES/LGBTQ objectives and progress tracking built into reporting and governance structures for the Group	June 2025 December 2025 December 2025
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Introduce accountability for Equality, Diversity and Inclusion activity and Health Inequalities at Board Committee level	Ensure Equality and Health Inequality impact assessments are reviewed at relevant Board Committee when service changes are introduced Training and Coaching for NED's to ensure that they are able to critically challenge the Exec team when impact assessments are being discussed and agreed at committees and Trust Board.	July 2025 July 2025

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To demonstrate that we have clear metrics and governance in place that allow both executives and non-executives to identify and track improvements for both staff and patients.	To ensure that the new Group Structure governance arrangements are able to identify improvements, hold our Care Groups and Corporate Directorates to account for both remedial and proactive actions required. To work with executive and site teams to ensure that they are pursuing performance for these objectives as part of their routine performance meetings and structures.	April 2025 September 2025

Patient Equality Team
NHS England and NHS Improvement
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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(25)093

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 June 2025
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 – April 2025 - 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 (ARG CiC) meeting on 24 April 2025. The Trust Boards are asked to: • Note the public highlight report from the April 2025 ARC CiC meeting. • Approve the recommendation from the ARG CiC that the 2024/25 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 24 April 2025
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:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	12 June 2025 – Public
Report from:	Audit, Risk and Governance Committees-in-Common
Report from meeting(s) held on:	24 April 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 24 April 2025 including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- Accounting Policies 24/25 HUTH & NLAG
- Going Concern Reports 24/25 – HUTH & NLAG
- Draft Annual Accounts 24/25 – HUTH & NLAG
- Draft Annual Governance Statements 24/25 – HUTH & NLAG
- Status of Trust Annual Reports 24/25
- Draft Head of Internal Audit Opinions 24/25 – HUTH & NLAG
- Internal Audit Progress Report / Overdue recommendations– HUTH & NLAG
- External Audit Planning Reports and Updates – HUTH & NLAG
- Group Internal Audit Plan 25/26
- Group LCFS Update
- Group Annual Counter Fraud Operational Plan 25/26
- Group Fraud & Corruption Policy
- Group Board Assurance Framework
- Group Risk Register & Risk Management Policy
- Group Waiving of Standing Orders Report 24/25
- Group Losses and Compensations Report 24/25
- Group Standards of Business Conduct Declarations 24/25
- Group Standards of Business Conduct Policy
- Salary Overpayments 24/25 – NLAG
- Group Document Control Report
- Global Internal Audit Standards – ARG CiC Duties
- Group Information Governance (IG) Highlight Report

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

3.0 Matters for reporting / escalation to the Trust Boards

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

a) **Going Concern Reports 2024/25 – NLAG & HUTH** – The Going Concern reports for both HUTH and NLAG were received and accepted by the ARG CiC who endorsed the recommendations that the HUTH and NLAG Trust Boards can assume the 2024/25 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis. It was agreed to recommend this to the Boards-in-Common.

b) **Draft Annual Accounts 2024/25 – NLAG & HUTH** – Both sets of draft annual accounts were received by the Committees, with key points highlighted in writing and discussed by the Assistant Director of Finance – Planning and Control. ARG CiC members asked a number of questions in relation to items in the draft accounts and these were duly answered. The ARG CiC thanked the Finance team for both the quality of the draft financial statements for the two Trusts and the speed of their production in April. The External Auditors at both Trusts will now commence their audits of the draft accounts.

c) **Draft Annual Governance Statements (AGS) 2024/25 – NLAG & HUTH** – The Committees received the initial draft AGS for both Trusts, noting that some sections required further updates before being finalised. A number of adjustments / corrections were proposed by ARG CiC members for inclusion in the final version, with any further comments / corrections to be supplied to the Group Director of Assurance for consideration. The final drafts will be received by the Committees in June 2025 for approval and inclusion in the Trust's Annual Reports for 2024/25.

d) **2024/25 Internal Audit Plan and Overdue Recommendations** – the Committees received the latest report from Audit Yorkshire and RSM on progress with the 2024/25 plan. Six internal audit reports had been finalised since the last meeting, three of which resulted in 'Limited Assurance' ratings (BAF and Risk Management – HUTH and NLAG & Annual Leave) and one with 'Minimal Assurance' (Inventory Management - HUTH). These were discussed by the Committees, and the HUTH Inventory Management report is to be brought back to the July 2025 meeting for a further update on progress. With regard to the BAF and Risk Management reports and recommendations the Committee recognised that improvements in the system of risk management had taken place with the Directors and Nursing and Assurance meeting with Care Group leadership to improve reporting, monitoring and management of risks. The Committee further noted that there were still improvements to be made. The Committees were pleased to note the reduced number of overdue recommendations for both Trusts, recognising this was a much-improved position to this time last year. However, the ARG CiC noted the further revised implementation dates for a number of digital recommendations and agreed to highlight this to the Boards to question whether digital resource / capacity was sufficient for all of the demands placed on it.

e) **Group Internal Audit Plan 2025/26** – the Group's new Internal Auditors, KPMG, were in attendance and presented a prioritised long list of review areas to be considered for inclusion in the 2025/26 Group Internal Audit Plan. The

ARG CiC considered a number of items listed and after further discussion approved the items listed. A discussion took place around the possible inclusion of a review of Job Planning, however following discussion it was agreed to make a referral to the Workforce, Education and Culture Committees-in-Common to request a status update on the position with the work currently being conducted to improve Job Planning in 2025.

f) **Group Risk Management Policy** – the ARG CiC received and approved the new Group Risk Management Policy.

g) **Standards of Business Conduct Declarations 2024/25** – the ARG CiC were concerned at the low level of declarations from Consultants with regard to receipt of sponsorship and hospitality and secondary employment. It was agreed to refer this matter to the Workforce, Education and Culture Committees-in-Common.

h) **Group IG Highlight Report** – the Group Chief Strategy and Partnerships Officer informed the Committees of the progress made with reducing the number of overdue recommendations. He also advised of the enormous amount of work that had gone into the new Cyber Assessment Framework (CAF) Toolkit which will be submitted with a status of 'Approaching Standards' with an improvement plan. The Committees acknowledged the amount of work which had gone into the new CAF and thanked all those involved for their hard work. The Committee also recognised the improvement in closing down audit recommendations from previous years but also recognised that this had been an issue due to lack of capacity in the team.

i) **NLAG External Audit Service – Contract Extension 2025/26** – The NLAG ARG Committee-in-Common was informed that its recommendation to extend the existing External Audit contract with Sumer NI, in line with the contract terms, had been approved by the Council of Governors at their meeting on 16 April 2025.

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):

5.1.1 The ARG CiC received its routine item on the Board Assurance Framework (BAF) and also received a presentation on the BAF and Risk Register from the Group Director of Assurance. Also in attendance for these items was the Acting Chief Executive. Both Directors answered questions from the ARG CiC around training, reporting, articulation of high-level risks, issues versus risks, terminology, risk tolerance and the use of a high-level flowchart to assist in staff understanding. The ARG CiC were pleased to see progress being made and thanked the Group Director of Assurance and Acting Chief Executive for the presentation update.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the highlight report from the ARG CiC.
- Approve the recommendation from the ARG CiC that the 2024/25 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis.

Simon Parkes
NLAG ARG CiC Chair / NED
24 April 2025

Jane Hawkard
HUTH ARG CiC Chair / NED

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(25)094

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 June 2025
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Annual Accounts – Delegation of Authority to the Audit, Risk & Governance Committees-in-Common**
Executive Summary	In order to ensure the timely sign off of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) audited accounts and reports by the Acting Group Chief Executive and the respective External Auditors, prior to submission to NHS England on 30 June 2025, the Trust Boards-in-Common is requested to delegate formal authority to the Audit, Risk and Governance Committees-in-Common at its meeting on Friday 20 June 2025 to sign off the audited accounts and reports on its behalf. The Trust Boards-in-Common is asked to: • Note the key dates in the final accounts process. • Delegate formal authority to the Audit, Risk and Governance Committees-in-Common to sign off the NLAG and HUTH 2024/25 audited accounts and reports on behalf of the Trust Boards-in-Common.
Background Information and/or Supporting Document(s) (if applicable)	NHS England 2024/25 Accounts Timetable
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:

Report to Trust Boards-in-Common – June 2025

ANNUAL ACCOUNTS and REPORTS 2024/25 - DELEGATION OF AUTHORITY

1. Introduction

The Audit, Risk and Governance Committees-in-Common (ARG CiC), under their delegated powers (Group Standing Financial Instruction's ref: 3.1.3 b), review the draft accounts and associated reports for Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) on behalf of the Trust Boards-in-Common, before they are submitted to NHS England (NHSE) and the External Auditors. This review took place at the ARG CiC meeting on 24 April 2025, prior to submission to NHSE and the External Auditors on 25 April 2025.

The ARG CiC also review the audited accounts and reports, including each Trust's Annual Governance Statements (AGS) and Annual Reports, before they are submitted to the Trust Boards-in-Common for approval, prior to the final submission to NHSE in line with the national deadline. The key dates for the 2024/25 audited accounts and reports, as confirmed by NHSE are as follows:-

Thursday 12 June 2025	Trust Boards-in-Common meeting.
Friday 20 June 2025	ARG CiC meeting where the final audited accounts and associated reports for both Trusts in the Group will be reviewed in detail. The Acting Group Chief Executive and Group Chair are invited to attend this meeting.
W/C 23 June 2025 – exact date to be confirmed	Acting Group Chief Executive sign off date for both Trusts audited accounts and reports. Once signed by the Acting Group CEO, will be passed to the respective External Auditor for formal sign off prior to return and submission to NHSE.
Friday 30 June 2025	Final audited accounts and reports for both Trusts to be formally submitted to NHSE by noon.

The audited accounts and reports for NLAG and HUTH will not be ready for final review by the time of the June 2025 Trust Boards-in-Common meeting, given that it falls early in the month. The Trust Boards-in-Common can therefore, as in previous years, delegate formal authority to the ARG CiC to approve the audited accounts and reports on its behalf before submission to NHSE by the deadline of noon on 30 June 2025.

The Trust Boards-in-Common are receiving the draft annual accounts, draft Trust Annual Report and draft Annual Governance Statements for 2024/25 for both Trusts at its private meeting on 12 June 2025. The final signed off versions of all these documents will be shared with the Trust Boards-in-Common at their private meeting on 14 August 2025 for information.

2. Recommendation

The Trust Boards-in-Common are asked to note the key dates in the final accounts process and are requested to delegate formal authority to the Audit, Risk and Governance Committees-in-Common at its meeting on 20 June 2025 to sign off the NLAG and HUTH 2024/25 audited accounts and reports on behalf of the Trust Boards-in-Common, prior to formal signing by the Acting Group Chief Executive and the External Auditor and submission to NHSE.

Emma Sayner
Group Chief Financial Officer
May 2025

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(25)095

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 June 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	David Sharif, Group Director of Assurance
Title of Report	**Provider Licence and Code of Governance compliance for 2024-25**
Executive Summary	In striving to adhere to best practice across NHS corporate governance matters, this paper sets out: 1. the legacy requirement for the Boards to report compliance against two remaining elements of the **Provider Licence**, with regard to supporting: • our aim to reduce inequalities between persons with respect to their ability to access services (2b); and • our current registration with the CQC (G6). 2. the requirements of the **Code of Governance** by NHS England and the assessment of Trusts' compliance against these standards. The Code sets out a series of standards that the Trust is required to include information within the Annual Report, or via a 'comply or explain' statement. Corporate Governance has undertaken an assessment of the Trust's compliance against the Code of Governance standards in order that the Annual Report complies. As part of the year-end processes, External Audit are required to review the Annual Reports to ensure the content reflects the specified requirements against this Code and the requirements laid out in the DHSC group accounting manual 2024 to 2025. By taking this item in the public Boards, this report can also be referenced within the Annual Report. The close working undertaken to produce the 2024/25 Annual Reports for HUTH and NLAG has helped facilitate a detailed review of the draft Annual Reports against each of the standards and requirements of the Code (around 90 in total). The exercise identified 14 areas where further narrative will be added to reflect the approach and activities of the Group and comply fully with the standards, plus 8 proposed additions to strengthen the reporting further. The attached report details the assessment undertaken and highlights the narrative changes due to be made to the Annual Reports. **Recommendation:** • Accept the statements relating to the Provider Licence for HUTH and NLAG, as stated above; and

	• Accept the assessment regarding the Code of Governance requirements.
Background Information and/or Supporting Document(s)	See above
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

Code of Governance review - 2024/25

This report details each disclosure (both a summary and detail) from Schedule A: Disclosure of corporate governance arrangements, NHS England, 23 February, 2023. It indicates whether the disclosure is complusory or a 'comply or explain' disclosure. Each has a brief assessment against the draft annual reports for NLAG and HUTH, together with the additional material to be added prior to its completion where necessary to ensure compliance.

NB Blue text indicates FT only dsclosure

The provisions listed as 'requirement' mean that a supporting explanation in a trust's annual report is required, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

For the provisions listed as 'comply or explain', the disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

comply or explain

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.10	**Board must manage conflicts of interest and prevent third-party influence from overriding independent judgement.**
Complete Complusory: ✗ All trusts	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.
Assessment:	The annual report meets the criterion satisfactorily. It demonstrates a structured and transparent approach to managing conflicts of interest and protecting independent board judgment. While this section could be strengthened by referencing specific conflict scenarios or enforcement actions, the formal structures and policies are in place and described clearly.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.11	**Board concerns must be recorded. Departing non-executives with concerns should submit a statement to the chair.**
Missing Complusory: ✗ All trusts	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.
Assessment:	The draft report does not meet this criterion. It omits reference to the process or policy for managing unresolved concerns by directors or handling written statements of concern from departing NEDs.
Report addition:	Additionally, in the event that a non-executive director resigns and has unresolved concerns relating to the operation of the board or the conduct of the trust, they are invited to provide a written statement outlining their concerns. During the reporting period, no unresolved concerns or resignation-related statements were submitted by any member of the board.
Section A, 2.2	**Board should define and report the trust's vision and values, aligned with system strategies and collaboration.**
Complete Complusory: ✗ All trusts	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.
Assessment:	The annual report meets the criterion comprehensively. It articulates a formally adopted vision and values framework that is clearly aligned with the ICP strategy and the trust's role within system and provider collaboratives. The values are embedded in behaviours, culture, leadership development, and operational planning—demonstrating coherence and intentional implementation.
Section A, 2.4	**Board must monitor and report on delivery effectiveness, quality, risk, and performance against plans and obligations.**
Complete Complusory: ✗ All trusts	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.
Assessment:	The annual report clearly meets the criterion. The board demonstrates strong systems and governance processes to monitor and ensure effectiveness, quality, and delivery across all major operational and strategic areas. Risk is actively managed through structured oversight, and performance is continuously reviewed against system, regulatory, and contractual expectations.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.5	**Board must define metrics and seek independent advice for assurance on complex or high-risk matters.**
Complete Complusory: ✗ All trusts	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.
Assessment:	The annual report clearly satisfies this criterion. It demonstrates the use of robust and dynamic performance measurement tools (e.g. SPC-based IPR), and links metrics to national targets and local priorities. Independent internal audit is embedded within governance processes and is used effectively in high-risk and complex areas to deliver assurance to the board.
Section A, 2.6	**Report the trust's clinical governance approach and quality improvement plans in line with regulatory guidance.**
Complete Complusory: ✗ All trusts	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.
Assessment:	The annual report meets the criterion in full. It outlines a comprehensive and nationally aligned clinical governance structure, clear leadership roles, and multiple levels of operational and strategic oversight. The board demonstrates accountability for quality improvement and ensures that guidance from regulatory bodies (CQC, NHS England, DHSC) is embedded within its quality governance and assurance processes.
Section A, 2.7	**Chair and committee chairs must engage stakeholders and ensure stakeholder views are understood and reported.**
Complete Complusory: ✗ All trusts	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.
Assessment:	The annual report fully meets the criterion. The Chair actively engages with stakeholders through formal and informal channels, ensures committee chairs

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.9	**Board must enable staff to raise concerns confidentially and ensure proper investigation and follow-up.**
Complete Complusory: ✗ All trusts	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.
Assessment:	The annual report meets the criterion effectively. The trust has robust mechanisms for staff to raise concerns confidentially and anonymously, regular board-level oversight of these concerns, and procedures for independent investigation and follow-up.
Section B, 2.1	**Chair sets board and council agendas, ensuring time is allocated to strategic discussions.**
Incomplete Complusory: ✗ All trusts	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.
Assessment:	This criterion is partially met. While there is clear evidence that the Chair sets the agenda for the Council of Governors, the annual report lacks a direct statement of the Chair's responsibility for managing time allocation.
Report addition:	Adequate time is allocated for the discussion of all agenda items, with particular emphasis on strategic matters, including organisational transformation, workforce, quality of care, financial sustainability, and system-level collaboration. The Chair ensures that board meetings are structured to support effective scrutiny and decision-making on these areas, in alignment with the Trust's vision and the wider system strategy.
Section B, 2.10	**Only committee members may attend key meetings unless invited.**
Complete Complusory: ✗ All trusts	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.
Assessment:	These sections confirm that the Trust complies with the governance expectation that only committee members are entitled to attend, with others present only by invitation.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.11	**A senior independent director should be appointed to support and appraise the chair. Annual appraisals should occur.**
Complete Complusory: ✗ All trusts	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.
Assessment:	The Annual Report 2024/25 confirms compliance with the governance expectation.
Section B, 2.12	**Non-executives appoint and oversee executives, meet without executives, and hold them accountable.**
Complete Complusory: ✗ All trusts	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.
Assessment:	These disclosures demonstrate that the Trust complies with the governance expectation regarding the role of NEDs in executive appointments, performance oversight, and independent meetings with the Chair.
Section B, 2.14	**Directors must disclose other commitments. The board must approve any new ones and explain time expectations.**
Complete Complusory: ✗ All trusts	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.
Assessment:	These disclosures demonstrate that the Trust complies with the governance expectations regarding director time commitments, external appointments, and transparency.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.15 **Incomplete** Complusory: ✗ All trusts	**All directors must have access to the company secretary for governance advice. Board decides on appointment/removal.** All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.
Assessment:	The function of the company secretary is clearly fulfilled by the Group Director of Assurance, and directors have access to governance advice. However, the formal process for appointment and removal of this role is not explicitly stated as a board decision in the report.
Report addition:	The appointment and removal of the Group Director of Assurance is a matter reserved for the full board, ensuring appropriate oversight and alignment with the trust's governance framework.
Section B, 2.16 **Complete** Complusory: ✗ All trusts	**All directors must challenge constructively, monitor performance, and ensure controls and reporting are robust.** All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
Assessment:	These disclosures confirm that the Trust meets the governance expectation for active and informed board engagement, particularly by non-executive directors, in shaping strategy, scrutinising performance, and ensuring robust governance.
Section B, 2.16 **Complete** Complusory: ✗ All trusts	**Board is collectively responsible for healthcare quality, training, and research, following clinical governance standards.** The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.
Assessment:	The Annual Report 2024/25 confirms that the board of directors collectively holds responsibility for the quality and safety of healthcare services, education, training, and research, in line with the expectations of the Department of Health and Social Care (DHSC), NHS England, the Care Quality Commission (CQC), and other relevant NHS bodies.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.17 **Complete** Complusory: ✗ All trusts	**Board should meet regularly and reserve certain matters for its own decisions.** The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.
Assessment:	These disclosures confirm that the board meets regularly and retains clear oversight of key decisions through a defined schedule of reserved matters.
Section B, 2.17 **Complete** Complusory: ✗ All trusts	**Board members share joint responsibility for decisions, with specific duties remaining for the chief executive.** All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.
Assessment:	These disclosures confirm that the Trust complies with the governance expectation that all directors share collective responsibility for board decisions, while recognising the distinct statutory role of the Chief Executive as accounting officer.
Section B, 2.2 **Incomplete** Complusory: ✗ All trusts	**Chair ensures timely, clear information for directors and governors and supports governor development.** The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.
Assessment:	This criterion is partially met. The trust appears to be fulfilling the underlying intent (through structured reporting and development opportunities), but the Chair's accountability for these functions should be more clearly stated in the report.
Report addition:	The Chair is responsible for ensuring that all members of the Board of Directors and the Council of Governors receive accurate, timely, and clear information to support informed decision-making and effective fulfilment of their statutory responsibilities. This includes access to performance reports, strategic updates, and committee outputs, ensuring transparency and alignment across governance structures. For the Council of Governors, the Chair also oversees the provision of development opportunities and ensures that governors have the necessary knowledge and skills to undertake their role. This includes: Access to briefings and development sessions on key service priorities and system changes Participation in structured visits, review activities, and NHS England-aligned training Annual individual development reviews for governors to assess support needs Through these arrangements, the Chair supports a well-informed and capable governance body that contributes effectively to the trust's success and accountability to its stakeholders.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.3	**Chair promotes a culture of openness and supports effective relationships between executive and non-executive directors.**
Incomplete Complusory: ✗ All trusts	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.
Assessment:	Whilst there are several indirect references that suggest the intended culture is being supported in practice, the annual report does not contain a direct statement about the Chair's role in promoting a culture of openness, trust, and debate.
Report addition:	The Chair plays a key role in promoting a culture of openness, honesty, respect and constructive challenge within the Board. Through effective leadership and facilitation, the Chair ensures that all directors are able to contribute meaningfully to board debate and assurance processes.
Section B, 2.4	**Chair ensures effective collaboration between the board and council of governors.**
Complete Complusory: ✗ FTs only	A foundation trust chair is responsible for ensuring that the board and council work together effectively.
Assessment:	The draft Annual Report 2024/25 does provide evidence that the Chair is fulfilling the responsibility of ensuring the Board and Council of Governors (CoG) work together effectively, though the references are more implicit than explicit.
Section B, 2.5	**Chair must be independent at appointment. Chair and CEO roles must be separate. Chair should not sit on the audit committee.**
Complete Complusory: ✗ All trusts	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.
Assessment:	The draft Annual Report 2024/25 provides clear evidence that the Trust complies with the governance expectations outlined.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.7 **Complete** Complusory: ✗ All trusts	**At least half the board, excluding the chair, should be independent non-executive directors.** At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.
Assessment:	The draft Annual Report 2024/25 provides clear evidence that the Board of Directors meets the requirement that at least half of its members, excluding the Chair, are independent Non-Executive Directors (NEDs).
Section B, 2.8 **Complete** Complusory: ✗ FTs only	**No one should serve simultaneously as a director and governor of any NHS foundation trust.** No individual should hold the positions of director and governor of any NHS foundation trust at the same time.
Assessment:	The Annual Report provides sufficient evidence that the Trust complies with the criterion. There is no indication that any individual simultaneously holds both a director and governor position
Section B, 2.9 **Complete** Complusory: ✗ All trusts	**Committee membership should rotate. Councils should seek diverse, skilled non-executive directors.** The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.
Assessment:	The Annual Report 2024/25 provides strong evidence that the trust is: Actively refreshing committee membership and avoiding undue reliance on individuals. Including NEDs with clinical backgrounds on the board. Prioritising diversity in board appointments through structured governance and EDI strategies.

comply or explain

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.1	**Nominations committees identify and plan for director appointments, considering future risks and required skills.**
Incomplete Complusory: ✗ FTs only	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.
Assessment:	The Annual Report 2024/25 partially addresses the governance expectation.
Report addition:	The trust's nominations and appointments processes are supported by external advice where appropriate. For senior appointments, including the Chair and Chief Executive, the selection panel includes an external assessor from NHS England and/or a representative from the Integrated Care Board (ICB), in line with best practice. The trust engages with NHS England to agree the approach to these appointments. Succession planning is reviewed annually to ensure the board maintains the skills and experience needed to meet future challenges and strategic priorities.
Section C, 2.2	**Committees should review board composition and skills annually and define requirements for appointments.**
Incomplete Complusory: ✗ FTs only	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.
Assessment:	The Annual Report 2024/25 confirms that the trust operates with two distinct nominations committees, each with clearly defined responsibilities, but it only partially meets the full expectations of the NHS Foundation Trust Code of Governance regarding board composition review and succession planning.
Report addition:	The Remuneration Committees-in-Common review the board's structure, size and composition. This includes an evaluation of the balance of skills, knowledge, experience and diversity. The findings inform succession planning and the development of role specifications for future appointments. The trust is committed to maintaining a board that reflects the communities it serves and is equipped to meet future strategic challenges.

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.3	**Nominations committees must be chaired by the chair or independent director; governors may chair for non-exec roles.**
Complete Complusory: ✗ FTs only	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.
Assessment:	These arrangements demonstrate that the Trust complies with the governance requirement regarding the appropriate chairing of nominations committees.
Section C, 2.4	**Governors must agree a clear nominations process and receive committee recommendations for appointments.**
Complete Complusory: ✗ FTs only	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.
Assessment:	These disclosures confirm that the Trust has a clear, governor-led process for nominating and appointing the Chair and NEDs, with final decisions resting with the full Council of Governors.
Section C, 2.5	**Chair and non-executive appointments should use open advertising and NHS England advice.**
Missing Complusory: ✗ FTs only	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.
Assessment:	The draft Annual Report 2024/25 does not confirm that open advertising or advice from NHS England's Non-Executive Talent and Appointments team was used in the appointment of the Chair or Non-Executive Directors (NEDs), as recommended by the Code of Governance.
Report addition:	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team was used in the recruitment of Non-Executive Directors (NEDs), as recommended by the Code of Governance.

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.6	**Non-executive nominations must involve a governor/independent majority in committees and interview panels.**
Could enhance Complusory: ✗ FTs only	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.
Assessment:	The NLAG Annual Report 2024/25 confirms that the trust operates with two nominations committees and that the committee responsible for appointing Non-Executive Directors (NEDs), including the Chair, is structured in line with the NHS Foundation Trust Code of Governance expectation. To fully demonstrate compliance, the trust could include an explicit statement on the membership of nomination committees.
Report addition:	The interview panel for the appointment of Non-Executive Directors includes a majority of governors and/or independent members, in line with the NHS Foundation Trust Code of Governance
Section C, 2.7	**Governors should consider the board and committee views on skills needed when appointing non-executive directors.**
Complete Complusory: ✗ FTs only	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.
Assessment:	The NLAG Annual Report 2024/25 confirms that the Council of Governors (CoG) works closely with the Appointments and Remuneration Committee (ARC) to appoint Non-Executive Directors (NEDs), including the Chair, and that the process includes consideration of the qualifications, skills, and experience required for each role.
Section C, 3.1	**NHS England appoints trust non-executives. Executive appointments involve panels including external assessors.**
Incomplete Complusory: ✗ NHS Trusts only	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.
Assessment:	The Annual Report 2024/25 confirms that the trust follows a two-committee structure for executive and non-executive appointments, but it does not fully meet the NHS Trust governance expectation. The report does not mention whether: NHS England was engaged in the appointment process for the Chair or NEDs. A representative from NHS England or the Integrated Care Board (ICB) served as an external assessor on any selection panel. NHS England was consulted to agree the approach for executive appointments.
Report addition:	Resolved in addressing Section C, 2.1

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.1 **Complete** Complusory: ✗ All trusts	**Directors and governors must meet the fit and proper persons test, including qualifications, integrity, and conduct.** Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.
Assessment:	The Annual Report 2024/25 confirms that the trust has policies and processes in place to ensure that directors and governors meet the 'fit and proper persons' test, as required by the NHS provider licence and CQC Regulation 5.
Section C, 4.10 **Complete** Complusory: ✗ FTs only	**Governors may be removed for misconduct. Disputes should be resolved by an independent assessor if needed.** In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.
Assessment:	The Trust is compliant with the requirement to have a fair and transparent process for the removal of governors. The policy is clearly documented and aligns with NHS England's expectations. The Trust could enhance transparency by explicitly stating the voting threshold for removal (e.g. 75%) and confirming whether an independent assessor would be used in cases of dispute.
Section C, 4.11 **Complete** Complusory: ✗ All trusts	**Board must maintain skills and plan for succession with the council of governors.** The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.
Assessment:	The Trust is compliant with the requirement to retain the necessary skills across its board and to work with the Council of Governors on succession planning. The governance framework includes structured appointment processes, regular evaluations, and strategic workforce planning. While the Trust outlines its approach to board composition and succession planning, future reports could benefit from more detailed examples of how succession risks are identified and mitigated in practice.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.12	**Remuneration committee must conduct risk assessments before approving early executive departures.**
Complete Complusory: ✗ All trusts	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.
Assessment:	The Trust confirms that executive departures are managed in accordance with contractual terms and subject to appropriate oversight. While the report outlines the governance framework for executive exits, there is limited explicit reference to the use of formal risk assessments prior to departure decisions. The Trust is broadly compliant with the requirement to manage executive departures in line with contractual terms and national guidance. The Remuneration Committees-in-Common oversee all such decisions, and there is no indication of inappropriate severance arrangements. The Trust should explicitly document and disclose the completion of a formal risk assessment prior to any executive departure that deviates from standard terms, in line with NHS England's Code of Governance expectations.
Section C, 4.3	**Chair should not serve beyond nine years unless extended for succession planning, with reasons clearly explained.**
Complete Complusory: ✗ All trusts	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.
Assessment:	Tenure: Sean Lyons was appointed as Chair in February 2022. There is no indication in the report that he has served on the board prior to this appointment. Therefore, as of the end of the 2024/25 reporting year, he would have served three years as Chair — well within both the six-year and nine-year thresholds. Extension or Succession Planning: There is no indication that his term has been extended beyond six years, nor is there any mention of a need for NHS England agreement or a rigorous review. Conclusion: The report meets the criterion. The Chair's tenure is within the acceptable limits, and no extension has been made that would require additional scrutiny or explanation.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.4	**Governors must face re-election every three years. Biographies and performance info should be provided.**
Complete Complusory: ✗ FTs only	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.
Assessment:	The Annual Report demonstrates that the Trust is compliant with the requirement that elected foundation trust governors are subject to re-election at intervals not exceeding three years. It also aligns with best practice by limiting governors to a maximum of three consecutive terms.
Section C, 4.5	**Annual board and individual director evaluations must occur, with NHS England or governors leading as appropriate.**
Could enhance Complusory: ✗ All trusts	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.
Assessment:	Whilst narrative demonstrates strong compliance with the NHS Code of Governance across the three criteria reviewed, the Trust does not explicitly confirm the use of the NHS Leadership Competency Framework, although its practices suggest alignment.
Report addition:	For all board members, the Trust has introduced appraisal processes based on the NHS Leadership Competency Framework
Section C, 4.6	**Chair and directors must act on evaluation outcomes and address development needs.**
Could enhance Complusory: ✗ All trusts	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.
Assessment:	Whilst the Trust is compliant with the requirement that the Chair and directors act on the results of board evaluations, the report does not provide specific examples of development actions taken by individual directors. Including such examples in future reports would enhance transparency and demonstrate impact.
Report addition:	To include some examples

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.8 **Complete** Complusory: ✗ FTs only	**Governors must assess and communicate their impact and effectiveness, including accountability and engagement.** Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: holding the non-executive directors individually and collectively to account for the performance of the board of directors communicating with their member constituencies and the public and transmitting their views to the board of directors contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors. **Assessment:** The Annual Report confirms that the Council of Governors (CoG) at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) has a structured approach to evaluating its performance and communicating its impact to members and the public. While the CoG's engagement activities are well-documented, future reports could benefit from more explicit examples of how member and public feedback has directly influenced board decisions or strategic plans.
Section C, 5.10 **Complete** Complusory: ✗ All trusts	**Board and council must receive high-quality, relevant information and agree their needs with executive directors.** The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees. **Assessment:** The Trust is compliant with this criterion. The Annual Report provides strong evidence that both the Board of Directors and the Council of Governors are provided with high-quality, timely, and relevant information to support effective decision-making. The Trust demonstrates a robust approach to ensuring that both the Board and Council of Governors receive concise, accurate, and timely information. The use of SPC charts, structured committee reporting, and regular engagement between executives and governors supports effective oversight and decision-making. While the report outlines the provision of information, it could be strengthened by including examples of how feedback from governors or NEDs has influenced the format or content of reports. The Trust may consider publishing a summary of how information needs are reviewed and agreed annually between the Board, governors, and executive team.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.1	**All directors and governors should receive induction and regular training updates.**
Complete Complusory: ✗ All trusts	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.
Assessment:	The Trust provides structured induction and ongoing development opportunities for both directors and governors. These programmes are designed to ensure that all individuals are equipped with the knowledge and skills necessary to fulfil their roles effectively. The Trust is compliant with the requirement to provide appropriate induction and ongoing development for directors and governors. The governance framework includes structured onboarding, regular training, and performance reviews. While the Trust outlines a strong framework for induction and development, future reports could include more detail on how the effectiveness of these programmes is evaluated and how feedback is used to improve them.
Section C, 5.11	**Non-executives should challenge management when needed and seek deeper analysis or external advice if necessary.**
Complete Complusory: ✗ All trusts	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides clear evidence that Non-Executive Directors (NEDs) are empowered to challenge executive assurances and are supported with the information and mechanisms necessary to make informed decisions. The Trust has established a governance framework that enables NEDs to challenge executive assurances effectively. The use of structured performance reporting, access to internal and external audit, and the ability to seek independent advice ensures that the Board can make informed decisions and request deeper analysis when necessary. The report could be strengthened by including specific examples of instances where NEDs requested further analysis or external assurance on complex or high-risk issues. It may be helpful to include a summary of how often NEDs have exercised their right to seek independent advice or escalate concerns through formal channels.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.12	**Board should provide directors with access to independent advice when needed, approved by non-executive majority.**
Complete Complusory: ✗ All trusts	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that Non-Executive Directors (NEDs) have access to independent professional advice at the Trust's expense when necessary to discharge their responsibilities. The Trust has appropriate provisions in place to ensure that NEDs can access independent professional advice when needed. This supports their ability to provide effective oversight and challenge. The availability of this support is clearly stated in the Annual Report and aligns with good governance practice. The report could be enhanced by including a statement confirming that the availability of independent advice is made clear to NEDs at the time of appointment. It would be beneficial to include examples or a summary of instances where external advice was sought, or to confirm whether this occurred during the reporting period.
Section C, 5.13	**Committees and councils must have enough resources to perform duties, agreed in advance.**
Complete Complusory: ✗ All trusts	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides evidence that both Board committees and the Council of Governors are supported with appropriate resources to carry out their duties effectively. The Trust has established robust support mechanisms for both its Board committees and the Council of Governors. These include administrative, professional, and developmental resources that enable effective governance, oversight, and engagement. The arrangements are clearly documented and appear to be functioning well. The report could be strengthened by explicitly stating that the resource arrangements for the Council of Governors are agreed in advance, as required by the criterion. It may be helpful to include a summary of the budget or staffing allocated to support the Council of Governors and Board committees.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.14	**Non-executives must evaluate if they receive timely information and can apply their skills to challenge decisions.**
Complete Complusory: ✗ All trusts	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.
Assessment:	The Trust is compliant with this criterion. The Annual Report demonstrates that Non-Executive Directors (NEDs) are supported to apply their experience and judgement, and are provided with the information necessary to challenge recommendations and make informed decisions. The Trust has created an environment where NEDs are empowered to apply their leadership experience and professional judgement. They are provided with timely and relevant information and are encouraged to challenge executive recommendations. The governance structure supports their active involvement in decision-making and oversight. The report could be enhanced by including specific examples of how NEDs have used their external experience to influence decisions or challenge recommendations. It may be helpful to include a summary of any formal feedback from NEDs on the adequacy and timeliness of the information they receive.
Section C, 5.16	**Board should consider and respond to governor input on forward plans, explaining what was or wasn't included.**
Complete Complusory: ✗ FTs only	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides evidence that the Council of Governors (CoG) is consulted on the Trust's forward planning and that their views are considered and responded to appropriately. The Trust has demonstrated that it engages the Council of Governors in the development of its forward plans and provides opportunities for governors to contribute views. The Trust also communicates which views have been incorporated and explains its rationale where they are not, through structured meetings and briefings. The report could be strengthened by explicitly stating how the Trust informs the Council of Governors which of their views were incorporated into the final plans and why others were not. Including a short case example of a governor-influenced change to the forward plan would enhance transparency and assurance.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.17 **Complete** Complusory: ✗ All trusts	**Trusts should provide indemnity and/or insurance for directors and governors where appropriate.** The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that appropriate insurance arrangements are in place for directors, and that governors are protected from liability when acting in good faith. The Trust has confirmed that it maintains appropriate insurance to protect its directors from legal liability. While not legally required, the Trust acknowledges the low risk of liability for governors acting in good faith and references the Trust Constitution as the source of any indemnity provisions. The report could be strengthened by explicitly stating whether governors are covered by an indemnity or insurance policy and, if so, referencing the relevant section of the Trust Constitution. Including a brief summary of the scope or provider of the directors' insurance policy would enhance transparency.
Section C, 5.2 **Complete** Complusory: ✗ All trusts	**Chair must support continuous learning and training, including for recruitment and diversity topics.** The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality, diversity and inclusion, including unconscious bias.
Assessment:	The Trust provides structured support to ensure that both directors and governors continually update their skills, knowledge, and familiarity with the organisation and its obligations. The Chair plays an active role in promoting development, and the Trust offers resources and training aligned with national expectations. The Trust is compliant with the requirement to ensure that directors and governors regularly update their skills and knowledge. The Chair actively supports development, and the Trust provides structured opportunities for learning and engagement. The Trust should explicitly confirm that directors and governors involved in recruitment receive training on equality, diversity and inclusion, including unconscious bias, to fully align with NHS England's Code of Governance.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.3 **Complete** Complusory: ✗ All trusts	**Directors need access to trust information, operations, and policies to function effectively.** To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.
Assessment:	The Trust ensures that directors and governors have access to the organisation's operations and staff, and are appropriately briefed on its values, policies, and procedures. This supports their ability to fulfil their roles effectively and in alignment with the Trust's strategic objectives.The Trust is compliant with the requirement to ensure that directors and governors have access to operations, staff, and are briefed on values and policies. The governance framework supports transparency, engagement, and alignment with the Trust's mission. While access and briefings are well-documented, future reports could include more specific examples of how directors and governors engage with frontline services and how feedback from these interactions informs governance decisions.
Section C, 5.4 **Complete** Complusory: ✗ All trusts	**New directors and governors must receive tailored induction and access training aligned with development needs.** The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.
Assessment:	The Trust provides a structured and tailored induction for new directors and governors, with opportunities to engage with stakeholders and access development resources. This supports effective governance and alignment with NHS England's Code of Governance. The Trust is compliant with the requirement to provide tailored induction and stakeholder engagement opportunities for directors and governors. The Chair plays an active role in ensuring that new appointees are well-prepared and supported. Future reports could include more detailed examples of how directors engage with patients, clinicians, and system partners in practice, and how this informs board-level decision-making.
Section C, 5.5 **Complete** Complusory: ✗ All trusts	**Chair should review and agree each director's training needs.** The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.
Assessment:	The Trust is compliant with the requirement that the Chair ensures directors regularly review and update their training and development needs. The annual evaluation process and board development programme provide a structured mechanism for this. The Trust could strengthen its compliance by explicitly confirming that the Chair conducts individual development reviews with each director, separate from the collective board evaluation.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.6 **Complete** Complusory: ✗ FTs only	**Foundation boards must ensure governors have necessary skills and knowledge.** A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.
Assessment:	The Trust demonstrates a clear commitment to ensuring that governors are equipped with the skills and knowledge necessary to discharge their duties effectively. This is achieved through structured induction, ongoing development, and regular engagement with the Trust's leadership and operations. The Trust is compliant with the requirement to ensure that governors are equipped with the skills and knowledge to discharge their duties. The governance framework includes structured induction, ongoing training, and active engagement with Trust leadership and operations. Future reports could include more detail on how the effectiveness of governor training is evaluated and how feedback is used to improve the development programme.
Section C, 5.8 **Complete** Complusory: ✗ All trusts	**Chair must ensure directors and governors receive timely and clear information. Clarification should be sought as needed.** The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.
Assessment:	The Trust demonstrates compliance with this criterion. There is clear evidence of structured governance processes, regular reporting, and mechanisms for directors and governors to access and clarify information.The Trust has established robust governance mechanisms to ensure that directors and governors receive accurate, timely, and clear information. The use of structured reporting tools (e.g. IPR), regular meetings, and transparent publication of materials supports effective oversight. Governors are actively engaged and supported in their role, and there is a clear culture of accountability and openness. Timeliness of Information: While the IPR is comprehensive, the report does not specify the timeliness of data delivery to directors and governors. Clarifying lead times for report circulation could strengthen assurance. Digital Access and Tools: The report references the use of intranet platforms (e.g., Bridget), but further detail on how digital tools support real-time access to information for directors and governors would be beneficial. Feedback Loops: While governors can raise concerns, the report could better articulate how feedback from governors is systematically captured and acted upon by the Board.

Reference, coverage and assessment	Disclosure and assessment
Section C, 5.9	**Chair must ensure effective information flow across the board, council, and committees, and support development.**
Complete Complusory: ✗ All trusts	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides clear evidence that the Chair has facilitated effective information flow across the Board, between directors and governors, and supported induction and development activities. The Annual Report demonstrates that the Chair has fulfilled responsibilities for ensuring effective communication and governance across the Board and Council of Governors. The Chair has actively supported induction, development, and performance oversight of Board members and governors, contributing to a well-functioning governance structure. While the report outlines the Chair's role in induction and development, it could benefit from more specific examples of professional development activities undertaken by Board members or governors. The report could include a summary of feedback from governors or NEDs on the effectiveness of communication and development support provided by the Chair.
Section D, 2.1	**Board must have an independent audit committee with at least two to three members, including financial expertise.**
Could enhance Complusory: ✗ All trusts	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.
Assessment:	The Trust is fully compliant with Criterion. The Audit, Risk and Governance Committee-in-Common is properly constituted, independent, and financially competent. The committee's structure, membership, and operations align with NHS governance expectations and demonstrate a strong commitment to effective oversight.
Report addition:	Will be enhanced in future editions in addressing Section C, 4.2

Reference, coverage and assessment	Disclosure and assessment
Section D, 2.2	**Audit committee oversees financial integrity, internal controls, audit effectiveness, and stakeholder reporting.**
Complete Complusory: ✗ All trusts	The main roles and responsibilities of the audit committee should include: monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors reviewing and monitoring the external auditor's independence and objectivity reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.
Assessment:	The Trust is compliant with Criterion. The Audit, Risk and Governance Committee-in-Common performs all expected duties, including oversight of financial reporting, internal and external audit, and internal controls. The committee's structure, reporting lines, and documented activities demonstrate a mature and effective governance function. The Trust could further enhance transparency by: Publishing a summary of key issues discussed and resolved by the committee during the year. Including a brief narrative on how the committee's work influenced Board decisions or improvements in governance.
Section D, 2.3	**Trusts must rotate external auditors: NHS trusts every five years, foundation trusts every 10 years or sooner.**
Complete Complusory: ✗ All trusts	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.
Assessment:	The Trust is fully compliant with Criterion. The external audit function was re-tendered in 2023, well within the 10-year expectation and 5-year statutory requirement. The process was transparent, involved NHS England support, and resulted in a multi-year contract with appropriate review mechanisms.

Reference, coverage and assessment	Disclosure and assessment
Section D, 2.5	**Trusts must have a policy for non-audit services provided by external auditors.**
Complete Complusory: ✗ All trusts	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.
Assessment:	The Trust is fully compliant with Criterion. It has implemented a clear and effective policy on the engagement of its external auditor for non-audit services, with appropriate oversight by the Audit, Risk and Governance Committee-in-Common. The absence of non-audit engagements during the reporting year further reinforces the auditor's independence.
Section E, 2.1	**Executive performance pay must align with public interest and patient care priorities.**
Could enhance Complusory: ✗ All trusts	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
Assessment:	The Trust has a structured and transparent approach to executive remuneration, including annual appraisals and benchmarking. However, the absence of performance-related pay mechanisms means there is no direct alignment between executive remuneration and outcomes for patients, service users, or taxpayers. The Trust's approach is consistent with public sector norms but does not meet the full intent of this criterion.
Report addition:	remuneration
Section E, 2.2	**Chair and non-executive pay should follow the established NHS remuneration structure.**
Complete Complusory: ✗ All trusts	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.
Assessment:	The Trust demonstrates full compliance with the criterion. The remuneration structure for the Chair and NEDs is clearly defined, appropriately benchmarked, and transparently disclosed. The governance process ensures that remuneration reflects responsibilities and is subject to oversight by the Council of Governors.

Reference, coverage and assessment	Disclosure and assessment
Section E, 2.4	**Contracts should avoid rewarding poor performance. Include claw-back clauses for re-employment in the NHS.**
Incomplete Complusory: ✗ All trusts	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.
Assessment:	The Annual Report outlines the Trust's approach to early termination and compensation for executive directors. While it confirms that there are no contractual provisions for payments on termination and that severance payments are subject to national guidance, it does not mention claw-back provisions or mitigation clauses.
Report addition:	Where applicable, director-level contracts of employment include provisions for payments in lieu of notice and claw-back in line with national guidance. Also, any severance payment that requires NHSE approval, obtains that approval prior to payment.
Section E, 2.5	**Any director severance must be discussed early with the NHS England regional director.**
Incomplete Complusory: ✗ All trusts	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.
Assessment:	The Annual Report confirms that the Trust adheres to national guidance on severance payments, including the requirement for Treasury approval for special severance payments. However, it does not explicitly state that discussions with the NHS England regional director occur at the earliest opportunity.
Report addition:	Covered by addition to Section E, 2.4
Section E, 2.7	**Remuneration committee sets pay for executives and monitors senior management remuneration, as defined by the board.**
Complete Complusory: ✗ All trusts	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.
Assessment:	The Trust fully meets the criterion. The Remuneration Committees-in-Common have clear delegated authority to set and monitor remuneration for executive directors and senior management. The governance structure is well-defined, and the use of national benchmarking tools ensures consistency and fairness.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.1 **Complete** Complusory: ✓ All trusts	**Board must ensure effectiveness, efficiency, and quality, address partnership opportunities, and report on sustainability risks and governance in the annual report.** The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy. **Assessment:** A Group governance model with aligned structures between NLAG and HUTH supports integrated decision-making. This includes joint boards, shared performance frameworks, and coordinated committee workplans. The Audit, Risk and Governance Committee-in-Common evaluates internal controls, oversees the internal audit plan, and monitors implementation of audit recommendations. These activities directly support delivery and compliance. Board evaluation and development are built into an annual cycle, with formal reviews under the NHS “Well-led” Framework, and alignment with the Code of Governance for Foundation Trusts. The Integrated Performance Report (IPR) provides ongoing oversight of strategic delivery, supported by a Scheme of Delegation and metrics to monitor accountabilities. Clinical governance is underpinned by a structured chain of accountability from the Group Chief Nurse and Group Chief Medical Officer through to divisional and site-level leadership. The trust meets the criterion effectively. It has clearly articulated governance arrangements that are embedded within a dual-trust group model. There is comprehensive evidence of risk management integration, strategy alignment, and systematic board oversight across operational and strategic priorities.
Section A, 2.3 **Complete** Complusory: ✓ All trusts	**Board must assess and monitor culture, ensure alignment with trust values, take corrective action, and report workforce wellbeing initiatives in the annual report.** The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust’s vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board’s activities and any action taken, and the trust’s approach to investing in, rewarding and promoting the wellbeing of its workforce. **Assessment:** The annual report meets the criterion comprehensively. It explains the board’s structure, evaluations, and actions clearly. The trust outlines a robust and evidence-based approach to workforce investment, reward, and wellbeing—supported by formal strategies, performance indicators, and structured engagement mechanisms.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.8	**Annual report should describe stakeholder engagement, list key partnerships, and explain governance of collaboration and risk management.**
Complete Complusory: ✓ All trusts	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.
Assessment:	The annual report meets the criterion thoroughly. It provides robust evidence that the board integrates stakeholder interests in decision-making, has entered key regional and system-level collaborations, maintains effective engagement mechanisms, and oversees those partnerships through formal governance and risk management systems.
Section B, 2.13	**Responsibilities of the chair, CEO, SID, board, and committees should be clearly defined, agreed, and published.**
Complete Complusory: ✗ All trusts	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.
Assessment:	This confirms that the Trust meets the governance requirement for transparency and clarity in leadership roles and committee responsibilities.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.13	**State the number of board and committee meetings and each director's attendance in the annual report.**
Complete Complusory: ✓ All trusts	The annual report should give the number of times the board and its committees met, and individual director attendance.
Assessment:	The annual report fully meets the criterion. It: States the number of Board and committee meetings held Discloses individual attendance for every director at each relevant meeting, including: Trust Board Audit, Risk and Governance Committee-in-Common This satisfies the full requirement under the NHS Foundation Trust Code of Governance.
Section B, 2.17	**Annual report should explain the roles of governors, how disputes are resolved, and how decision-making is structured.**
Complete Complusory: ✓ FTs only	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.
Assessment:	The annual report meets this criterion. While it does not provide a formal "schedule of matters" table, it clearly describes the roles and responsibilities of the Council of Governors, outlines the approach to dispute resolution, and provides a summary of the governance structure and decision-making distribution across the Board, CoG, committees, and executives.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.6	**Identify independent non-executive directors in the annual report and justify their independence if any potential conflicts exist.**
Missing Complusory: ✓ All trusts	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: has been an employee of the trust within the last two years has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme has close family ties with any of the trust's advisers, directors or senior employees holds cross-directorships or has significant links with other directors through involvement with other companies or bodies has served on the trust board for more than six years from the date of their first appointment is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.
Assessment:	The annual report does not provide a clear statement identifying which Non-Executive Directors (NEDs) the board considers to be independent, nor does it address any circumstances that might impair or appear to impair their independence.
Report addition:	In accordance with the Code of Governance, the Board of Directors has reviewed Non-Executive Directors' continued service and their registered interests, and considers them to remain independent due to their consistent objectivity, lack of operational involvement, and continued constructive challenge.
Section C, 2.5	**Name any external consultants in the annual report, along with any links to the trust or directors.**
Incomplete Complusory: ✓ FTs only	If an external consultancy (for Board recruitment) is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
Assessment:	No explicit reference.
Report addition:	The Trust did not engage any external consultants for Board recruitment in the reporting period.

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.8	**Annual report must describe how governors appoint the chair and non-executives and outline the nominations committee's role.**
Complete Complusory: ✓ FTs only	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.
Assessment:	The Annual Report provides a clear and comprehensive description of the process followed by the Council of Governors (CoG) to appoint the Chair and Non-Executive Directors (NEDs). It confirms that the CoG has an Appointments and Remuneration Committee (ARC) responsible for these appointments and outlines the committee's remit and activities. The narrative is assessed as Complete. The Trust demonstrates full compliance with the requirement to describe the process for appointing the Chair and NEDs. The Annual Report outlines the structure, responsibilities, and activities of the Appointments and Remuneration Committee, including its role in reviewing appointments, remuneration, and reappointments. The narrative is transparent and well-documented. While the report references the ARC's terms of reference, it would be helpful to include a direct link or appendix reference to where these are published online. Consider including a summary of any changes or improvements made to the appointment process during the reporting year.
Section C, 2.9	**Governors must be re-elected at least every three years with performance and biography shared for informed voting.**
Complete Complusory: ✗ FTs only	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that elected governors are subject to re-election at intervals not exceeding three years and that biographical and performance information is provided to support informed voting. The Trust meets the requirement for regular re-election of governors and provides sufficient information to support transparency and accountability. The election process is clearly documented, and governors' performance is monitored and reported. The report could be strengthened by explicitly stating that biographical details and prior performance information (e.g. attendance, engagement) are shared with members during the election process. Including a sample or summary of the election materials (e.g. candidate statements) would enhance assurance that members are equipped to make informed decisions.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.13 **Incomplete** Complusory: ✓ All trusts	**Annual report must explain the nominations process, board evaluation, succession planning, diversity policy, and board demographics.** The annual report should describe the work of the nominations committee(s), including: the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served the gender balance of senior management and their direct reports. **Assessment:** To fully meet the Code of Governance, the trust should: Include a summary of the board's ethnic composition and how it compares to the workforce and community. Provide a succession planning narrative that explicitly links to diversity goals. Confirm the timing and provider of the next externally facilitated Well-led review, and disclose any connections. **Report addition:** Appropriate wording under development for inclusion
Section C, 4.2 **Complete** Complusory: ✗ All trusts	**Board must publish statements on its balance and suitability, and post these on the website.** Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website. **Assessment:** The Trust is compliant with this criterion. The Annual Report includes a clear statement from the Board affirming the appropriateness of its composition and governance arrangements, and this information is also made available on the Trust's website. The Trust has made a clear and formal statement regarding the appropriateness of the Board's composition and governance arrangements. This is supported by detailed disclosures in the Annual Report and supplemented by information available on the Trust's website, meeting the expectations of the NHS Code of Governance. The report could be enhanced by including a direct quote or boxed statement from the Board summarising its view on balance and appropriateness, to make the declaration more prominent. A hyperlink or specific reference to the exact location of the statement on the Trust's website would improve accessibility and transparency.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.2	**Include in the annual report a description of each director's skills, expertise, and experience.**
Could enhance	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
Complusory: ✓	
All trusts	
Assessment:	The Annual Report 2024/25 does not include a dedicated section that provides a description of each director's individual skills, expertise, and experience. It refers to details available on the trust's website. This approach partially meets the NHS Foundation Trust Code of Governance requirement. However, to fully comply, the annual report should include a brief summary of each director's background, qualifications, and relevant experience directly within the report itself.
Report addition:	To consider a short synopsis in future editions
Section C, 4.7	**Trusts should undergo external Well-led reviews every 3–5 years. Reviewers and any trust links must be reported.**
Could enhance	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.
Complusory: ✓	
All trusts	
Assessment:	Probably worth adding a statement to the effect that a Well-led review will be conducted during 2025-26.
Report addition:	A Well-led review will be conducted during 2025-26.
Section C, 4.9	**Governors who fail to attend or have serious conflicts may be removed, using a fair and shared policy.**
Complete	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.
Complusory: ✗	
FTs only	
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that a clear and fair policy exists for the removal of governors who fail to attend meetings or have conflicts of interest, and that this policy is shared with governors. The Trust has adopted and communicated a clear and fair process for the removal of governors who do not fulfil their duties. This includes non-attendance and conflicts of interest. The process is embedded in the Trust's governance framework and is supported by transparent reporting of attendance. The report could be enhanced by referencing the specific section of the Trust Constitution where the removal policy is detailed. Including a brief summary of how the policy has been applied (if at all) during the reporting year would provide additional assurance.

requirement	
Reference, coverage and assessment	**Disclosure and assessment**
Section C, 5.15 **Complete** Complusory: ✓ FTs only	**Governors must gather public and member views on the trust's plans and report how this was done in the annual report.** Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
Assessment:	The NLAG Annual Report 2024/25 confirms that the Council of Governors (CoG) has fulfilled its statutory duty to canvass the views of members and the public on the trust's forward plan, including its objectives, priorities, and strategy, and to communicate those views to the Board of Directors.
Section C, 5.7 **Complete** Complusory: ✗ FTs only	**Board and governors must receive timely, relevant info. Governors need updates on ICS plans affecting the trust.** The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that both the Board of Directors and the Council of Governors are provided with timely, relevant, and high-quality information, including updates on Integrated Care System (ICS) plans and decisions that affect the Trust and its patients. The Trust has established effective mechanisms to ensure that both the Board and Council of Governors receive timely and relevant information. This includes updates on ICS plans and decisions that impact the Trust and its patients. The Trust's approach aligns with statutory guidance and supports informed oversight and engagement. The report could be strengthened by explicitly referencing the NHS England document Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors and how its requirements are operationalised. Including a summary of how governors' feedback on ICS matters has influenced Trust decisions would enhance transparency.

Reference, coverage and assessment	Disclosure and assessment
Section D, 2.4	**Annual report must address key audit issues, auditor independence, and details on audit function and non-audit services.**
Complete Complusory: ✓ All trusts	The annual report should include: the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.
Assessment:	The Trust demonstrates full compliance with the audit-related disclosure requirements. The Annual Report outlines the ARG CiC's responsibilities and activities, including oversight of financial reporting, internal and external audit, and auditor independence. The report provides clarity on auditor tenure, appointment process, and safeguards for independence, with no non-audit services reported.
Section D, 2.6	**Directors must confirm the annual report is fair, balanced, and understandable, reflecting performance and strategy.**
Complete Complusory: ✓ All trusts	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
Assessment:	The Trust meets the requirement to explain the directors' responsibility for preparing the annual report and accounts. The report includes a clear and formal declaration that the report is fair, balanced and understandable, and provides the necessary information for stakeholders to assess the Trust's performance, business model and strategy.
Section D, 2.7	**Board must assess and report on principal risks, following reporting manual guidance.**
Complete Complusory: ✓ All trusts	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
Assessment:	The Trust demonstrates full compliance with Criterion. The Annual Report provides a detailed and structured overview of the Board's approach to identifying, assessing, and managing both emerging and principal risks. The integration of risk oversight into governance structures and the use of formal frameworks such as the BAF and Risk Register provide strong assurance of effective risk management.

Reference, coverage and assessment	Disclosure and assessment
Section D, 2.8 **Complete** Complusory: ✓ All trusts	**Board must monitor and annually review internal controls and report on their effectiveness in the governance statement.** The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.
Assessment:	The Trust demonstrates compliance with Criterion. The Annual Report outlines a robust and systematic approach to monitoring and reviewing internal controls and risk management. The inclusion of the Annual Governance Statement, supported by internal and external audit functions, provides strong assurance that the Board is fulfilling its responsibilities in this area.
Section D, 2.9 **Complete** Complusory: ✓ All trusts	**Board must confirm if going concern accounting is appropriate and explain any material uncertainties.** In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.
Assessment:	The Trust is compliant with Criterion. The Annual Report includes a clear and unambiguous statement on the going concern basis of accounting, supported by appropriate governance oversight and in line with national reporting guidance. The absence of material uncertainties further reinforces the Trust's financial and operational stability.
Section E, 2.3 **Complete** Complusory: ✓ All trusts	**Annual report should disclose if directors retain earnings from external roles.** Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.
Assessment:	Whilst there is no explicit statement in the remuneration report or elsewhere in the Annual Report that addresses whether any executive director who exited the Trust during the year retained earnings from subsequent appointments, the report lists all directors who left the Trust in 2024/25 (e.g., Lee Bond, Shaun Stacey, Stuart Hall) and provides their remuneration up to the point of departure. It includes detailed tables of salary, pension, and benefits for all directors, including those who exited. It confirms that no bonuses were paid and that exit packages were disclosed where applicable.

Section E, 2.6	**Board must establish a remuneration committee of at least three independent non-executives, with terms publicly available.**
Could enhance Complusory: ✗ All trusts	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.
Assessment:	The Trust fully meets the structural and governance expectations for its remuneration committee. It is composed of independent NEDs, has a clearly defined remit, and includes HR advisory input. The only minor omission is the lack of a statement regarding the use (or non-use) of external remuneration consultants and any potential conflicts of interest.
Report addition:	remuneration

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC (25) 096

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 June 2025**
Director Lead	**Helen Wright and Gill Ponder, Chairs of CIC**
Contact Officer / Author	**Helen Wright and Gill Ponder, Chairs of CIC**
Title of Report	Capital and Major Projects CIC Highlight Report
Executive Summary	This report sets out the items of business considered by the Capital and Major Projects Committees-in-Common at their meeting(s) held on Tuesday 22 April 2025 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC also had a time out session to review its Terms of Reference and workplan. **The Boards in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the proposed change of name of the CIC and approve the updated Terms of Reference.
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:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	Thursday 12 June 2025
Report from:	Capital and Major Projects Committees in Common
Report from meeting(s) held on:	22 April 2025
Quoracy requirements met:	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 (CIC) at their meeting(s) held on 22 April 2025 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:

22 April 2025

- Board Assurance Framework
- Estates Risk Register Review
- Time out session – Terms of Reference review
- Digital Strategy 2025 - 2028

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) Estates Risk Register – The CIC received the risk register and commended the grip and management of the risks. There had been £9.7m backlog maintenance funding received which would be used for critical infrastructure upgrade programmes.

b) Digital Strategy – The strategy was presented to the CIC. The CIC agreed that digital transformation could facilitate significant improvements in productivity but that this requires a collaborative approach and should be aligned across strategic plans. The Digital Hospital was covered, alongside EPR and AI, however getting the basics right and having the right tools to do the job is a priority (e.g. server and hardware replacements and systems/equipment that are reliable and just work). The committee

was once again advised that the Group cannot fully account for its digital spend and assets due to systems being delivered outside of the digital directorate. It was acknowledged that this is a well known issue and consensus was that this should be addressed as a priority by the Executive team to reduce the strategic, financial, cyber-security and operational risks associated. The Chair agreed to write to the Acting Chief Executive to recommend that the group prioritises centralising the management of its digital systems.

c) It was recognized that success of the Digital strategy is dependent on data quality. A review of Data and Business Intelligence would be carried out within a year of the Strategy commencing.

d) The CIC also asked that the save to invest strategy be added, and a list of other dependencies such as key skills within the team. The CIC endorsed the Digital Strategy for approval at the Board subject to alignment and collective ownership of the ambitious productivity target.

c)The CIC discussed its Terms of Reference and proposed to change the name of the CIC to the Strategic Programmes and Partnerships CIC, as this would highlight the partnerships element and focus on major strategic programmes. It was agreed that the operational/performance capital issues would be covered by Performance, Estates and Finance CIC and the major capital schemes would continue to be scrutinised at the Strategic Programmes and Partnerships CIC. The frequency of the committee was also discussed and it may be more appropriate to move to Quarterly given the strategic nature of the content. This will be evaluated across the next few meetings. The Boards in Common are asked to review and approve this change.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business: Digital Strategy – the correlation between the digital strategy and availability of funding to ensure that the strategy is deliverable within the current financial envelope.

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 Digital and Capital BAF risks were presented to the CIC and there were no proposed changes to either of the risk ratings. The Digital BAF risk to be discussed with the Group Chief Digital Officer to review the risk in line with the new Digital strategy.

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.

Helen Wright, Chair of the Committees in Common

Gill Ponder, Chair of the Committees in Common

22 April 2025

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Front Sheet
Trust Boards in Common

Meeting name	Trust Boards in Common BIC (25) 097
Meeting date	12 June 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Board Assurance Framework (BAF)
Executive Summary	The following report highlights the Q3 current risks and scores: 1. Group Culture and Leadership – 20 2. Performance – 20 3. Patients – 20 4. Research and Innovation – 12 5. Partnerships – 12 6. Digital – 16 7. Capital – 15 8. Financial Sustainability – 16

These Committees is invited to consider the risk score factors.

There are actions underway addressing all of the BAF risks. For all Group risks, both individually and in combination more generally for all strategic risks, robust management and oversight is required to preserve and nurture the Group's reputation and credibility for patients and broader stakeholders.

The risk appetite levels agreed by the Boards-in-Common are now included in this report as a prompt. No proposed changes to risk appetites were deemed necessary.

Each CiC receives a quarterly update on the BAF for review and approval, the last round being February 2025. The next round of discussions will inform the June quarter.

Recommendations:

The Trust Boards in Common are asked to:

- Note and review the BAF risks
- Note that the risks have been reviewed by the Executive Team and the Committees-in-Common

Background information and/or Supporting Document(s) (if applicable)	All BAF risks have been updated following discussion between the Executive Team and the Group Director of Assurance.	
Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each Committees-in-Common, with final receipt and approval agreed at the Board.	
Implications for equality, diversity and inclusion, including health inequalities	No immediate EDI Concerns	
Financial implication(s)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group	
Recommended action(s) required	☑ Approval ☐ Discussion ☐ Assurance	☑ Information ☐ Review ☐ Other

Board Assurance Framework

NHS
Humber Health
Partnership

Purpose of the report

The purpose of the report is to update the Committee regarding the Group's strategic culture and leadership risk. The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

Overleaf, a table summarises the current assessment for the finance risk:

- The risk description;
- The risk owner/s;
- The current risk score (and whether a change from the previous report);
- The target score (the maximum acceptable);
- The optimum score; and
- The risk appetite category.

The subsequent pages additionally set out, by each risk (over three pages each):

#1

- The strategic risk description;
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information) with a circle indicated for each of the risk scores; current, tolerable and target.

#2

- The controls and assurances and their respective gaps

#3

- The actions being taken to mitigate the current gaps;
- An estimated completion date; and
- The lead officers involved.

Summary

NHS Humber Health Partnership

The following table summarises the 8 strategic risks facing the Group and the key aspects including their current score with current mitigations towards the target score. There are 5 risks scoring 15 or over. The risks coloured red indicate those risks scoring above the maximum score set by the appetite score.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk
1	Staff support	WEC	We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to improve our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will not improve.	Simon Nearney, Group Chief People Officer	20		4/30/2025	Balanced	12	8
2	Performance	PEF	We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.	Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South	20	0	1/24/2025	Open	16	4
3	Patients	QS	We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.	Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse	20		5/1/2025	Cautious	9	4
4	Research and innovation	QS	We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts.	Kate Wood, Group Chief Medical Officer	12		5/1/2025	Balanced	12	4
5	Partnerships	CAMP	We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward-facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.	Jonathan Lofthouse, Group Chief Executive, Ivan McConnell, Group Chief Strategy & Partnerships Officer	12		4/28/2025	Balanced	12	4
6	Digital	CAMP	We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.	Kate Wood, Group Chief Medical Officer	12	-4	4/22/2025	Open	9	6
7	Capital	CAMP	We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources for equipment, (including medical, digital and estates,) and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands, access issues for our patients and not deliver transformational change for the benefit of our patients.	Emma Sayner, Group Chief Financial Officer	15		10/23/2024	Open	9	4
8	Financial sustainability	PEF	We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.	Emma Sayner, Group Chief Financial Officer	16	-4	2/4/2025	Open	15	9

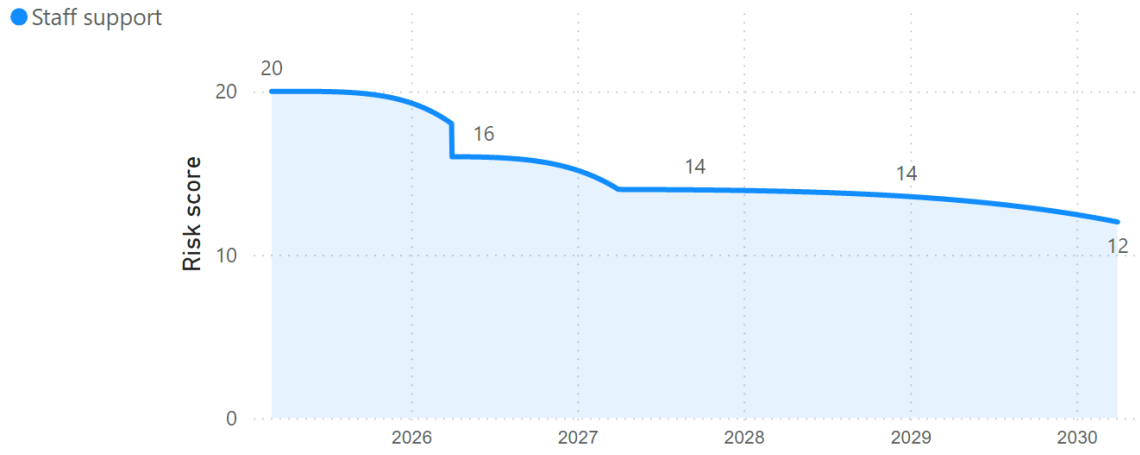
1. Staff support

The strategic risk affecting our objective, 'Supporting our teams today and embedding a positive Group culture and leadership' is led by Simon Nearney, Group Chief People Officer and reported to the Workforce, Education and Culture Committees-in-Common. Under the risk category of Staff support, the risk's current score is 20 and its score last changed on 30/04/2025. The actions were last reviewed on 30 April 2025. In full, the risk is:

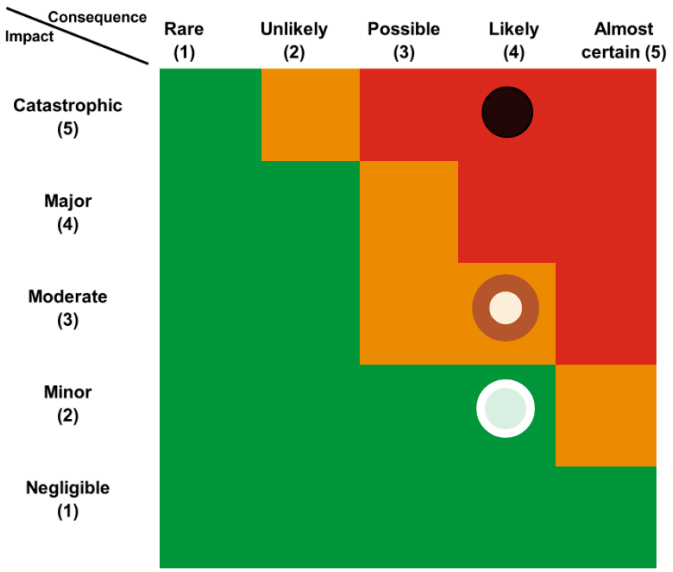
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to improve our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will not improve.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Tolerable score = 12 (L:4, C:3)

Optimal score = 8 (L:4, C:2)

Risk appetite statement (Balanced)

Our staff are the most important ingredient to deliver safe and effective care to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.

1. Staff support

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Annual Care Group Workforce plans
Care Group Performance and Accountability
CESR Programme
Cultural transformation programme
EDI Steering Group
E-Rostering for clinical staff
Group Leadership Strategy (in development)
Group People Strategy 2025-28
Group Senior Management Team (was EMC) will receive escalation reports from the Group Workforce Transformation Committee
HR Directors Chairs meeting (NHS Employers)
International recruitment drives
Medical Workforce Strategy 2025-28
Required Learning Steering Group
Talent management team for international recruitment
Workforce Transformation Committee

Gaps in control (and Action ID)	5	6	7	8	38	Total
Hard to recruit roles in medical specialities	1	1	1			3
Healthcare Assistant issues and high turnover	1	1				2
Management and Leadership consistency in delivering the People Promise to staff				1	1	2
Sufficient attraction, to recruit and retain staff to work in the area	1	1	1	1		4
Total	**3**	**3**	**2**	**2**	**1**	**11**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
⊟ **External**
Staff survey and quarterly pulse surveys
Workforce Report to HNY and Care Partnership ICB Workforce Board
Workforce Report to Pay and Agency meetings
WRES / WDES reports
⊟ **Internal**
Bi-annual Safer Staffing Report
Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee
Integrated Performance Report

Assurance gaps (and Action ID)	5	6	7	Total
Consultant vacancy position		1	1	2
Frequent culture and staff experience measures			1	1
Plans to address ageing workforce profile	1			1
Total	**1**	**1**	**2**	**4**

1. Staff support

The table below details the 4 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
6	Recruitment drives using the Group name to attract high calibre candidates	31/03/26	01/04/26	Focus currently on medical, adminstration and HCAs (where volume issues)	30/04/25	Simon Nearney, Group Chief People Officer	True
7	Cultural Transformation action plan development	31/03/26	01/04/30	Some work will be iterative over the year.	29/01/25	Simon Nearney, Group Chief People Officer	True
8	Group Leadership network and training programme - November 2024	30/12/25	01/04/27	New leadership programme for the Group will be launched end date.	29/01/25	Simon Nearney, Group Chief People Officer	True
38	Launched Group Well-being platform	28/02/25	01/04/26	Went live with platform - now responding to requests from staff accessing the offer	29/01/25	Simon Nearney, Group Chief People Officer	True

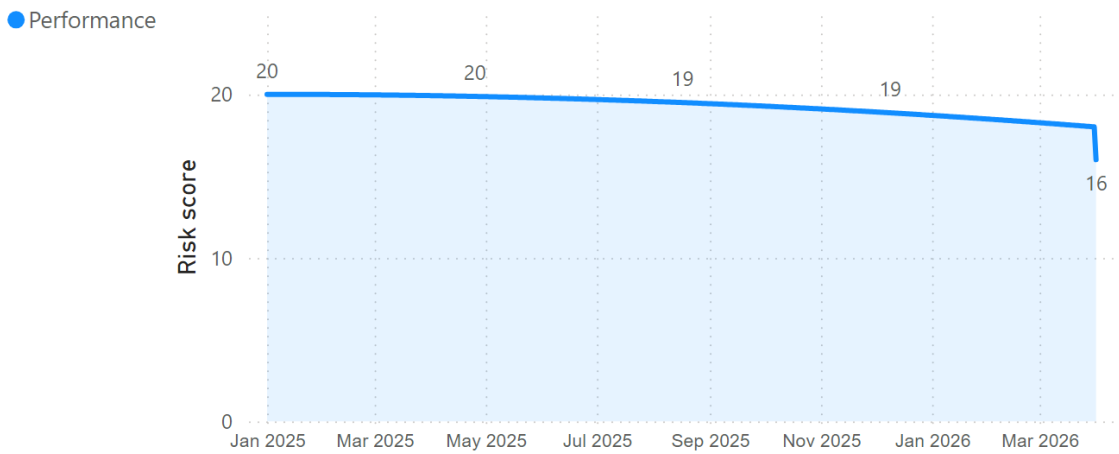
2. Performance

The strategic risk affecting our objective, 'Achieving upper quartile performance' is led by Clive Walsh, Interim Site Chief Executive - North and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Performance, the risk's current score is 20 and its score last changed on 24/01/2025. The actions were last reviewed on 24 January 2025. In full, the risk is:

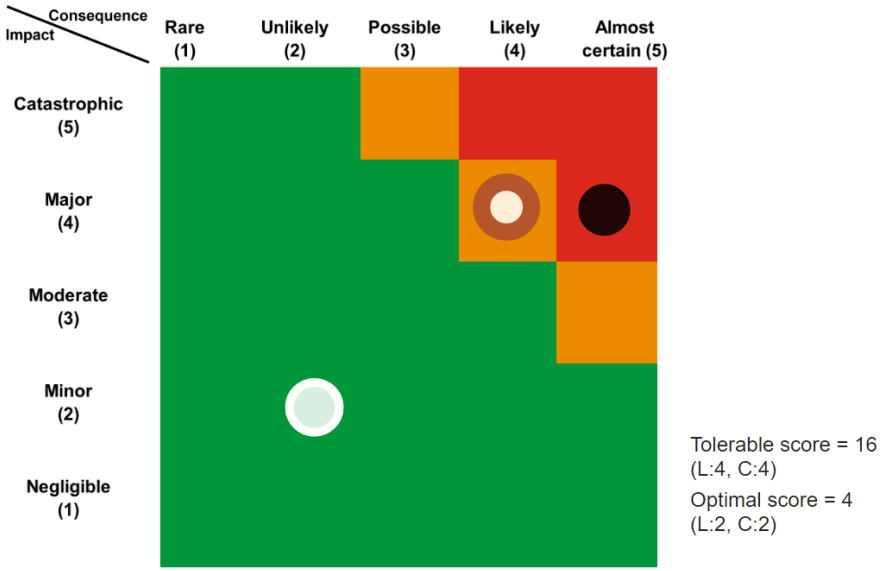
We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Tolerable score = 16 (L:4, C:4)

Optimal score = 4 (L:2, C:2)

Risk appetite statement (Open)

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

2. Performance

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Care Group Performance and Accountability
Financial Planning Improvement Board
Flow programme
Planned Care Board
Unplanned Care Board

Gaps in control (and Action ID)	21	28	31	37	41	Total
Data quality issues in supporting metrics			1			1
Lack of timely / realtime performance reporting (eg weekly dashboard)					1	1
Lack of trajectory setting to support robust performance management		1				1
Unresolvable gap between national expectations / targets and available finance, degrading or overriding control				1		1
Weak culture of improvement/change management	1			1		2
Total	**1**	**1**	**1**	**2**	**1**	**6**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
External
Acute Provider collaboration reports
GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients
NHS tiering arrangements and support or freedoms
Internal
2025-26 Operational Plan Assurance Statement
Integrated Performance Report
Planned Care Board reporting to Performance, Estates & Finance CiC
Unplanned Care Board reporting to Performance, Estates & Finance CiC

Assurance gaps (and Action ID)	20	31	42	Total
Absence of a comprehensive demand and capacity (bed) model that supports scenario analysis and planning	1			1
Absence of routine data quality monitoring and patient record validation		1	1	2
Total	**1**	**1**	**1**	**3**

2. Performance

NHS Humber Health Partnership

The table below details the 7 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
20	Strategic Bed Review (based on optimum LoS)	31/12/24	01/04/26	Deep dive LOS and bed work in progress report presented to PEF on 4/3/25. PA Consulting to undertake a bed utilisation review (ahead of developing in-house modelling capacity)	04/03/25	Ivan McConnell, Group Chief Strategy & Partnerships Officer, Clive Walsh, Interim Site Chief Executive - North, Adam Creeggan, Group Director of Performance	True
37	Developing skills and capability of Care Group leadership to tackle day-to-day challenges and lead on effective transformation programmes, intra-Care Group and cross-sites	31/03/26	01/04/26	Need to align financial incentives to help focus transformational mindset		Simon Nearney, Group Chief People Officer, Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South	True
21	Embed QI Methodology		01/04/26			Ivan McConnell, Group Chief Strategy & Partnerships Officer, Amanda Stanford, Group Chief Nurse	False
28	Work being monitored via South and North Site Reviews (SS, OA2 - expected impacts from key actions in UEC improvement plan to KPIs (four hour performance, Doctor 1 Seen time, ambulance handover)and NS OA6 - FDS for cancers		01/04/26			Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South	False
31	Standing up revised organisational data quality governance		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	False
41	Delivery of BI investment		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	False
42	External PTL validation exercise (using AI) to help cleanse PTL and ensure future booking capacity is optimised		01/04/26		04/03/25	Adam Creeggan, Group Director of Performance	False

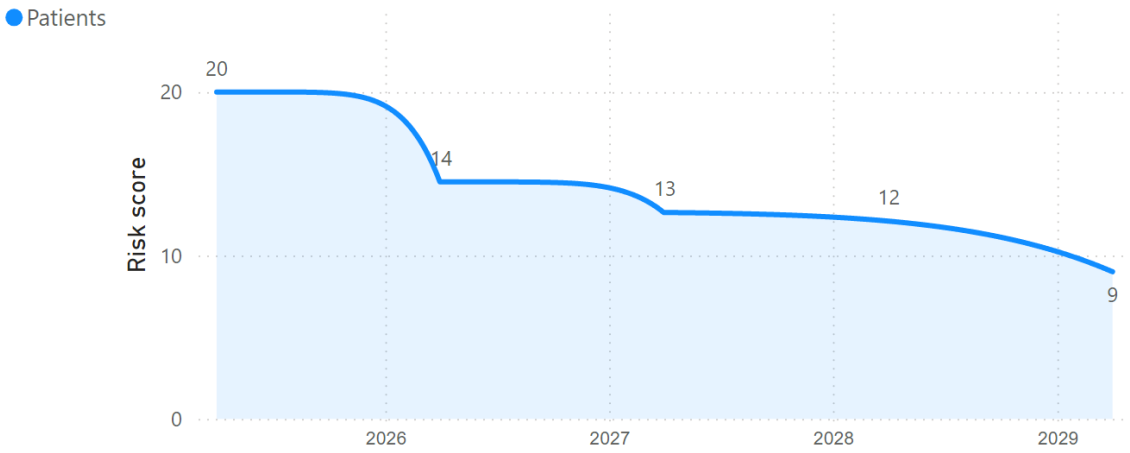
3. Patients

The strategic risk affecting our objective, 'Listening to our patients and keeping them safe' is led by Amanda Stanford, Group Chief Nurse and reported to the Quality and Safety Committees-in-Common. Under the risk category of Patients, the risk's current score is 20 and its score last changed on 01/05/2025. The actions were last reviewed on 04 February 2025. In full, the risk is:

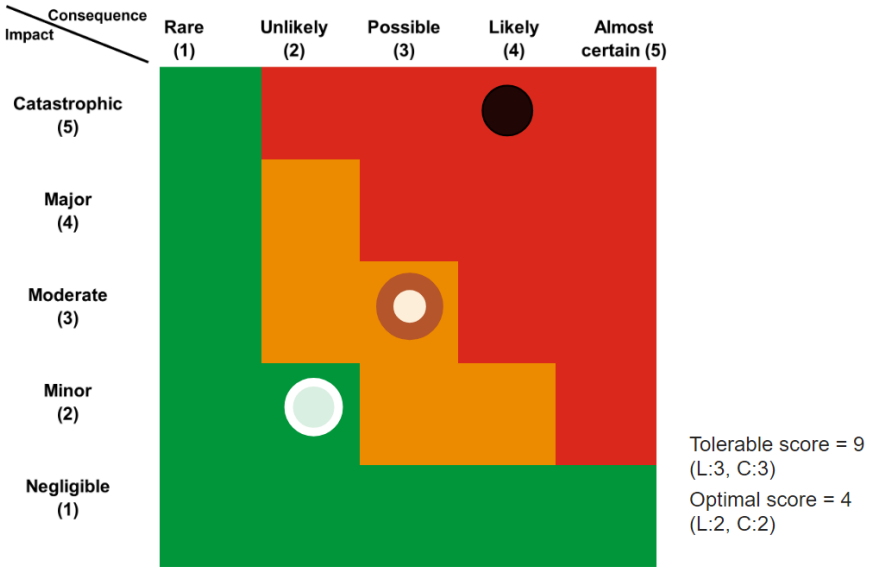
We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Cautious). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Tolerable score = 9 (L:3, C:3)

Optimal score = 4 (L:2, C:2)

Risk appetite statement (Cautious)

Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.

3. Patients

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Accreditation Frameworks
Care Group Performance and Accountability
Continuous Professional Development for all health professionals and mapped to Quality Priorities
Freedom to Speak Up Guardian
Incident Reporting culture
Infection Control Committee
Maternity and Neonatal Assurance Group
Mortality Improvement Group
National Best Practice for Audits
National NICE Guidance
Patient Experience and Learning
Patient Safety and Learning Group
Peer Review Process
Quality and Safety Strategy
Risk and Compliance Group
Safe Staffing Models
Statutory and Mandatory Training
Strategic Safeguarding Board

Gaps in control (and Action ID)	12	13	14	15	30	52	Total
Absence of Group Clinical Strategy					1		1
Comprehensive safety culture	1	1		1			3
Data quality issues in supporting metrics	1						1
Fully safe staffing levels (North)		1					1
Lack of consistent basic hygiene compliance				1			1
Lack of involvement in national quality audits						1	1
Robust EQIA process			1				1
Strong speak up and reporting culture				1			1
Total	**2**	**2**	**1**	**3**	**1**	**1**	**10**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
External
External agency visit and inspection reports
GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients
National Patient Survey
Internal
Bi-annual Safer Staffing Report
Clinical audit outcomes
Complaint levels
CQC Action Plan
Friends and Family Test reporting
Incident reporting
Integrated Performance Report
Maternity Neonatal Dashboard
Ouputs from QI Programme
Risk Management metrics
Statutory and mandatory compliance levels
Ward accreditation metrics

Assurance gaps (and Action ID)	12	13	15	Total
Poor regulatory status	1	1		2
PSIRF Processes not fully embedded	1		1	2
Total	**2**	**1**	**1**	**4**

3. Patients

NHS Humber Health Partnership

The table below details the 7 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
11	Develop and publish Risk Management strategy	01/05/25	31/03/26	Draft anticipated during May 2025	01/05/25	Amanda Stanford, Group Chief Nurse	True
12	Develop and publish Quality and Safety Strategy	01/06/25	31/03/26	2nd draft to Q&S 29/4/25, 1st draft to Q&S 27 March 2025. Final draft to be circulated to Patient Safety and Learning Group and stakeholders.	01/05/25	Amanda Stanford, Group Chief Nurse	True
14	Embed EQIA process (outlined in six-month finance report for 2024-25)	01/04/25	31/03/26	Process agreed. Need to ensure PMO deliver EQIAs ultimately to Q&S on quarterly basis	24/10/24	Emma Sayner, Group Chief Financial Officer, Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse	True
15	Develop and embed the Ward Accreditation programme	31/03/25	01/04/29	250 people to trained to date. SOPs agreed. Peer reviews set for next six months. Next iteration of reporting based on new programme. Action complete	04/02/25	Amanda Stanford, Group Chief Nurse	True
39	CQC preparations for Care Groups	30/09/25	01/04/29		04/02/25	Amanda Stanford, Group Chief Nurse	True
52	Developing and implementing a robust clinical audit programme	31/03/26	31/03/27	Programme developed, now in process of implementation	01/05/25	Kate Wood, Group Chief Medical Officer	True
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/06/25		1st Draft to NMB end of Jan	04/02/25	Amanda Stanford, Group Chief Nurse	False

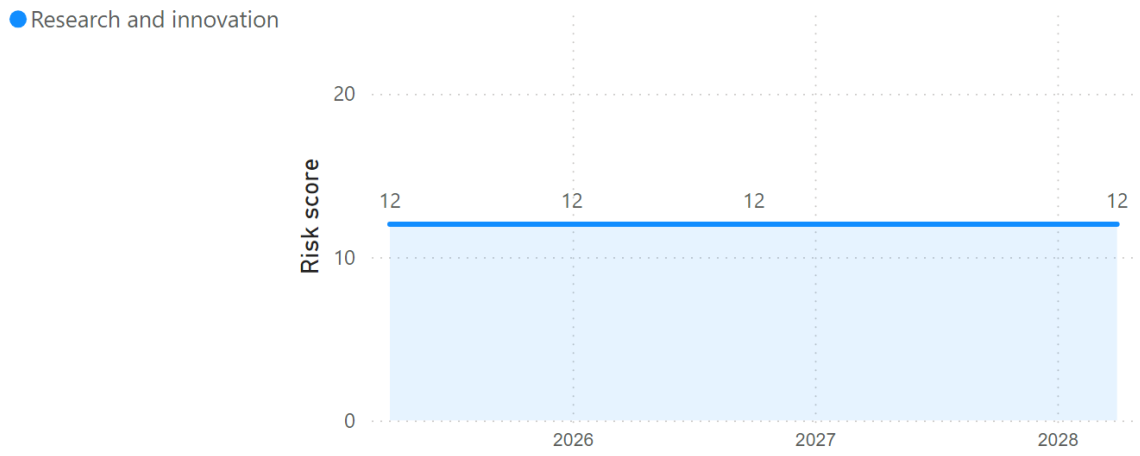
4. Research and innovation

The strategic risk affecting our objective, 'Developing research and innovation capabilities' is led by Kate Wood, Group Chief Medical Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Research and innovation, the risk's current score is 12 and its score last changed on 01/05/2025. The actions were last reviewed on 01 May 2025. In full, the risk is:

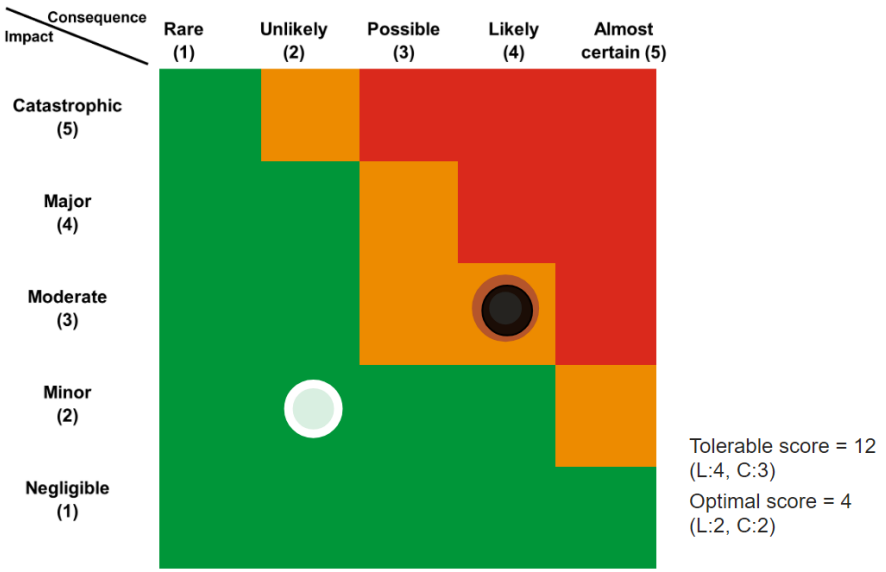
We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Balanced)

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

4. Research and innovation

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Available research service capacity eg labs
Business cases for investment / disinvestment decisions
Financial clarity over existing research resources
Innovation infrastructure
Protected time
Research and innovation strategy
Research Committee
Senior research team

Gaps in control (and Action ID)	29	Total
Lack of compelling research and innovation strategy	1	**1**
Lack of extensive collaboration and credibility	1	**1**
Lack of innovation infrastructure	1	**1**
Total	**3**	**3**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
⊟ **External**
External agency visit and inspection reports

Assurance gaps (and Action ID)	29	Total
Lack of available protected time for research and skilled resources to develop innovation	1	**1**
Total	**1**	**1**

4. Research and innovation

The table below details the 1 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
29	Develop and publish research and innovation strategy	31/03/25	31/03/28	Feb T100 received consultation draft. Agreed at Q&S in April 2025. Final publication format being produced	18/02/25	Kate Wood, Group Chief Medical Officer	True

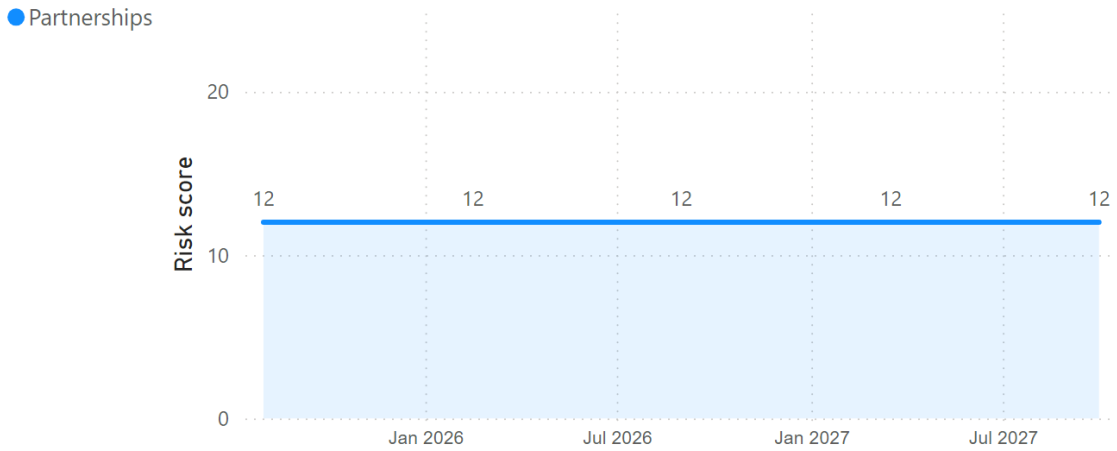
5. Partnerships

The strategic risk affecting our objective, 'Playing an active role in our health and care system' is led by Ivan McConnell, Group Chief Strategy & Partnerships Officer and reported to the Capital and Major Projects Committees-in-Common. Under the risk category of Partnerships, the risk's current score is 12 and its score last changed on 28/04/2025. The actions were last reviewed on 28 April 2025. In full, the risk is:

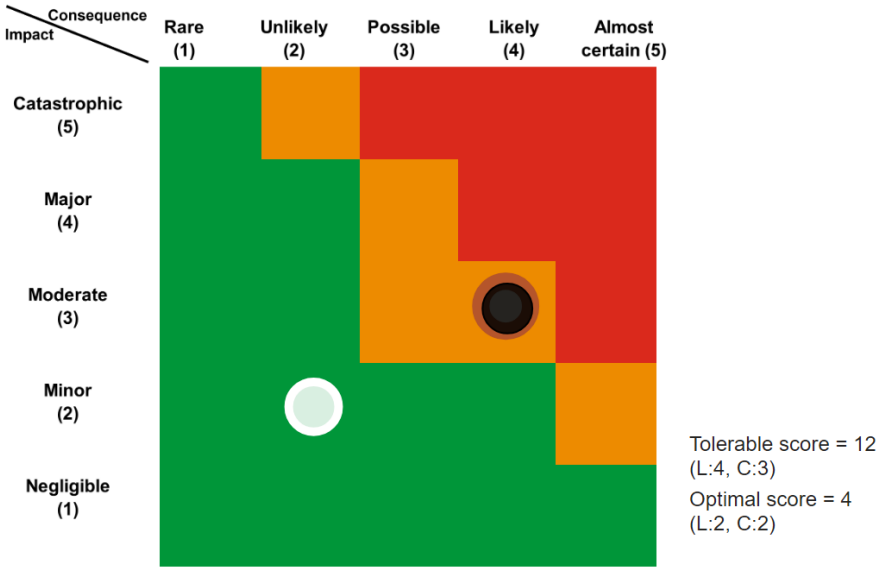
We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward-facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Balanced)

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

5. Partnerships

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Goole service review
Humber and North Yorkshire Collaboration of Acute Providers
Integrated Care Board
Place Boards

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	1	1
Lack of continuous leadership plus inconsistent engagement across region	1	1
Total	**2**	**2**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
⊟ **External**
Establishment of operational CDC (vs strategic build) and financial delivery through PFIB
Positive Task and finish participation from Place Boards

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	1	1
Weak partnership approach embedded in Group strategies	1	1
Total	**2**	**2**

5. Partnerships

The table below details the 1 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
32	Develop and publish partnership strategy	31/07/25	30/09/27	On course for completion	28/04/25	Ivan McConnell, Group Chief Strategy & Partnerships Officer	True

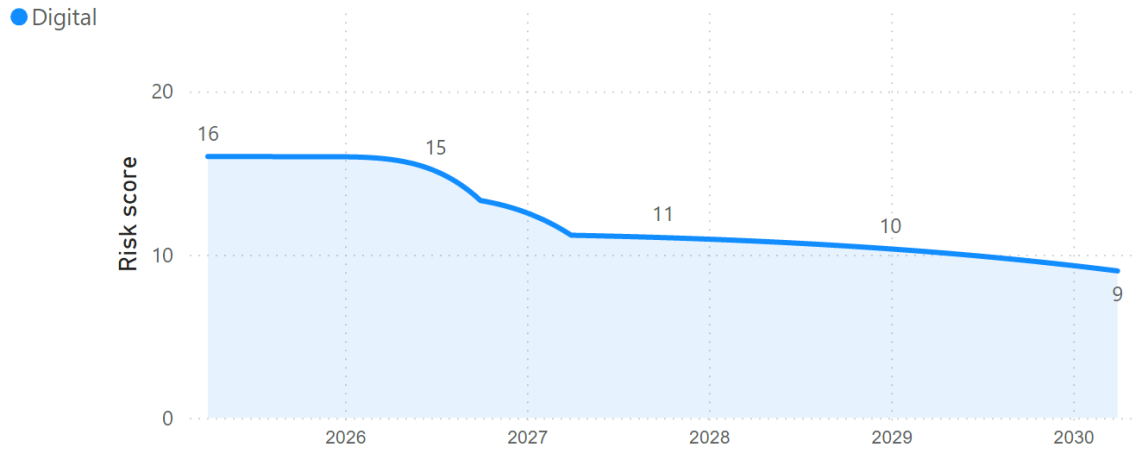
6. Digital

The strategic risk affecting our objective, 'Developing our digital infrastructure' is led by Kate Wood, Group Chief Medical Officer and reported to the Capital and Major Projects Committees-in-Common. Under the risk category of Digital, the risk's current score is 12 and its score last changed on 22/04/2025. The actions were last reviewed on 22 April 2025. In full, the risk is:

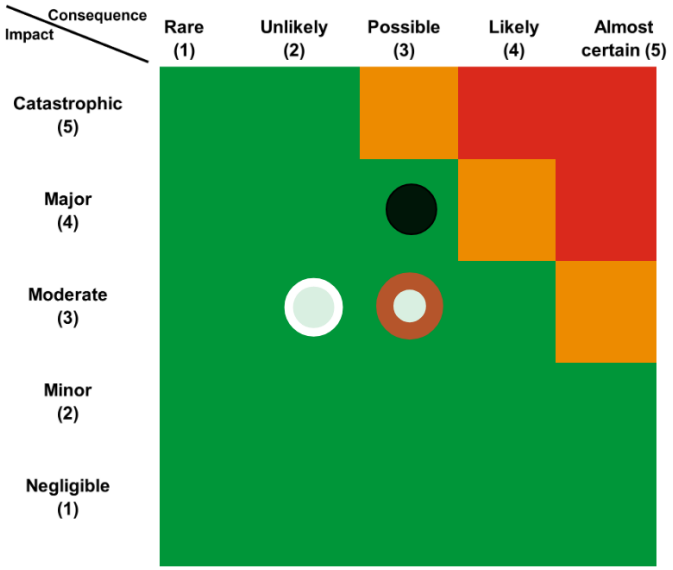
We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Tolerable score = 9 (L:3, C:3)

Optimal score = 6 (L:2, C:3)

Risk appetite statement (Open)

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

6. Digital

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Digital governance group
Digital Strategy
Financial management education for directors and budget holders
Financial Strategy
ICB Digital Governance
Long term Financial Model
Outline EPR Business case
Supplementary business cases eg DrDoctor, Electronic Document Management System

Gaps in control (and Action ID)	25	44	45	Total
Lack of comprehensive digital asset register			1	**1**
Lack of comprehensive oversight of all digital investment and management	1	1	1	**3**
Weak commercial and contractual grip and control	1			**1**
Total	**2**	**1**	**2**	**5**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
⊟ **Internal**
Self-assessment of CAF

Assurance gaps (and Action ID)	25	26	Total
Gaps in financial tracking and funding	1		**1**
Lack of technical expertise from the Board		1	**1**
Total	**1**	**1**	**2**

6. Digital

The table below details the 3 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
25	Produce and publish Digital Strategy - covering governance, staffing, resourcing, and engagement necessary to achieve objectives	31/03/25	31/03/30	Feb T100 received consultation draft Going to Board in May-25	22/04/25	Kate Wood, Group Chief Medical Officer, Andy Haywood, Group Chief Digital Officer	True
44	Digital Foundations Business case	30/11/25	30/09/26	financial profile piece	22/04/25	Andy Haywood, Group Chief Digital Officer	True
45	Centralisation of digital resource, governance and oversight, including a single group-wide asset register	31/03/26	31/03/27		23/04/25	Andy Haywood, Group Chief Digital Officer	True

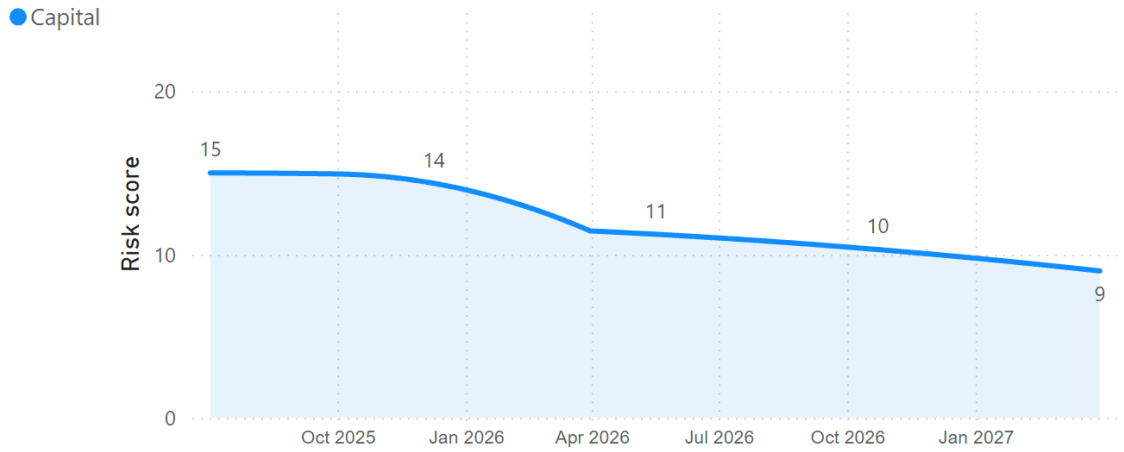
7. Capital

The strategic risk affecting our objective, 'Using major capital effectively' is led by Emma Sayner, Group Chief Financial Officer and reported to the Capital and Major Projects Committees-in-Common. Under the risk category of Capital, the risk's current score is 15 and its score last changed on 23/10/2024. The actions were last reviewed on 23 April 2025. In full, the risk is:

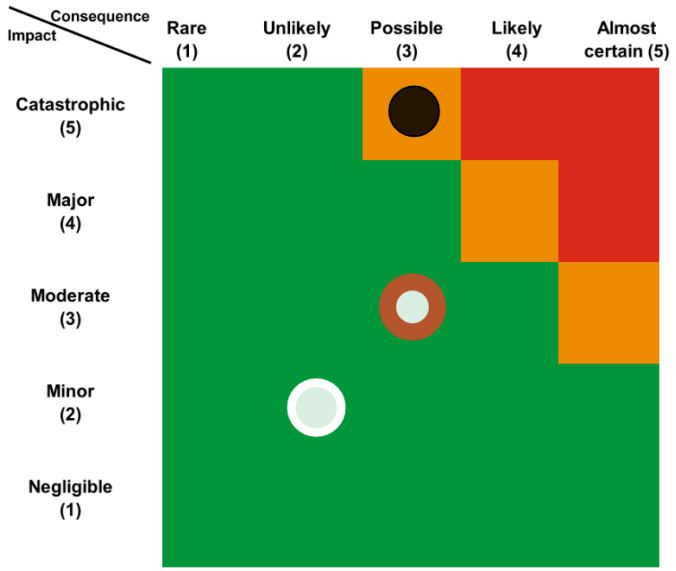
We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources for equipment, (including medical, digital and estates,) and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands, access issues for our patients and not deliver transformational change for the benefit of our patients.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Tolerable score = 9 (L:3, C:3)

Optimal score = 4 (L:2, C:2)

Risk appetite statement (Open)

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

7. Capital

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Business case review group
Business cases for investment / disinvestment decisions
Effective E&F governance structures
Effective management of operational estates risks
Estates 10 year Master Plan for Group
Financial management education for directors and budget holders
Financial Strategy
Long term Financial Model
Qualified and accreditated engineers
Regulatory frameworks

Gaps in control (and Action ID)	24	47	48	Total
Absence of comprehensive Estates Strategy / 10-year plan	1	1	1	**3**
Absence of Group Finance Strategy founded on clinical and estates strategies			1	**1**
Weak culture of improvement/change management		1		**1**
Total	**1**	**2**	**2**	**5**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
⊟ **External**
Compliance outcomes from regulators
⊟ **Internal**
Riddor performance
Status of operational estates risks and actions from risk register

Assurance gaps (and Action ID)	Total
Total	

7. Capital

The table below details the 3 actions underway to reduce the current risk score of 15. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
24	Develop Group estates strategy and 10-year Master Plan	01/07/25	31/03/27		23/04/25	Emma Sayner, Group Chief Financial Officer, Tom Myers, Group Director of Estates and Facilities	True
47	Establish and embed group wide understanding of estates utilisation and its contribution and alignment with the transformation programme	30/09/25	31/03/26		23/04/25	Emma Sayner, Group Chief Financial Officer, Tom Myers, Group Director of Estates and Facilities	True
48	Greater working on estates with system partners and exploration of alternative funding models	31/12/25	31/03/26		23/04/25	Emma Sayner, Group Chief Financial Officer, Tom Myers, Group Director of Estates and Facilities	False

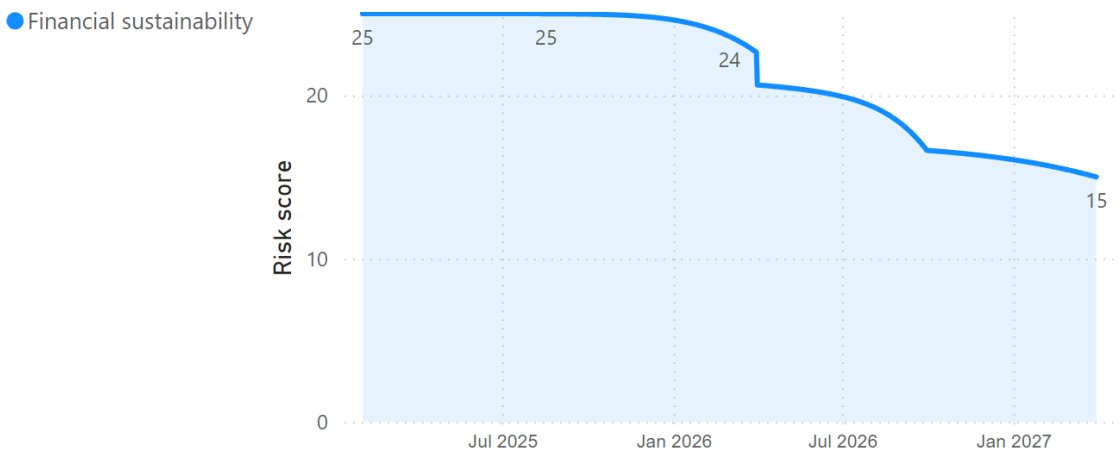
8. Financial sustainability

The strategic risk affecting our objective, 'Achieving financial sustainability' is led by Emma Sayner, Group Chief Financial Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Financial sustainability, the risk's current score is 16 and its score last changed on 04/02/2025. The actions were last reviewed on 23 April 2025. In full, the risk is:

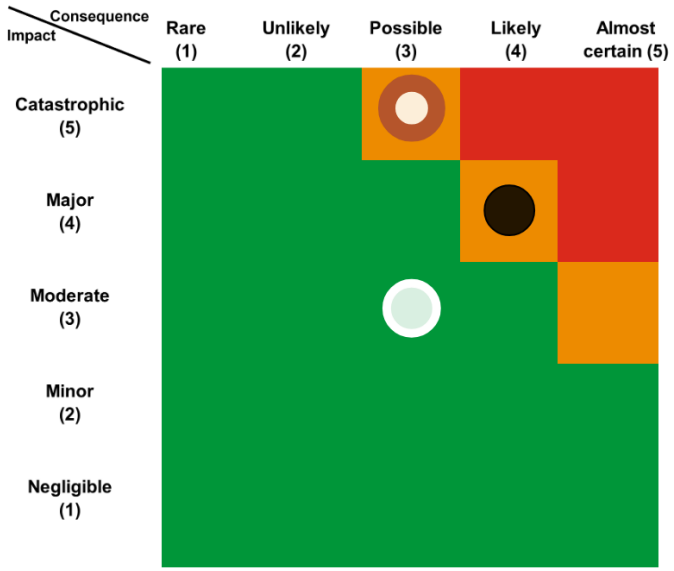
We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Tolerable score = 15 (L:3, C:5)

Optimal score = 9 (L:3, C:3)

Risk appetite statement (Open)

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

8. Financial sustainability

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control
Board capability and education
Budgetary control system
Business cases for investment / disinvestment decisions
Care Group Performance and Accountability
Cash management controls
Cost Improvement Programme
Financial management education for directors and budget holders
Financial Planning Improvement Board
Financial Strategy
High functioning Finance department advice and guidance
ICS finance model
Long term Financial Model

Gaps in control (and Action ID)	22	23	33	34	35	36	46	49	Total
Absence of Group Finance Strategy founded on clinical and estates strategies		1	1	1					3
Out of date Long Term Financial Model	1								1
Weak culture of improvement/change management					1	1	1	1	4
Total	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**8**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source and assurance
External
Internal audit review of key financial systems
Internal
2025-26 Operational Plan Assurance Statement
Budget control reports
Exception reporting on Standing Financial Instructions and Standing Orders compliance
In-year operational plan progress

Assurance gaps (and Action ID)	Total
Total	

8. Financial sustainability

NHS Humber Health Partnership

The table below details the 7 actions underway to reduce the current risk score of 16. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Update date	Action owner/s	Primary action
22	Develop a five-year long term financial model	30/06/25	31/03/27	Linked to Finance strategy development	23/04/25	Emma Sayner, Group Chief Financial Officer	True
23	Develop a comprehensive finance strategy	30/06/25	31/03/26	Underlying position drafted but complete Finance strategy to be developed at end of Q1 (from 31/3/25). Statement to May 25 PEF on update being prepared	23/04/25	Emma Sayner, Group Chief Financial Officer	True
33	Business Case Review Group	31/01/25	30/09/26	Started w/c 20/1/25	23/04/25	Emma Sayner, Group Chief Financial Officer	True
36	Develop a positive challenge culture within Finance e.g. to query why we do things and where we need value	31/03/26	30/09/26		23/04/25	Emma Sayner, Group Chief Financial Officer	True
46	Embedding a transformation plan / product with an external learning focus	31/03/26	01/04/26	to refresh each year	23/04/25	Ivan McConnell, Group Chief Strategy & Partnerships Officer, Emma Sayner, Group Chief Financial Officer, Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South	True
35	Utilise the Care Group Performance and Accountability Groups to focus and deliver on transformation	31/03/26	31/03/26		23/04/25	Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South	False
49	Establish Group PMO approach with specialised transformation programme and resources	30/06/25	31/03/26		22/04/25	Ivan McConnell, Group Chief Strategy & Partnerships Officer	False

Board Assurance Framework
Next steps and recommendations

Next steps

Audit, Risk and Governance Committees-in-Common received a detailed presentation on 24 April 2025 on the status and actions being taken to strengthen the Group's risk management system. This included a proposed format for future risk reporting to the Board (in support of the BAF) and to CiCs. This will include the development of a commentary on the high-scoring Group-wide risks, for which the current high risks are illustrated opposite. The advent of the single group-wide risk register will support this development in future reporting.

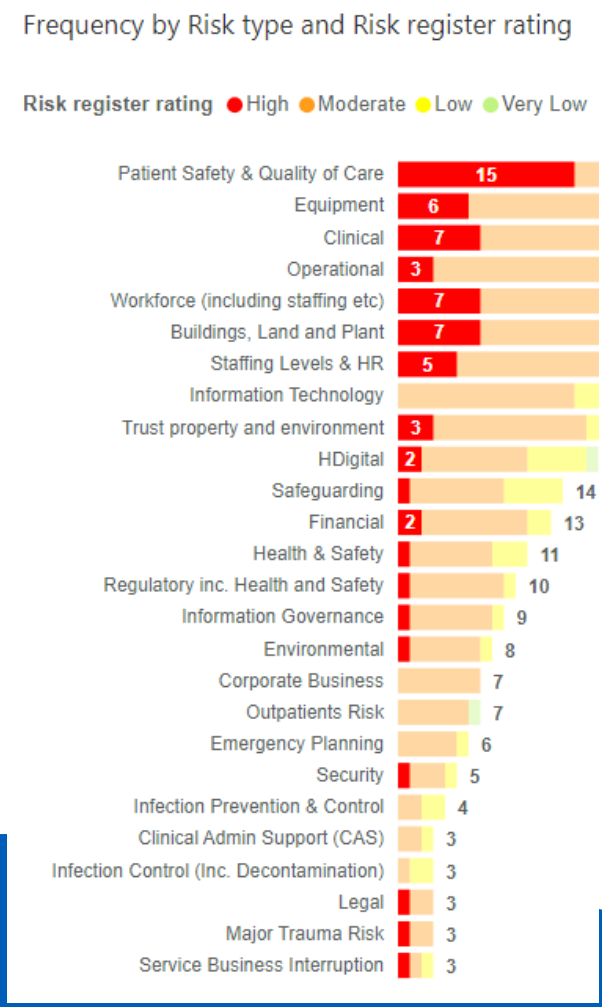
The management of the high-level risks will continue to be assessed through the Care Groups, corporate Directorates and the Risk and Compliance Group and the escalation processes in place. The Risk and Compliance Group will inform group-wide risks to the Group Risk and Assurance Committee before their adoption by corporate leads.

The Executive Team will continue to review their strategic risks between CICs and the Group Cabinet Risk and Assurance Committee will recommend any changes to risk ratings or BAF risks to the CICs. Final decisions will be made at the Boards-in-Common.

Recommendations

The Trust Boards in Common are asked to:

- Note and review the BAF risks
- Note that the risks have been reviewed by the Executive Team and the Committees-in-Common



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(25)099

Name of Meeting	Trust Boards-in-Common Public
Date of the Meeting	**Thursday 12th June 2025**
Director Lead	**Emma Sayner – Group Chief Financial Officer**
Contact Officer / Author	**Tom Myers – Group Director of Estates, Facilities & Development**
Title of Report	**Group Green Plan 2025 – 2028**
Executive Summary	the report outlines the group delivery plan and key areas of focus.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Estates Facilities and Development SMT 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
Humber Health
Partnership

GREEN PLAN 2025–2028

NET ZERO

OTHER FORMATS

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Email nlg-tr.comms@nhs.net

Write to Communications, Alderson House Hull Royal Infirmary, Hull, HU3 2JZ

CONTENTS

FOREWORD

Sustainability in healthcare is changing, and we have a significant part to play. Climate change is the greatest threat to human health in the 21st century, impacting everything from the types and numbers of cases we see to how and where we provide patient care. As healthcare providers, we have a responsibility to take action and lead by example in delivering care sustainably.

We must not lose sight of the imminent health emergency that climate change could bring, with more intense storms and floods, more frequent heat waves, and the wider spread of infectious diseases. Only the strongest and most determined response will impact on this, bringing with it direct improvements for public health and health equity.

As one of the UK's largest organisations, the NHS has a huge impact on our overall carbon footprint, producing 5.4% of the country's total carbon emissions. That's the equivalent the greenhouse gas emissions of 11 coal-fired power stations.

Our goal is to be recognised as the leading NHS organisation in the country in our journey to achieving both net zero emissions and fostering climate resilience. We will focus on delivering future models of healthcare that are more sustainable and have a lower impact on the world around us. We will work towards rapid decarbonisation of our services and ways of working, foster greater resilience and adaptation in our buildings and service models and enable an inclusive transition that reduces inequalities and leaves no one and nowhere behind.

Sustainability in healthcare is changing, and we have a significant part to play.

Collaboration is essential to delivering these goals and supporting sustainable and inclusive growth in the Humber. Partnership working with academic institutions and research organisations will allow us to access research funding to support further understanding of the impacts of climate change and actions we can take to reduce our effects on the environment. Partnerships with local industry and leaders in the renewable energy sector will ensure we continue to be at the forefront of NHS organisations in our carbon reduction and delivery of Net Zero.

Closer to home, the Humber is one of the coastal regions around the world officially listed at high risk due to rising sea levels and increasing flood threat.

The XDI Gross Domestic Climate Risk Report, published in 2024, lists Lincolnshire as one of the two UK regions at highest risk from climate change and with 90% of Hull standing below the high-tide line, the devastating floods of 2007 are a sign of things to come, should we choose to do nothing?

From every perspective, the case is compelling. We cannot retreat from climate change, and doing all we can to reduce it will need to be embedded into everything we do.

Amanda Stanford, Acting Chief Executive

NHS HUMBER HEALTH PARTNERSHIP OVERVIEW

Our Group is one of the largest in the NHS, with a budget of over £1.6 billion employing more than 19,000 staff. Our vision is: United by Compassion, Driving for Excellence.

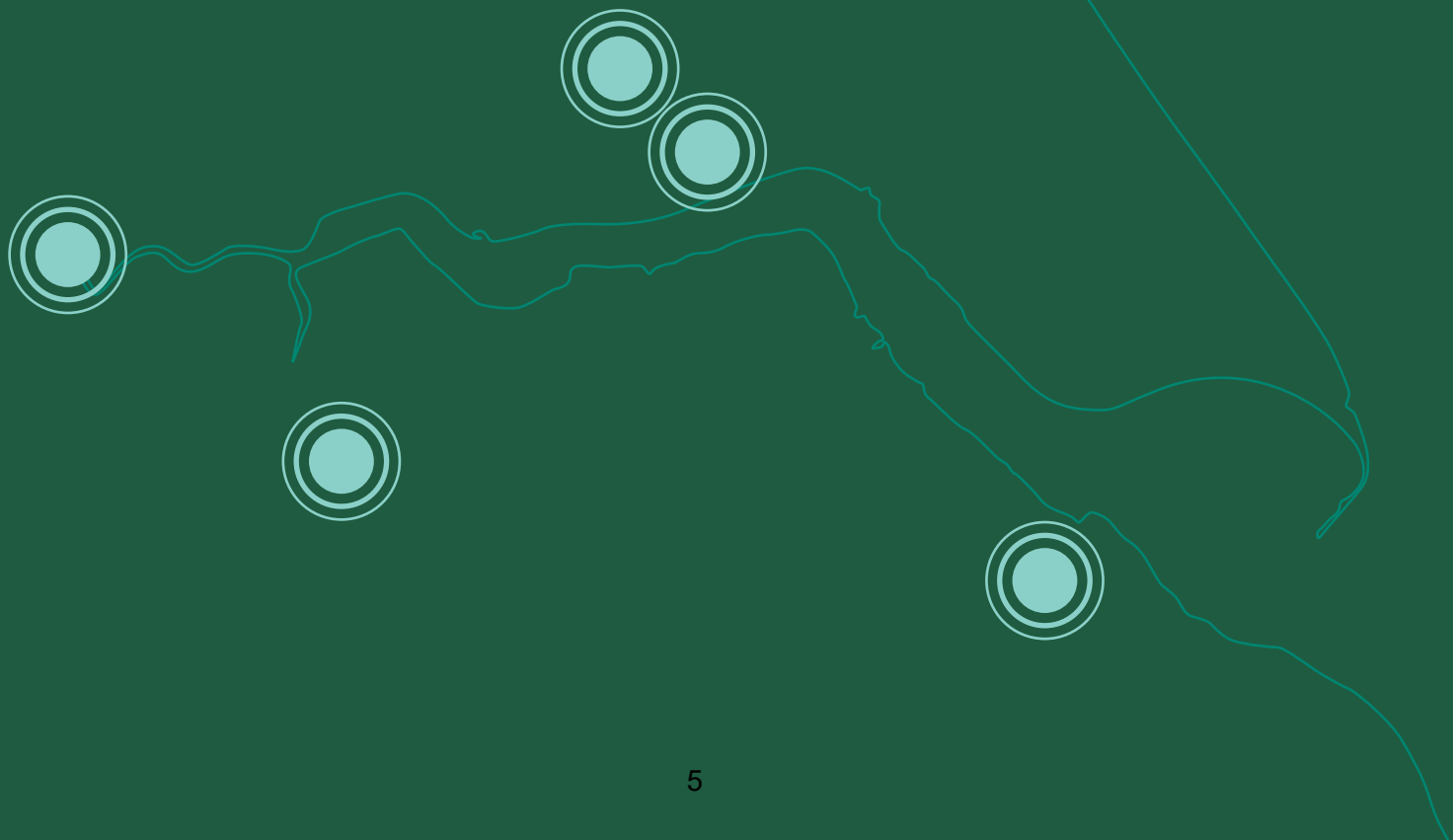
Made up of two Trusts - Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) – we're committed to delivering world-class services for the 1.65 million people we serve.

Our five main hospital sites are Castle Hill Hospital, Diana, Princess of Wales Hospital, Goole and District Hospital, Hull Royal Infirmary, and Scunthorpe General Hospital. We deliver a wide range of community services across North and North East Lincolnshire, including district nursing, physiotherapy, occupational therapy, psychology, podiatry and specialist dental services.

We see well over a million patients every year with just under 300,000 attendances at our emergency departments, more than 300,000 hospital admissions and more than a million outpatient appointments. We deliver around 8,200 babies each year and our community services provide vital healthcare to patients in their own homes.

As Teaching Hospitals working with the Hull York Medical School, we are a UK leader in research and innovation.

We've also been recognised for our work in supporting veterans, newly qualified nurses and our international recruitment programme.



THE TRUST STRATEGY

OUR TRUST VALUES

COMPASSION | HONESTY | RESPECT | TEAMWORK

THE FOUR PILLARS


EQUITY


PARTNERSHIPS


INNOVATION


CARE

Our Trust strategic Framework sets out a number of areas that support the goals within this green plan. Specific items are shown below but our work to deliver sustainable healthcare and move to net zero is embedded in everything we do.

Our work to build a digital hospital will not only improve the level and access to care we offer our patients but also reduce our emissions and financial costs.

We will play a part in local areas working with partner organisations, academic and industrial to advocate for our region. Supporting investment and the opportunity for the Yorkshire and Humber area to be seen as a global leader in net zero.

We will leverage our industry partnerships and expertise in carbon reduction and sustainability to ensure we are leading research and helping to define the future of sustainable healthcare.

We will forge new partnerships with industry – both local and further afield – to deliver our ambitious net-zero targets and play our role in driving economic regeneration on and around the Humber estuary.

To be a leader in sustainable healthcare and NetZero.

THE NATIONAL PICTURE

The NHS guidance sets out two targets for the reduction of emissions:

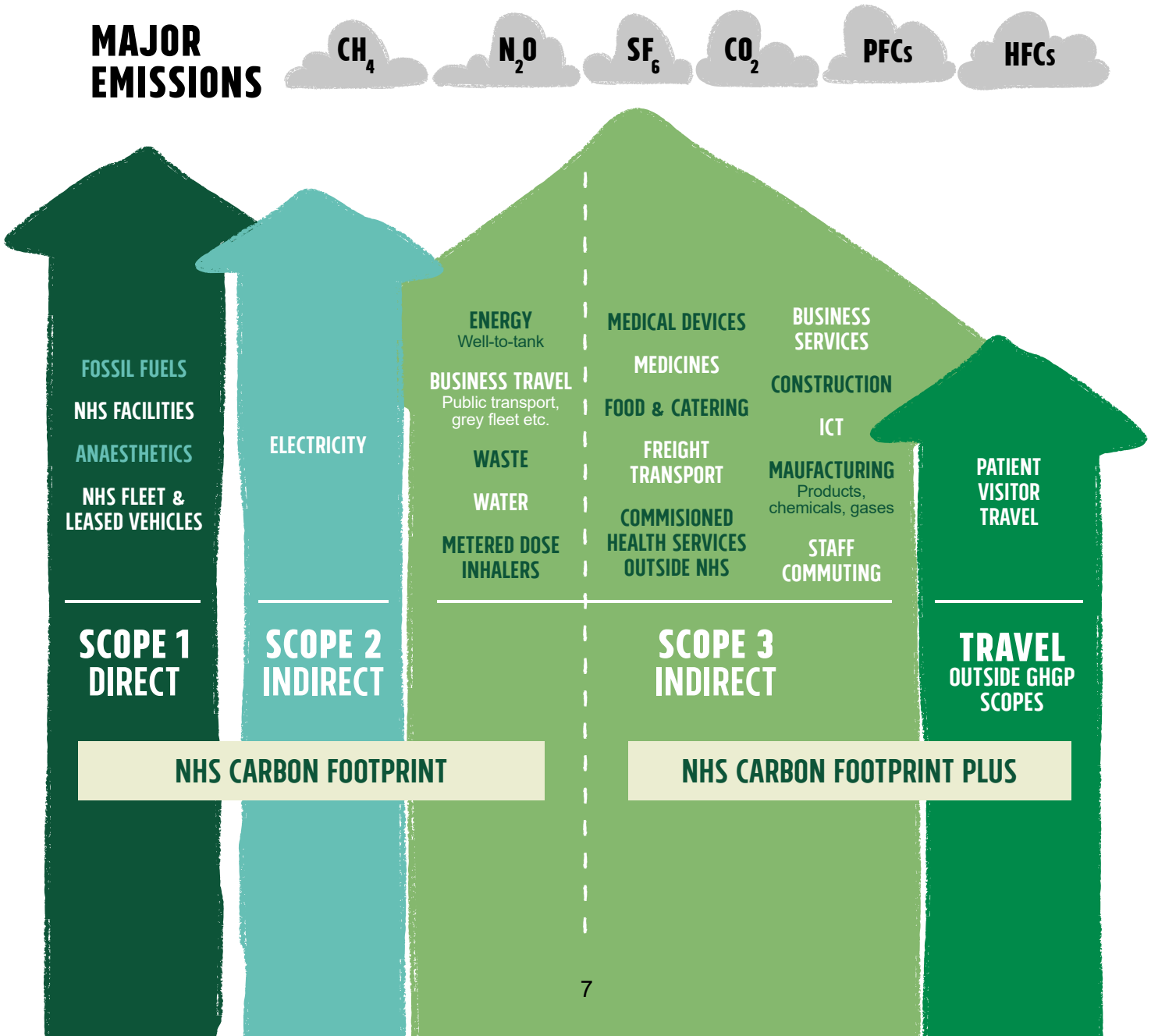
For the emissions we control directly (NHS Carbon Footprint), it's net zero by 2040, with an ambition to reach an **80% reduction between 2028 to 2032.**

For the emissions we can influence (NHS Carbon Footprint Plus), it's net zero by 2045, with an ambition to reach an **80% reduction between 2036 to 2039.**

Prioritising interventions that support world leading patient care and population health, and reduce inequalities.

Supporting NHS organisations to plan and make considered investments while increasing efficiencies and delivering value for taxpayers.

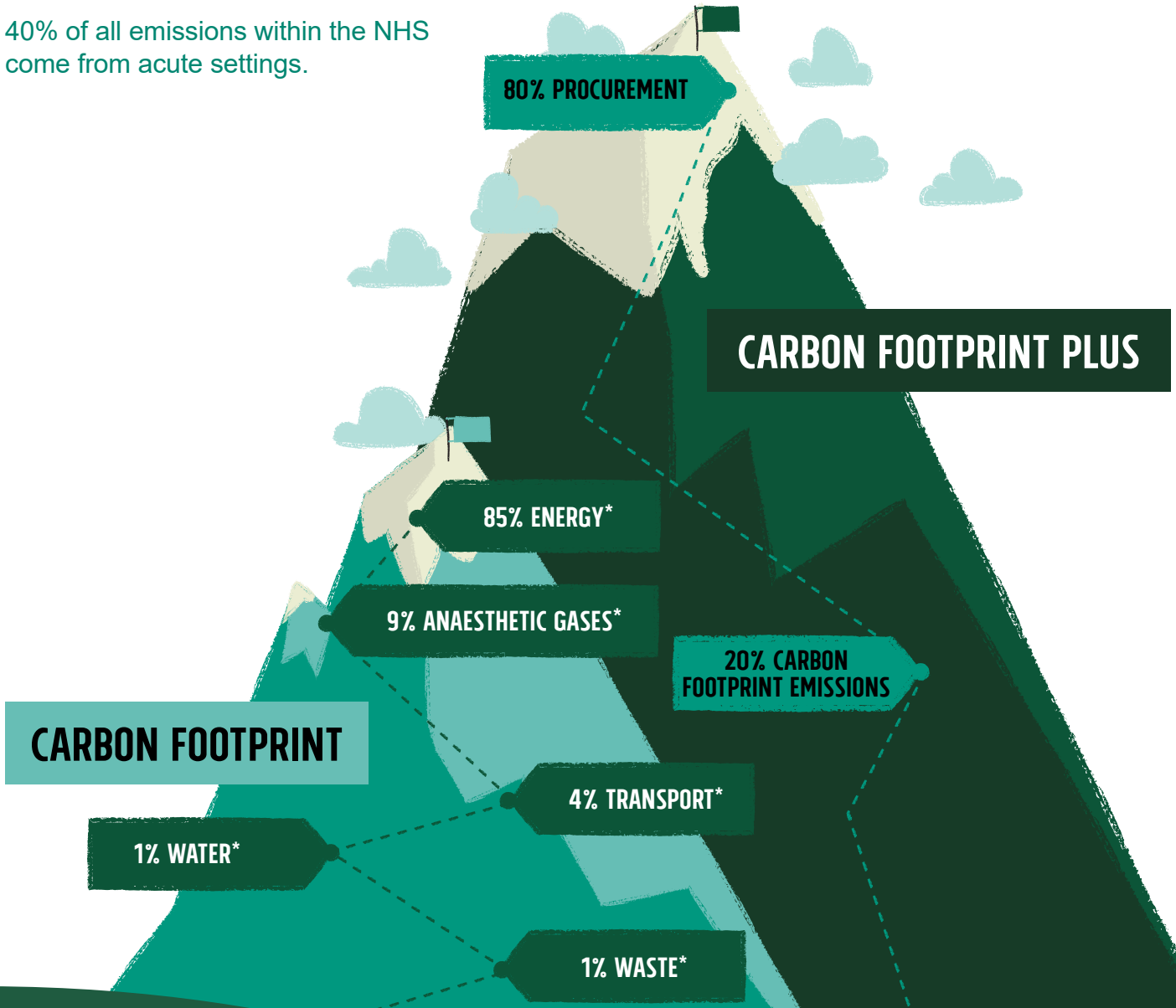
Ensuring every NHS organisation supports the ambition to reach net zero carbon emissions.



OUR CARBON EMISSIONS MOUNTAIN

The NHS has a target to achieve **80%** reduction by 2032.

40% of all emissions within the NHS come from acute settings.



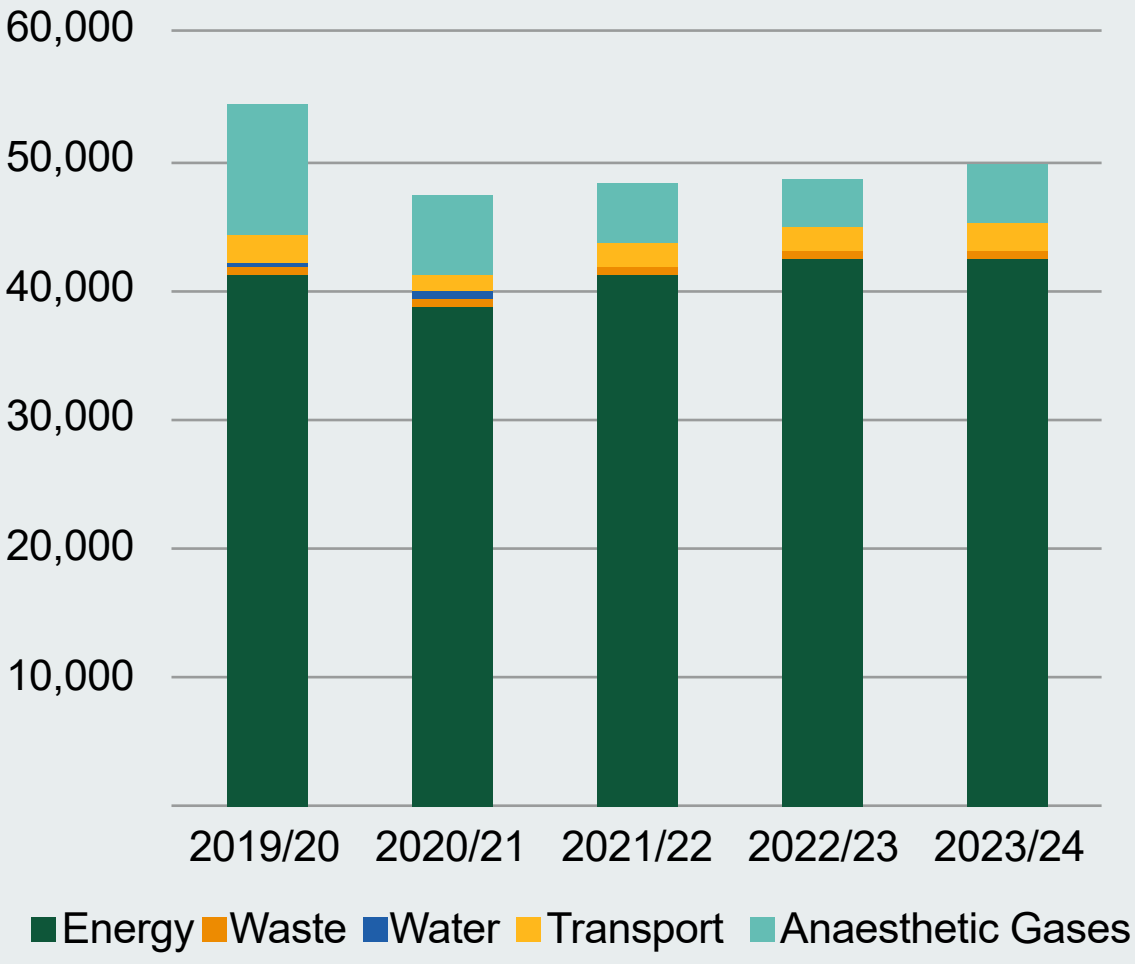
WHAT IT IS AND HOW WE'LL DO IT

Net Zero is the balance between the amount of carbon emissions produced and the amount removed from the atmosphere. We reach net zero when what we add is no more than what we take away.

As a trust we will seek to rapidly reduce our carbon emissions as much as possible. Where Net Zero cannot be achieved, we will offset this using carbon sequestration through rewilding or carbon capture on our own sites together with off site sources.

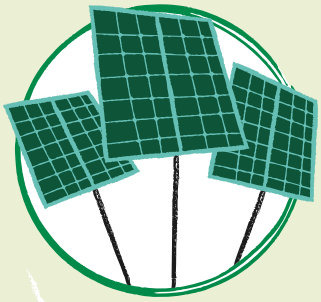
HUMBER HEALTH PARTNERSHIP EMISSIONS OVERVIEW

ENERGY CONSUMPTION	2019/20	2020/21	2021/22	2022/23	2023/24
Energy	41,248.23	38,984.87	41,388.53	42,681.33	42,745.75
Waste	648.14	553.61	485.81	478.90	455.52
Water	563.76	508.46	183.04	176.89	161.11
Transport	2,119.35	1,283.08	1,818.46	1,865.50	1,897.86
Anaesthetic Gases	9,877.65	5,808.52	4,236.50	3,295.30	4,338.67
TOTAL	54,457.12	47,138.54	48,112.34	48,497.92	49,598.91



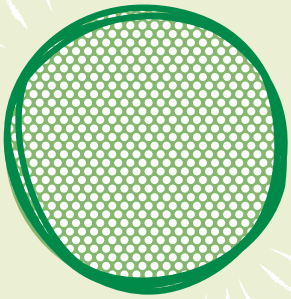
*Significant work has been completed to reduce energy emissions. The increases seen are due to new builds and expansion of combined heat and power plants

MAJOR ACHIEVEMENTS



PV SOLAR POWER

As a group we have almost 6 MW of solar PV installed with more on the way.



LEDs

100% of lights in the Group will be eco-friendly LEDs by the end of 2025.

NITROUS OXIDE REDUCTION REMOVAL OF DESFLURANE

56% reduction in emissions since 2019/20.

REMOVAL OF COAL BOILER

Coal fired boilers removed from Goole combined with other measures reduced emissions by 60%.

£68M OF EXTERNAL FUNDING FOR NET ZERO SECURED SINCE 2020

ASSURANCE AND GOVERNANCE

HOW WE DO IT

Build on the work already done as individual trusts and come together to make further improvements as a group.

Group sustainability committee established with membership from all group directorates and functions.

Evaluate sustainability impact of projects and policies

Ensure sustainability is included within business cases, services changes and board reports.

Collaborative working with partner organisations

HOW WE'LL MEASURE IT

Record the good work, progress, and examples already in place

Revise and review against net zero targets annually

"Given the global health imperatives, the NHS must stick to its net zero ambitions… Indeed often health and climate are mutually reinforcing goals"

LORD DARZI, 2024

WORKFORCE, NETWORKS AND LEADERSHIP

HOW WE DO IT

Net Zero Champions to offer direction and impetus from the start

Net Zero training for all staff

Additional Net Zero training for leaders and sustainability ambassadors

Regular Net Zero news and updates circulated to all staff

Encourage innovation and ideas which contribute to Net Zero goals

HOW WE'LL MEASURE IT

Training provision

Staff performance development review

Evaluation tools for Net Zero

HOW WE'VE DONE SO FAR...

Supported local University and schools

Shared best practice with SME's via Oh Yes Net zero

Supported National guidance documents

Sustainability delivers additional benefits of supporting economic growth, local jobs while improving patient care and supporting healthy communities.

DIGITAL TRANSFORMATION

HOW WE DO IT

Further encourage tele and video conferencing facilities

Reduce our use of paper and move to digital first processes

Purchase equipment with low power consumption

Host data in energy efficient data centres

Recycle ICT equipment

Establish a baseline for the ICT carbon footprint according to the guidelines set out in the published materials by the UK Government's Sustainable Technology Advice & Reporting (STAR)

Deploy powerdown software for equipment

HOW WE'LL MEASURE IT

Percentage of outpatient care delivered remotely

Percentage reduction in the use of paper

Revise and review against net zero targets

HOW WE'VE DONE SO FAR...

Implemented paperless systems for purchase requisitions and orders

NLAG awarded £5M as part of the digital Aspirant Programme to support ward boards and clinical monitoring systems

NET ZERO CLINICAL TRANSFORMATION

HOW WE DO IT

Reduce emissions while improving quality of care

Consider Net Zero principles in all clinical pathways and services

Commission services with focus on more efficient whole-life care

Offer more virtual appointments, reducing the need to travel

HOW WE'LL MEASURE IT

Measure and report the use of medicines, gases and their emissions

The number of follow-up appointments

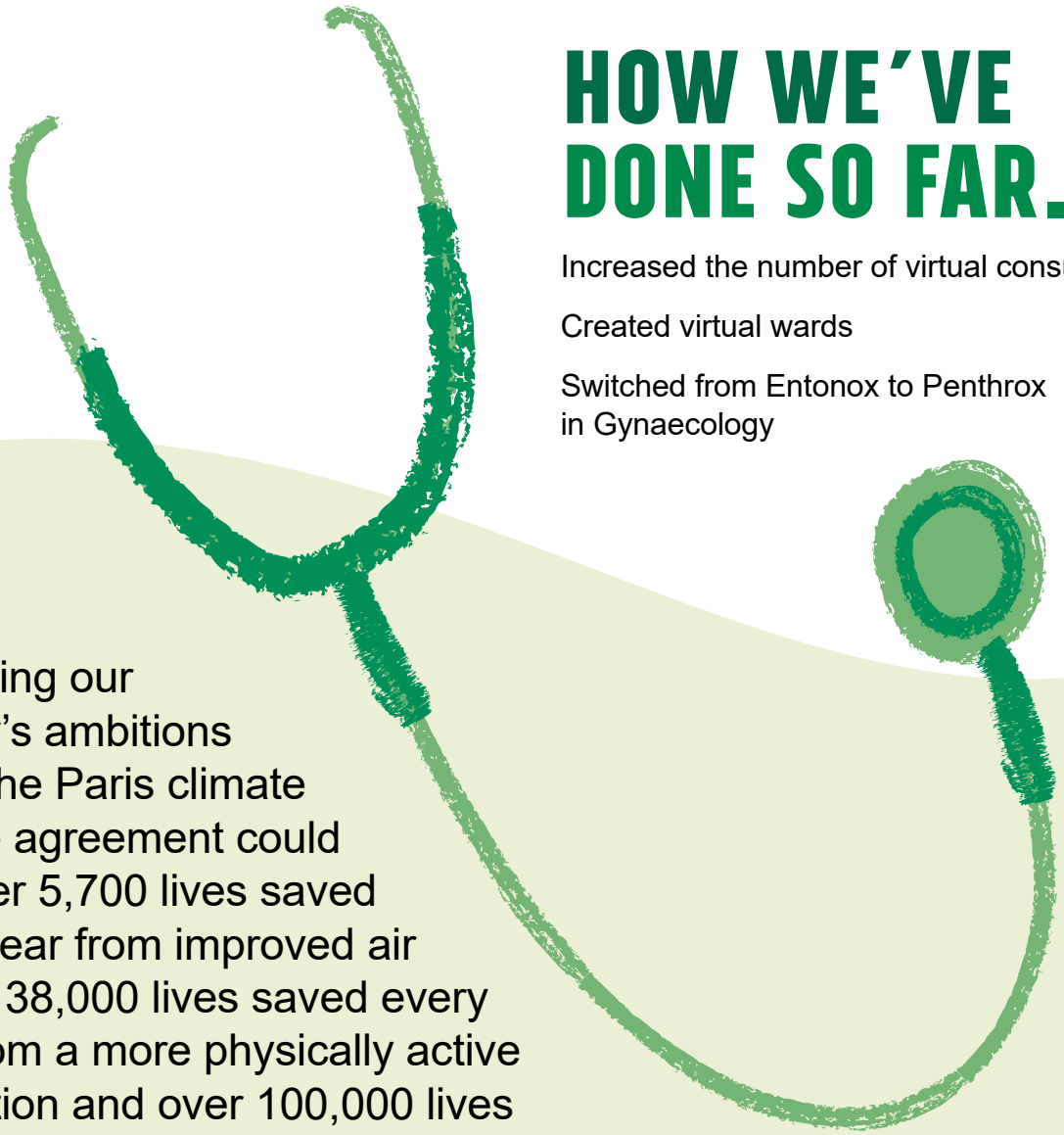
Review changes to clinical pathways in establishing cabin reduction and sustainability improvements

HOW WE'VE DONE SO FAR...

Increased the number of virtual consultations

Created virtual wards

Switched from Entonox to Penthrox in Gynaecology



"Reaching our country's ambitions under the Paris climate change agreement could see over 5,700 lives saved every year from improved air quality, 38,000 lives saved every year from a more physically active population and over 100,000 lives saved every year from healthier diet,"

DELIVERING A NET ZERO NHS

MEDICINES

HOW WE DO IT

Remove piped nitrous from all sites

Reduce medicine wastage

Monitor and manage Entonox usage

Support high quality, low carbon, respiratory care

Provide patients information in line with clinical guidelines

Reduce emissions from inhaler use

HOW WE'VE DONE SO FAR...

Removal of Desflurane

Reduced emissions of nitrous oxide/volatiles

across the group by 56% saving over £370k

Removal of piped nitrous oxide systems

Supported and informed NHS guidance on nitrous oxide

Inhaler recycling scheme

Anaesthetic gas capture equipment trialled

HOW WE'LL MEASURE IT

Greener NHS dashboard

Annual Trust emissions report

Medical gas committee

"Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs."

GRO HARLEM BRUNDTLAND

TRAVEL AND TRANSPORT

HOW WE DO IT

Assist patients, visitors, and staff to travel in more sustainable ways

Reduce the amount of business travel. Limit and offset business flights.

Only ZEV vehicles available through salary sacrifice scheme

Expand EV charging infrastructure

Work with suppliers to increase the efficiency of deliveries to minimise carbon emissions

Support the use of cycles and e-bikes with secure lockers, changing and shower facilities

HOW WE'LL MEASURE IT

Work with suppliers to report and reduce milage and emissions

The percentage of our fleet made up of ULEV and ZEVs

Percentage of salary sacrifice vehicles made up of ZEVs

HOW WE'VE DONE SO FAR...

Staff park-and-ride options

Secure covered cycle storage and changing facilities on Castle hill and Hull Royal

Secure cycle storage on all NLAG sites

Reduced of inter site travel with adoption teams calls

Installed EV chargers

E-cargo bike

ESTATES AND FACILITIES

HOW WE DO IT

Build sustainability into all new facilities, with improved green spaces, drainage systems and passive cooling solutions

Set energy/ utility benchmarks

Increase on-site renewable energy generation

Reduce energy demand within our buildings

Follow NHS net zero building standard

Improve climate resilience of our sites and services

HOW WE'VE DONE SO FAR...

Humber health has secured over £68.4M from external sources that support net zero work.

Coal fired boilers removed from Goole combined with other measures reduce to emissions by 60%

Almost 6MW of solar PV installed saving £4.7M in 3 years

Replaced glazing

Increased insulation

HOW WE'LL MEASURE IT

Assess sustainability impact and carbon cost of completed schemes

Monitor utility usage

Report carbon emissions performance

Monitor air quality on our sites

NHS Energy dashboard

SUPPLY CHAIN AND PROCUREMENT

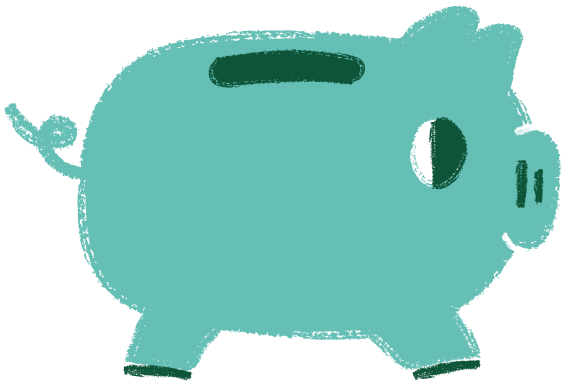
HOW WE DO IT

Work with sustainable, ethical, and local suppliers to meet our Net Zero targets

Remove single use plastics and products wherever possible

Reuse equipment, such as walking aids

All suppliers must publish a carbon reduction plan



HOW WE'LL MEASURE IT

Report on procurement emissions

Develop new foot-printing of supply chains and procurement

HOW WE'VE DONE SO FAR...

Trialling reusable tourniquets

Director of procurement as our nominated lead for sustainable supply chain and procurement

Removal of single used plastics in catering

Completed a high-level footprint of group procurement emissions

By using a reusable cup, you can significantly reduce your carbon emissions. For example, switching from disposable to reusable cups could save 52,000 tonnes of CO2e annually in the UK.

FOOD AND NUTRITION

HOW WE DO IT

Implement seasonal menus, high in locally sourced fruits and vegetables

Reduce food waste to less than 5%

Review the adoption of a digital meal ordering system

Use sustainable sources, such as SOIL

Introduce low carbon meals

HOW WE'LL MEASURE IT

Record any food waste

Record number/ percentage of low carbon meals

ERIC returns

HOW WE'VE DONE SO FAR...

Fresh food all sourced locally (NLAG)

Have seasonal menus

Food waste digester

CLIMATE CHANGE ADAPTATION

HOW WE DO IT

Set out actions to prepare for severe weather events

Improve climate resilience of local sites and services – including digital services

Implement the NHS Climate Adaptation Framework

Work with LRF partners to develop to ensure co-ordinated emergency and climate change adaptation planning

HOW WE'LL MEASURE IT

Number of overheating cases reported

Number of flood occurrences triggering a risk assessment

New builds and refurbishments with adaptation measures included

HOW WE'VE DONE SO FAR...

Day surgery building elevated

Hull CDC built with climate change adaptation measures.

Scunthorpe CDC built with climate change adaptation measures.

The total economic burden of 2007's floods on our region was approximately £2.7 billion and it took 14 months for the economy to recover.

Flood footprint of the 2007 floods in the UK:
The case of the Yorkshire and Humber Region

GREENSPACE AND BIODIVERSITY

HOW WE DO IT

Work with NHS and Humber Forest to increase tree planting

Ensure there is a net biodiversity gain in any new developments

Make our sites available for green prescribing

HOW WE'LL MEASURE IT

Number of trees planted

Measure and record biodiversity gain

Record use of our sites for green prescribing

HOW WE'VE DONE SO FAR...

Over 1,000 trees planted on CHH

Creation of green spaces NLAG

Woodland walk at CHH

Staff orchard planted at CHH

Raised bed and gardening group at HRI

Designated areas for biodiversity

Air quality sampling at sites

FINANCE

HOW WE DO IT

Support Net Zero projects through the creation of a self-generated fund

Include sustainability in business case submissions

Additional resource within sustainability to support Quality Improvement work and secure external funding

HOW WE'LL MEASURE IT

Review of number of business cases including consideration of environmental impact

Funding pot created

"Sustainability is a political choice, not a technical one. It's not a question of whether we can be sustainable, but whether we choose to be"

GARY LAWRENCE

WASTE AND WATER

HOW WE DO IT

Zero waste to landfill

Purchases fewer consumables

Recycle more

Ensure the provision of water efficient appliances within new buildings and refurbishments

Install water metering to help leak detection

HOW WE'LL MEASURE IT

Monitor usage

Auditing of waste streams

Report on the amount of waste recycled

HOW WE'VE DONE SO FAR...

Zero waste to landfill

Increased recycling by over 300%

Improved compliance with waste segregation

DELIVERY PLAN

Area of Focus	Number	Description
1. Assurance and Governance	1.1	Establish a group level net zero committee that reports to board/cabinet together with directorate sub committees.
	1.2	Develop a sustainability impact assessment to evaluate impact of projects or policies and embedded into his existing evaluation tools.
	1.3	Establish sustainability into the governance of trust processes and committees
	1.4	Ensure sustainability is included within business cases, service changes and board reports
	1.5	Group sustainability committee established with senior directorate leads
	1.6	Review green plan annually
	1.7	Sustainability in all JD's
	1.8	Implement a carbon management platform for reporting
2. Workforce, Networks and Leadership	2.1	Assess workforce capacity and skill requirements to deliver net zero goals
	2.2	Collaborative working with partner organisations
	2.3	Engage with research and innovation activities
	2.4	Mandatory net zero training for all staff
	2.5	Net zero champions network with regular news, meetings and training
	2.6	Carbon Literacy training for leaders and sustainability ambassadors
	2.7	Mandatory waste management training
3. Digital transformation	3.1	Maximise the benefits of digital transformation to reduce emissions and improve patient care.
	3.2	Supported by the Digital Maturity Assessment, find opportunities to embed sustainability in digital services
	3.3	Establish a baseline for the ICT carbon footprint according to the guidelines set out in the published materials by the UK Government's Sustainable Technology Advice & Reporting (STAR)
	3.4	Look to specify low power equipment
	3.5	Deploy powerdown software for equipment
	3.6	Prioritise the hosting of data in energy-efficient low carbon local or cloud-based data centres
	3.7	Scanning patient records
	3.8	Doctor Doctor
	3.9	Printing for meetings will be eradicated or by exception

Area of Focus	Number	Description
4. Net Zero Clinical Transformation	4.1	Identify a clinical lead for net zero clinical transformation
	4.2	Select an area to reduce emissions while improving quality of care, include sustainable quality improvement training
	4.3	Consider that zero principles in all service change reconfiguration and pathway redesigns
	4.4	Utilise the sustainable care pathways guidance
	4.5	Introduce more virtual consultations
	4.6	Commission services with focus on more efficient whole life care
	4.7	Develop a clinical working group to educate inform and target areas of opportunity
	4.8	Green surgery awards (?)
5. Medicines	5.1	Continue removal of piped nitrous at remaining sites
	5.2	Monitor and manage Entonox usage
	5.3	Support high quality lower carbon respiratory care
	5.4	Give patients information in line with clinical guidelines
	5.5	Reduce medicines wastage
	5.6	Safe prescribing, de-prescribing
6. Travel and transport	6.1	Change salary sacrifice scheme to ZEV's only
	6.2	Develop a net travel and transport strategy and roadmap
	6.3	Stop business travel reimbursement for UK domestic flights
	6.4	All new fleet to be ZEV were available
	6.5	Promote active travel
	6.6	Develop a plan for EV charging infrastructure
	6.7	Work with suppliers to increase the efficiency of deliveries and to minimise carbon
	6.8	Assist patients visitors and staff to travel in more sustainable
	6.9	Increase the number of online patient appointments
	6.10	Review group logisitcs requirements

Area of Focus	Number	Description
7. Estates and facilities	7.1	Continue to source external funding
	7.2	Update heat decarbonisation plans for each site
	7.3	Develop plans to increase on-site renewable energy generation
	7.4	Building management system optimisation software/digital twin
	7.5	Reduce energy demand within buildings
	7.6	Factor in the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions
	7.7	Follow NHS net zero building standard (and implement NHS net zero derogation schedule) move to action
	7.8	Energy Benchmarks
8. Supply chain and procurement	8.1	Ensure that supplier roadmap requirements are embedded
	8.2	Encourage supplies to use Evergreen sustainable supply assessment
	8.3	Single used products together with clinical teams
	8.4	Training for all financing procurement teams
	8.5	Walking aid reuse scheme
	8.6	Work with sustainable ethical and local suppliers to meet our net zero targets
	8.7	Paper less and digitally optimised environment
9. Food and nutrition	9.1	Record food waste in line with ERIC
	9.2	Have seasonal menus high in fruits and vegetables
	9.3	Review the adoption of a digital meal ordering system
	9.4	Incorporate the NHS E Low carbon menu bank
	9.5	Look to participate in NHS Chef of the year
	9.6	Consider on site food waste processing
	9.7	Develop business case for traditional cooked patient meal service

Area of Focus	Number	Description
10. Climate change adaptation	10.1	Comply with the adaptation provisions withing the NHS cores standards foe EPRR
	10.2	Set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services
	10.3	Implement the "Climate Adaptation Framework" as a comprehensive method to cultivate climate resilience.
	10.4	Work with resilience partners to ensure co-ordinated emergency planning and climate change adaptation planning
11. Green space and biodiversity	11.1	Ensure biodiversity net gain for any new developments
	11.2	Support local partners in making our sites available for green social prescribing
	11.3	Work with NHS and Humber forest to increase tree planting were possible
12. Finance	12.1	Create a ring fenced fund to support net zero projects
	12.2	Increase sustainability resource to support sustainable QI work and secure external funding
	12.3	Include sustainability in business cases
	12.4	Funding allocation for smaller schemes managed by the sustainability committee.
	12.5	Savings from net zero projects to have a percentage re-invested into net zero fund
13. Waste and water	13.1	Continue to increase levels of recycling
	13.2	Explore alternatives to traditional waste disposal
	13.3	Reduce the volume of consumables purchased
	13.4	Install water metering to help leak detection

NHS
Humber Health
Partnership

NET ZERO

THE MISSION

We want to engage our workforce and change the culture to inspire our people to deliver sustainable healthcare, reducing, reusing and recycling, wherever possible.

We want to work with staff and patients on pathways that deliver efficient and sustainable whole life care.

We want to minimise energy use, emissions and unnecessary journeys, and replace fossil fuels with zero carbon sources.

We want to create sustainable spaces for patients, staff, and visitors.

Green Plan 2025- 2028

Published by NHS Humber Health Partnership
May 2025

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(25)100

Name of Meeting	Trust Boards-in-Common Public
Date of the Meeting	**Thursday 12th June 2025**
Director Lead	**Emma Sayner – Group Chief Financial Officer**
Contact Officer / Author	**Tom Myers – Director of Estates, Facilities & Development** **Bill Parkinson – Associate Director of Safety & Statutory Compliance**
Title of Report	**Health and Safety Policy Statement**
Executive Summary	Every public sector organisation must have an annual board approved health and safety policy statement. This policy is for Humber Health Partnership Trust Board approval. Public policy statement of the Group's commitment to fulfil the duties under the Health & Safety at Work Act 1974, the Management of Health & Safety at Work Regulations 1999 (as amended) and the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Estates Facilities and Development SMT
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:

Humber Health Partnership

Health & Safety Policy Statement

Document control use only	
Reference	DCM814
Directorate / Care Group	Estates, Facilities & Development
Version	1.1
Result of last review	Minor changes
Issue date	

Author / Owner Use Only	
Group or Trust specific document	HHP (Group)
Date approved by owner (for minor changes only outside committee)	"enter date of approval"
Date approved	"enter date of approval"
Approving body	Trust Board
Next full review date	June 2026
Lead Director	Tom Myers – Director of Estates, Facilities & Development
Document type	Miscellaneous
Author / Contact	Bill Parkinson – Associate Director of Safety & Statutory Compliance
Key words	Health & Safety Policy Statement

Printed copies valid only if separately controlled

Contents

1. Summary

1.1 Every public sector organisation must have an annual board approved health and safety policy statement. This policy is for Humber Health Partnership Trust Board approval.

2. Definitions / Glossary

2.1 Humber Health Partnership (HHP) – Partnering group consisting of Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole NHS FT (NLaG)

3. Purpose, Legal Requirements and Background

3.1 Public policy statement of the Group's commitment to fulfil the duties under the Health & Safety at Work Act 1974, the Management of Health & Safety at Work Regulations 1999 (as amended) and the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

4. Scope

4.1 Covers the health and wellbeing of employees, patients, contractors and other members of the public.

4.2 This statement outlines the Group and its partnering Trusts' commitment and approach to the management of health & safety and does not provide detail on the management of specific health & safety risk topics.

4.3 Policies and procedures covering the assessment and control of specific health & safety risks (Lone working, Violence and Aggression etc.) are in place for each Trust as part of their statutory duties. However, as part of the direction of the Group and its strategy of working collaboratively, Group policies and procedures will be developed where appropriate.

4.4 Some policies, procedures and reports will remain within the sovereign organisations due to legal requirements.

5. Responsibilities, Accountabilities and Duties

5.1 Group Chief Executive – ultimately responsible for the implementation of effective health and safety arrangements, as outlined in the Risk Management Strategy.

5.2 Group Chief Financial Officer – Delegated executive responsibility for all elements in relation to health and safety (with the exceptions noted below)

5.3 Group Medical Director and Group Chief Nurse - delegated operational responsibilities within their own specific areas.

5.4 Chief Executives for the North and South sites – delegated responsibilities for health and safety within those services assigned to north or south operations

5.5 Group Director of Estates, Facilities and Development – delegated responsibilities for day-to-day

6. Policy Statement

6.1 Proactive approach

6.1.1 The Group recognises that a proactive approach to the management of health & safety is considered an essential element in a good safety management system. As part of its approach, the Group has in place a system of formal and informal inspections, visits, and audit processes which includes Directors.

6.1.2 Where appropriate, the Group also sources external verification of its health and safety management arrangements.

6.2 Commitments

6.2.1 In complying with its duties to its employees as outlined in the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999 (as amended) the Group is committed to: -

- Introducing, developing and maintaining safe systems of work which employees and others working for the Group and partnering Trusts are expected to follow, supervise, manage and review existing systems to improve and raise standards.
- Increasing the knowledge and skill base of its employees in relation to health & safety, ensuring that staff are competent to identify, assess and manage health & safety risks within their working environment.
- Supporting the Care Groups, Directorate and Group functions and their governance forums to ensure engagement and active involvement in improving health and safety performance.
- Using data from reactive and proactive monitoring to enable information to be communicated to staff, managers and directors on performance and facilitate benchmarking both internally and externally.
- Developing and setting annual and longer-term strategic objectives in relation to health and safety performance with are embedded within the business planning process.
- Maintaining a robust incident reporting system which facilitates learning lessons through corrective action and enables the identification of trends and root causes.
- Ensuring that equipment is purchased to required specifications, meets all statutory requirements and that staff have received adequate instruction and training, as well as required maintenance and inspections are carried out.
- Maintaining a comprehensive risk register and central risk assessment system (at Group and partnering Trust level) which includes specific health and safety risks and is used to assist in setting priorities and the

allocation of resources as well as in the development of health & safety strategic planning.

- Developing a positive safety culture throughout the Group and creating good leadership in the implementation of the safety management systems through the vision and values of the Group.
- Ensuring the promotion and improvement of the mental health and wellbeing of the staff across the Group and where appropriate/required ensuring health surveillance is undertaken.
- Ensuring that sufficient allocation of resources in relation to health & safety management as well as competent persons who are able to offer support and advice at all levels and in all areas of health & safety.
- The development of a safety management system to a recognised certifiable standard.

In addition to the responsibilities of the Group and partnering Trusts as an employer, all employees and other persons working as part of its activities (i.e. volunteers, contractors etc.), are expected to participate and co-operate with the systems of work implemented by the Group/Trust as part of their statutory duties. This involves taking reasonable care of themselves and others who may be affected by their acts (or omissions), including the safe and appropriate use of equipment (including safety equipment) and reporting any safety issues appropriately.

7. Monitoring Compliance and Effectiveness Process

7.1 Statutory obligations under the Safety Representatives and Safety Committees Regulations 1996 (as amended) and the Health and Safety Information for Employees Regulations 1989 (as amended) for health and safety are overviewed for the partnering Trusts via the Security, Fire, Health & Safety Group (HUTH) and the Health, Fire & Safety Group (NLaG). These bodies consist of union appointed health and safety representatives, management representatives, competent advisors and senior managers. These groups have delegated authority to approve health & safety related policies and procedures and meet at least once per quarter to review performance and compliance issues as well as considering measures to improve the effectiveness of the safety management system.

7.2 These groups can escalate any issues to the appropriate sub-board groups and submit regular highlight reports to the Performance, Estates & Finance (PEF) Committee.

8. Associated Documents

8.1

DCP086	Governance & Risk Management Strategy
DCR013	General Risk Assessment Procedure
CP137	Health & Safety At Work Policy

9. References*

9.1 Health and Safety at Work etc. Act. 1974. Available at: Legislation.gov.uk

(Accessed: January 8 2025)

9.2 Management of Health & Safety at Work Regulations 1999. (1999). UK Statutory Instruments No 3242 Available at: legislation.gov.uk/si/1999/3242 (

10. Consultation

10.1 Health & Safety Group (HUTH) and the Health, Fire & Safety Group (NLaG) overview this document to recommend submission to the Trust Board.

10.2 This statement is reviewed on an annual basis and signed off by the Group Chief Executive and Chief Financial Officer (as executive lead for the implementation of health and safety management across the Group) as shown in Appendix A.

11. Dissemination and Implementation

11.1 This document is a public document to be posted on Intranet and Internet sites so available to anyone. Any member or staff, patients or the public are entitled to receive a copy should they request one.

12. Document History / Version Control

Date	**Version**	**Revision description** [provide a brief summary of the changes from the previous version made to the document]
3/7/24	1.0	Changed to Group template format and updated to include roles of Chief Executive North and South, and Group Director of Estates, Facilities and Development.

13. Equality Act (2010)

13.1 NHS Humber Health Partnership (the Hull University Teaching Hospitals NHS Trust and the Northern Lincolnshire and Goole NHS Foundation Trust) is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

13.2 The Partnership is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best

possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

13.3 The Partnership aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

13.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably for any reason, including the "protected characteristics" as defined in the Equality Act 2010 (such as by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender). These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

NB. It is the responsibility of the document author / contact to carry out an Equality Impact Assessment (EIA) and if there is no impact identified, it is recommended to include the following statement: 'As part of its development this document and its impact on equality has been analysed and no detriment identified'.

14. Freedom to Speak Up

14.1 Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this document, please speak in the first instance to your line manager (if appropriate). The different ways to speak up and guidance on raising concerns are available in the Freedom to Speak Up in the NHS and Raising Concerns at Work policies. Staff can also contact either the NLaG or HUTH Freedom to Speak Up Guardians in confidence. Further details about how to raise concerns and the contact details of the Guardians are available on the Group intranet, Bridget: Freedom to Speak Up Guardians - Bridget.

15. Appendix A

This policy statement was reviewed at the following Trust Board meeting

[Insert date of Board meeting] and is signed accordingly below.

Amanda Stanford
Interim Group Chief Executive

Emma Sayner
Group Chief Financial Officer

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(25)101

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 June 2025
Director Lead	**Heather McNair, Interim Group Chief Nurse**
Contact Officer / Author	**Tracy Campbell, Director of Nursing – North Bank** **Jenny Hinchliffe, Director of Nursing – South Bank**
Title of Reports	**Report 1 – Mid-Year Safer Staffing Review** **Report 2 – Bi-annual Midwifery Staffing Oversight Report**
Executive Summary	**1. Mid-Year Safer Staffing Review** The third Safer Nursing Care Tool (SNCT) data collection was completed between 17th March and 15th April 2025. The Group used licensed Safer Nursing Care Tool (SNCT) software to review seventy-nine wards and departments across all hospital sites. The previous data collection period for inpatient wards was during August 2024 when elective activity and therefore occupancy was lower, and then again in November 2024 to account for seasonal variation. The most recent data has been reviewed and compared against the previous two collections. The levels of acuity, occupied bed days and care hours per patient day (CHPPD) across the Group are similar to the November 2024 SNCT data collection. The national Community Nurse Safer Staffing Tool (CNSST) use was paused, and a new license issued in December 2024. Data was collected in February 2025 with further collection planned for June and August as an issue has been identified with the tool and further validation of the data is required. The headroom across the group is 21.6% and it is recommended that this remains under review until in line with national recommendations. Newly Qualified Nurse (NQN) Recruitment – NQN recruitment has been completed at HUTH. Confirmed allocation of places is ongoing. NQN recruitment at NLAG is ongoing. CHPPD – The latest model hospital data for January 2025 for NLaG indicated a provider value of 9.5 (quartile 4 – highest 25%) against a peer median of 7.9 and provider median of 8.5. The latest model hospital data for January 2025 for HUTH indicated a provider value of 7.3 (quartile 1 –lowest 25%) against a peer median of 7.9 and provider median of 8.5. Low CHPPD levels are evident on the SNCT collection. Shift Fill Rates – There is a reduction in fill rates for HUTH, fill rates at NLAG remain stable. Nurse Staffing Risks: The current nurse staffing risk for NLaG

has been reviewed. A new risk has been produced and is currently on Ulysses in the proposal stage. Considering care hours per patient days (CHPPD), vacancies, turnover, TES usage, and SNCT recommendations, it is recommended that the risk level is reduced from 16 to 12.

A nurse staffing risk has been identified for HUTH. Considering the SNCT recommendations for establishments, which identifies significant shortfalls within some areas, and high acuity, TES usage, turnover, fill rates and CHPPD, it is recommended that the risk level is 20.

The SNCT review has highlighted significant gaps at HUTH (initial overall priorities for HUTH and NLAG were costed at £9.2m) and further work has been undertaken to further prioritise and risk assess recommendations (cost £3.885m – includes some requirements identified outside establishment review process) to support a phased investment plan over the next 3 years.

It is recommended that the Boards-in-Common:

- Note the content of the paper and ongoing work requested by HHP Executive Cabinet to understand options to address recommendations to maintain patients and staff safety at HUTH
- Note that further data will be collected bi-annually (March and September) and that a 3-year workforce and investment plans is being developed, this will include age profiling, recruitment and retention planning, and management of staffing risks

Note that as per best practice, establishments will be reviewed and reported to Board twice per year going forward.

2.Bi-annual Midwifery Staffing Oversight Report

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

The only available workforce modelling tool for maternity services is the nationally recognised Birthrate Plus® (BR+). Birthrate Plusâ (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. 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. HUTH - data has been collected for a full Birthrate Plusâ . The report has been received by the Trust and indicates a negative variance of 20.13wte from the current funded establishment with 21% uplift. A further updated staffing report will be submitted in August 2025 to Trust Board detailing a full review of the recommendations. NLAG - data is currently being collected for a full Birthrate Plusâ review and this may impact the recommendations on numbers of midwives required across all areas of the service. This reported is expected by the end of June 2025. It is recommended that: · The contents of the Bi – Annual Midwifery Staffing Report are noted by the Trust Boards-in-Common. · Full review the revised BR+ Report requirements is undertaken, reporting to Quality Committee-in-Common and Trust Board-in-Common to ensure compliance with MIS Year 7 requirements to demonstrate there is agreed plan to fund to BR+ recommendation including an agreed timescale. · Further updated staffing report reflecting BR+ recommendations to be submitted to Trust Board in August 2025.
Background Information and/or Supporting Document(s) (if applicable)	**Report 1 – Mid-Year Safer Staffing Review** Safe Staffing for Nursing in Adult Acute Wards in Acute Hospitals (NICE 2014) Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board 2016) Developing Workforce Safeguards (NHSI 2018) Nursing Workforce Standards (Royal College of Nursing 2021) Safer Nursing Care Tool – the Shelford Group **Report 2 – Bi-annual Midwifery Staffing Oversight Report** Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board 2016) Developing Workforce Safeguards (NHSI 2018) Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017)
Prior Approval Process	1. N/A 2. HHP Executive Cabinet

Financial Implication(s) (if applicable)	1. N/A 2. N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	1. N/A 2. N/A
Recommended action(s) required	**1. Mid-Year Safer Staffing Review** ü Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below: **2.Bi-annual Midwifery Staffing Oversight Report** ☐ Approval ☐ Information ü Discussion ☐ Review ü Assurance ☐ Other – please detail below:

Mid-Year Safer Staffing Review

1.0 Introduction

The purpose of this paper is to provide the Boards-in-Common with an update on the nurse staffing establishment review in line with the guidance and requirements for the Board as cited by the National Quality Board (NQB) (July 2016) and Developing Workforce Safeguards (NHSI 2018). A safe staffing review should be reported to the Board twice a year, based on evidence-based tools, outcomes, and clinical judgements. A triangulated approach to safe staffing is used based on patients' needs, acuity, dependency and risks.

Recruitment of registered nurses has improved over the past 12 months; however, although turnover is reducing, retention remains a challenge to ensure the organisation meets key targets and is agile enough to meet future agendas for health and social care. Work priorities are being aligned across the Group in line with the NHS People Plan and Promise (NHS England 2020) and the Group People Strategy, and a three-year nursing workforce plan is being developed.

2.0 Safer Nursing Care Tool

The third Safer Nursing Care Tool (SNCT) data collection across the Group was completed between 17th March and 15th April 2025. Licensed SNCT software was used to review all in-patient wards, including paediatrics, and departments including EDs across all hospital sites. The previous data collection periods for inpatient wards were during August 2024 when elective activity and therefore occupancy was lower, and then again in November 2024 to account for seasonal variation.

The following information was reviewed:

- Information from the SNCT reviews
- Ward budgets and establishments, with a clear breakdown of staffing budgets at each band
- Agency and bank use
- Roster management
- HR benchmarks including vacancy, sickness, appraisals rates, mandatory training compliance
- Occupancy and fill rates
- National benchmarking of CHPPD data using the Model Hospital
- Quality and safety nurse sensitive indicator data

The most recent SNCT data has been compared with the previous two collections. The levels of acuity, occupied bed days and care hours per patient day (CHPPD) across the Group are similar to the November 2024 SNCT data collection (appendix 1), suggesting that in some areas where staffing levels remain the same, the risk has not decreased. SNCT CHPPD remains consistently low in some clinical areas across HUTH, and this is confirmed in the Model Hospital data, which places HUTH in the lowest quartile nationally, which could have an impact on quality, safety and patient experience, as well as on staff experience.

There is evidence that the SNCT level allocated to patients in High Observation Beds (HOBs) on some wards is incorrect based on the unexpected increased number of recorded level 2 patients in these beds which could incorrectly inflate recommended staffing levels. Level 2 patients are described as "*may be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated*

Level 2 facility /unit". The data has been validated by senior nurses within care groups at the time of collection indicating that additional training is required for both ward staff submitting the data and senior nurses validating the data. Refresher training will be implemented prior to the next collection in mid-September, with a particular focus on HOBs, to ensure that the information captured is accurate. Additionally, processes will be implemented to validate data across care groups.

Temporary escalation spaces (TES) continue to add pressure to the established workforce. Where bed occupancy was increased in clinical areas, these patients have been included in the data collection. These wards show as over 100% bed occupancy. Every effort is made to deploy staff to support clinical areas when occupancy is above 100%, however, when the bed occupancy is above 100% for a sustained length of time, more robust and sustained level of staffing is required. This remains a risk considering the current minimum staffing levels and a poor uptake of bank and agency shifts at HUTH.

2.1 Headroom

The Auditor General (2002), Hurst (2003), Healthcare Commission (2005) and RCN (2006) all recommend flexible headroom allowances ranging from 22% to 25%. The SNCT tool has 22% time-out allowance included in the multipliers and establishment. The Carter review (2016) recommended between 22% - 24%.Headroom is a judgement about allowing clinical staff time away from the clinical area to complete their professional and mandatory training requirements. The headroom across the group is 21.6% and it is recommended that this remains under review.

It has been agreed to correct the headroom calculation error and move the sickness absence element of headroom onto a Bank budget line at NLAG. This may result in temporary over establishment in some clinical areas which will be managed through turnover.

2.2 Community

The Community Nursing Safer Staffing Tool (CNSST) was approved by the National Board for Community Nursing in March 2022, however, this was paused due to concerns raised with the national team. A new license was issued in December 2024. Data collection was completed by the community nursing teams in North Lincolnshire in February 2025 with further data collection planned for June and August 2025 as an issue has been identified with the tool and further validation of the data is required. Community nursing teams continue to see increased demand with the need to defer an increasing number of visits on a daily basis (following risk assessment and prioritisation on clinical need).

2.3 Emergency Departments

The Emergency Departments (EDs) across the Group continue to see an increase in attendances and challenges with flow out of the departments. All of the Group EDs experience overcrowding which poses a challenge in providing safe care for patients and staff wellbeing when the footprint of the ED grows to accommodate the demand.

ED SNCT guidance advises only to score a patient once if they are in the department over 12 hours. Concerns that have been raised by providers with the Shelford Team about the frequent significant number of patients in the departments over 12 hours who require care and treatment whilst waiting for a bed. The SNCT does not account for the patients being cared for in the department over 12 hours, nor the footprint of the departments and staff allocation requirements to safely manage patients. This requires professional judgement to be applied. Further work is being undertaken with the senior care group teams to review SNCT and activity data.

The SNCT percentage headroom in the ED SNCT tool is 27% and is an average of the EDs in the SNCT database. There is a recommendation that the percentage headroom does not fall

below 25%. The Trust headroom in ED is below this at 21.6% and is insufficient to support all the additional training and development required reviewed by nursing staff in ED (approximately 10 days). It is recommended that the headroom is reviewed.

To enable the EDs to safely manage the increase in attendances and the overcrowding, different models of care are being developed. These include the use of Clinical Decision Units (CDU) in the EDs in SGH and DPOW that enable better flow through the departments and supports capacity within the Majors area. Additional Registered Nurse resource continues to be used to deliver the CDUs and it is recommended that these posts are made substantive to provide a stable staff model to continue to grow this service.

Within HRI, ECA is often used to cohort patients that have self-presented and meet a majors patient threshold on triage and initial assessment but are unable to be accommodated in majors due to flow issues. ECA is also utilised for undifferentiated specialty patients requiring assessment and diagnostics and for lodged Majors patients waiting for admission. Based on occupancy, it is recommended that the posts currently used to staff ECA are made substantive.

3.0 Nurse Staffing Risks

A nurse staffing risk has been identified for HUTH. Considering the SNCT recommendations for establishments, which identifies significant shortfalls on some wards, combined with increased number of patients requiring enhanced therapeutic observations and care, TES and escalation bed usage, turnover, fill rates and the lower levels of CHPPD, it is recommended that the risk level is 20.

The current nurse staffing risk for NLaG has been reviewed. The risk has been updated with the proposal to reduce it from 16 to 12 (currently on Ulysses in the proposal stage). Remaining RN vacancies are likely to be filled by NQNs this year which may reduce the risk further, however registered and unregistered turnover remains a challenge and TES and escalation bed usage continues.

4.0 Quality Metrics

As described above, quality metrics are triangulated as part of the establishment review process and are considered when professional judgement is being applied. Additionally, quality metrics are triangulated monthly with workforce data by the Nurse Directors with oversight of Site Nurse Directors to identify areas of concern where additional support may be required.

A full review of quality data, and alignment of methods of collating this across the Group is commencing this year. This includes the alignment and implementation of the recently agreed Group nurse staffing red flags.

5.0 Newly Qualified Nurse Recruitment

Newly qualified nurse (NQN) recruitment for 2025 has been competed at HUTH and allocation is underway. As agreed, to support the recruitment of all successful NQNs and to provide safe staffing levels when turnover, maternity leave and long-term sickness are considered, some areas will be over established. This will support any additional capacity required over the winter 2025/26. Guidance will be produced to ensure any over-establishments are rostered to minimise any temporary staffing use.

NQN recruitment at NLAG continues and allocation is underway. Over establishment is likely

to be minimal and will reduce over the coming months with the predicted turnover, maternity leave, long-term sickness and any additional capacity required over the winter 2025/26.

6.0 Care Hours Per Patient Day (CHPPD)

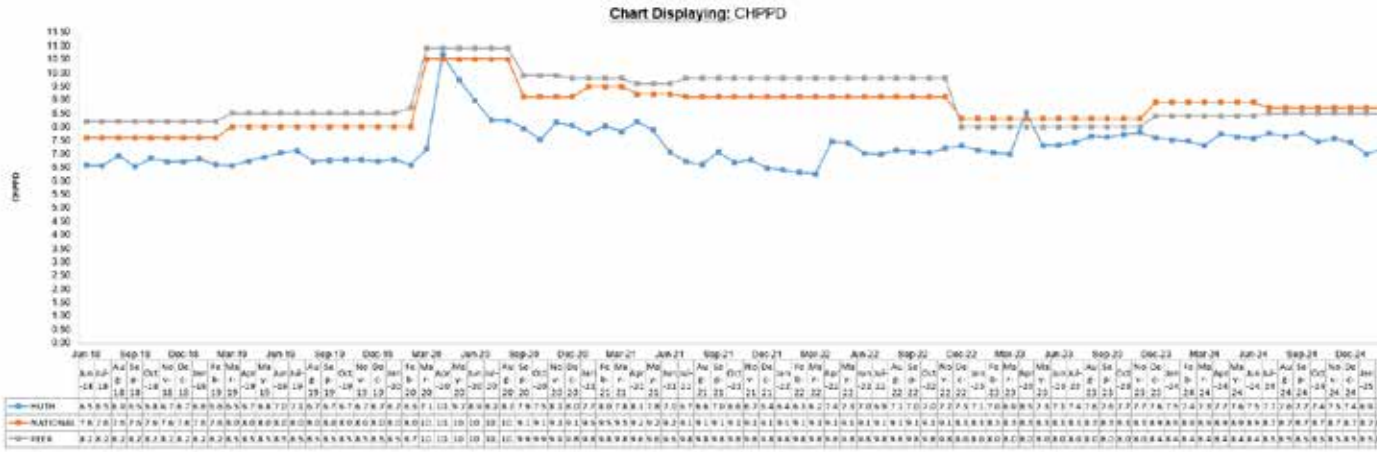
CHPPD is the total hours per day of Registered Nurses (RN), Midwives (MW) and care staff divided by the number of patients in the ward/department at 23.59 hours each night. This provides a score of the average care hours per patient per day. There are many factors that can affect the care hours required, for example, the proportion of single rooms. The acuity of the service delivery model is currently not considered, i.e. multiple locations of the HOBS with increased CHPPD. Additionally, reduced occupancy on surgical wards, particularly at Goole, and changes to ward configurations/ specialties have impacted on the overall data submitted and ability to benchmark.

CHPPD is presented differently across the Group and work is being undertaken to align how this can be collected in the same format.

6.1 HUTH

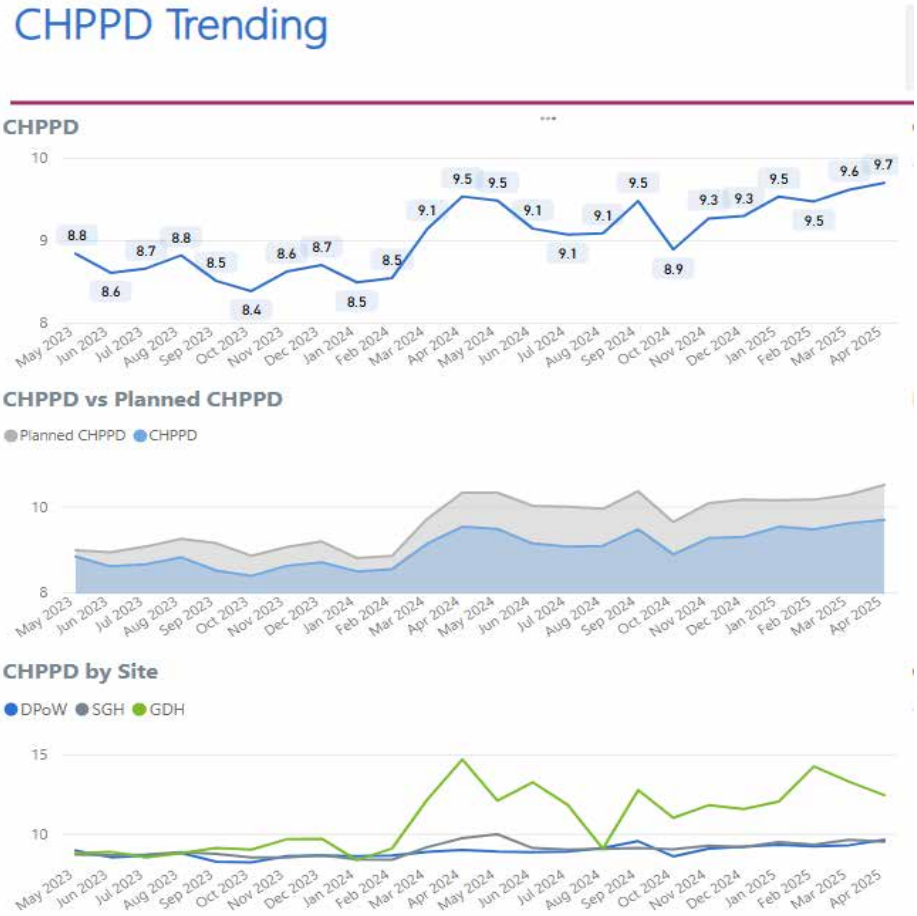
The latest model hospital data for January 2025 indicates a provider level of 7.3 (quartile 1 – lowest 25%) against a peer median of 7.9 and provider median of 8.5.

The table on the following page demonstrates the latest data collated by HUTH.



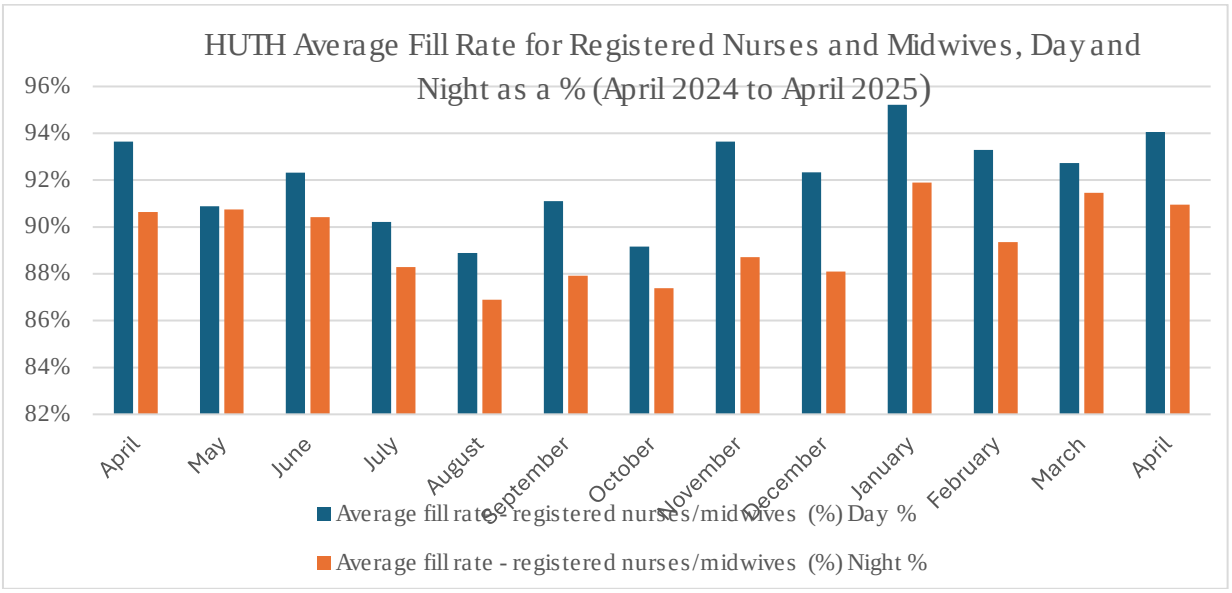
6.2 NLAG

The latest model hospital data for January 2025 indicates a provider value of 9.5 (quartile 4 – highest 25%) against a peer median of 7.9 and provider median of 8.5. Figures below shows the trend.



7.0 Registered Nursing, Midwifery and Unregistered Shift Fill Rates

HUTH



NLAG

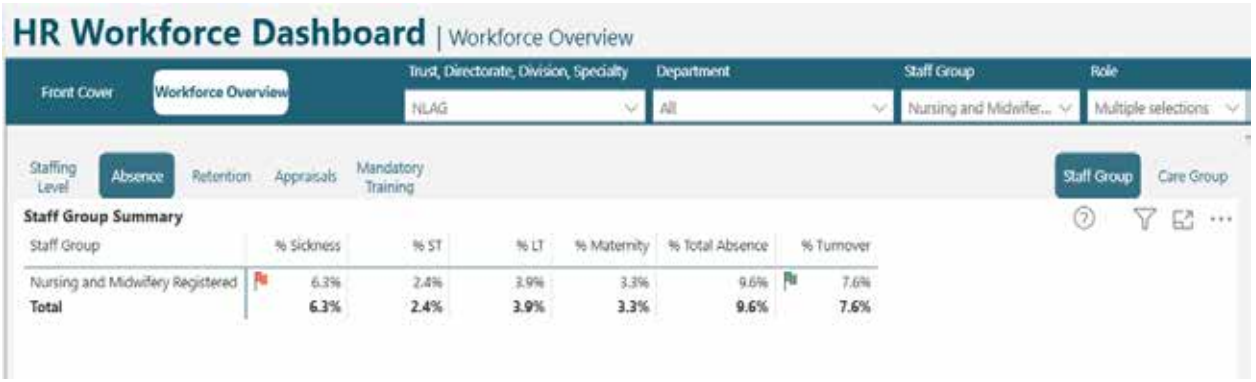
8.0 Absence

8.1 HUTH

The Graph below shows the sickness level of 4.5% for registered staff at HUTH in April 2025. This is a decrease on last month. Overall absence, including maternity leave is at 8.4%.

NLAG

NLAG registered staff sickness has risen to 6.3%, overall absence has risen to an overall of 9.6%, including maternity leave.

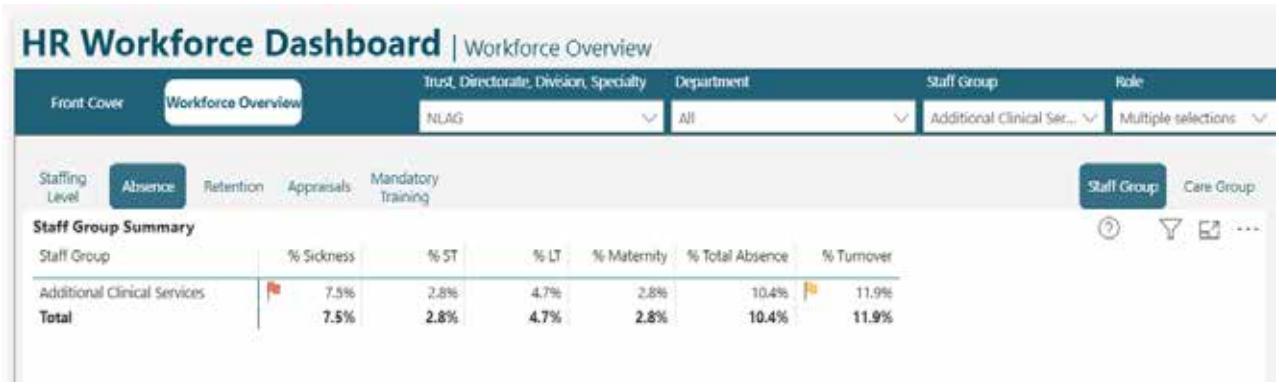


8.2 HUTH

HUTH sickness for unregistered staff is 6.3%, this is remaining relatively static. Overall absence, including maternity leave is at 8.3%.

NLAG

NLAG sickness for unregistered staff has reduced to 7.5% a reduction over the past 12 months from 8.5%. Overall absence, including maternity is 10.4%.



9.0 Nursing Red Flags

A project has commenced to align the definition of nurse staffing red flags across the Group. The red flags have now been approved by Nurse Directors. Training and information is being disseminated to clinical areas and a robust process for actioning and recording will be put into place.

10.0 Retention Strategies

There are a variety of retention strategies in place across the Group that focus on career conversations, career development, staff wellbeing and pastoral support. The Legacy Mentor project, career clinics, forums and 1-1 support either virtually or face to face remain in place. Collaborative work with the Professional Development Teams for HUTH and NLAG has commenced. Work streams are being agreed and these will be implemented across the Group and streamlined to avoid duplication. The impact of these initiatives will be monitored and reported back to WECC.

10.1 HUTH

Recruitment has now been completed for newly qualified nurses (NQNs) and midwives with appointment of 122 Adult nurses, 14 Paediatric nurses and 24 Midwives. Students are now in their final placement until they graduate in August and September. All student nurses have been appointed from Hull University and sixteen of our twenty-four student midwives.

There are 32 RNDAs and 34 TNAs currently on the programme, with 31 aiming for completion by November 2025. They will be supported to secure substantive registered nurse positions within the Trust.

10.2 NLAG

NQN recruitment at NLAG is ongoing.

There are 37 T-level students working across the 3 sites with students going on to secure offers from universities for health care related courses.

11.0 Recommendations

The 2024/25 safer nurse staffing establishment review paper went to WEC in November and Board in December 2024. It was recommended that further data which had been collected in November was analysed and utilised to support review of seasonal variation and prioritisation of recommendations. The updated paper with priorities went to HHP Executive Cabinet in February and June 2025. Further work has been undertaken to reassess priorities to support decision making, and additional work is being undertaken to understand options to address recommendations to maintain patient and staff safety at HUTH

The SNCT review has highlighted significant gaps at HUTH (initial overall priorities for HUTH and NLAG was costed at £9.2m, appendix 2) and further work has been undertaken to further prioritise and risk assess recommendations (£3.885m – includes some requirements identified outside establishment review process, appendix 3) to support a phased investment plan over the next 3 years. Of these areas that have been further prioritised, the quality metrics, professional judgement and rationale are detailed in (appendix 4).

It is acknowledged that establishment reviews have not commenced with e.g. Allied Health Professionals or Specialist Nurses. Therefore, given the size of investment required and the current financial challenges, Cabinet have requested that further work is undertaken to fully understand all options to maintain patient and staff safety, along with the supporting Equality Quality Impact Assessments. These options include maximising roster efficiencies, reviewing ward and department current run rates, and closing capacity.

It is acknowledged that the HASR recommendations on the south bank and the Group structure will have further implications on ward configurations and recommendations will need to continue to be prioritised across the Group. It is recommended that headroom is kept under review until in line with national recommendations, with a higher headroom in ED and other departments where additional mandatory training is required e.g. ICU.

Increase of supernumerary time for our clinical leaders as a minimum standard to 15 hours per week 12 months of the year at NLAG is recommended. The impact of increasing ward managers time on improving patient care and staff retention should not be underestimated.

Additional work is required to identify opportunities for introducing increased skill mix through additional use of the Band 4 Registered Nursing Associate (RNA) role which could safely replace some Band 5 RN roles. A three-year Group nursing workforce plan is being developed, this will include age profiling, recruitment and retention planning, and management of staffing risks. The Band 4 RNA role will be incorporated into the workforce plan.

Work is also underway to review the Care Navigator (south bank) and Patient Discharge Assistant (north bank) roles. A review of the Housekeeper role (north bank) will be undertaken. Recommendations will be incorporated into the full safer staffing establishment reviews in the autumn.

It is recommended that consideration is given to allocating the ‘enhanced therapeutic

observation and care' budget (currently in the Chief Nurse budget) to wards on the north bank where high levels of 1c and 1d patients were recorded indicating that additional nursing resource is routinely required. However, further work is ongoing to develop our enhanced therapeutic model and to understand the impact of this to ensure temporary staffing spend doesn't increase in other areas to support enhanced care.

There are several risks and benefits identified within the establishment review which need to be considered:

- Improved morale of nursing teams
- Improved patient safety and experience
- Better use of resources by having flexibility to redeploy staff for supportive care and manage sickness at short notice
- Investment in leadership and staffing enhances reputation to attract and retain staff.

The nursing and midwifery staffing vacancies continue to be closely monitored. It is highlighted that work needs to take place to actively recruit unregistered staff.

Although turnover is reducing, retention is problematic across the Group, particularly at NLAG. Flexible working has been identified as a priority and a flexible working group has commenced aimed at addressing the issues and finding solutions that work for our staff but are operationally acceptable. The education and workforce teams across the Group continue to work collaboratively with operational teams and to align processes that support recruitment, retention, education, and patient safety.

12.0 Conclusion

In conclusion, it is recommended that Boards-in-Common:

- Note the content of the paper and ongoing work to understand options to address recommendations to maintain patients and staff safety at HUTH
- Note that further data will be collected bi-annually (March and September) and that a 3-year workforce and investment plans is being developed, this will include age profiling, recruitment and retention planning, and management of staffing risks
- Note that as per best practice, establishments will be reviewed and reported to Board twice per year going forward.

Appendix 1 SNCT Data

Digestive Diseases

														Aug-24								Nov-24						Apr-25						
Site	Ward	Specialty	Beds	RN & HCA Total providing direct patient care and measure against SNCT recommendation			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		NOV SNCT excluding levels 1c & 1d			NOV SNCT including levels 1c & 1d		NOV SNCT aver. Occ.		SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			NOV SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
HRI	H100	Gastro	27	19.44	13.2	**32.6**	1 Apprentice Support Staff 2.79 **Total 35.39**	57/43	57/43	60/40	4+3 M-W 5+3 T-F 4+3 S-S	4+3	3+2	**28.23**	10.98	**39.21**	38.06	14.8	**52.86**	27	4.94	31.65	12.31	**43.96**	34.12	**47.38**	25.3	5.8	29.03	19.36	**48.39**	29.42	19.61	**49.03**	27.3	4.58
HRI	H6	Acute Surgery	27	19.21	11.9	**31.06**	2.63 x support staff and 1 x apprentice **Total 34.69**	57/43	50/50	60/40	4+3+PDA	4+2	3+2	**26.56**	10.33	**36.89**	29.21	11.36	**40.57**	24.2	5.72	26.43	10.28	**36.71**	34.09	**47.34**	25.9	5.6	25.79	13.89	**39.68**	25.79	13.89	**39.68**	26.2	4.74
HRI	H60	Acute Surgery	28	19.21	11.8	**31.01**	Support staff 2.43 **Total 32.44**	57/43	50/50	60/40	4+3+PDA	4+2	3+2	**28.69**	11.16	**39.85**	29.51	11.48	**40.99**	26.8	5.11	29.18	11.35	**40.52**	No change	No change	26.2	5.9	28.64	14.45	**41.28**	No Change	No Change	**No Change**	27.3	4.75
	SAU	0700-2000		4.08		**4.08**						1+0	2+0	**0**																					
CHH	C14	UGI + Max facial	23 +	20.81	9.27	**30.08**	Apprentice 1 Support staff 2.33 **Total 32.61**	57/43 50/50	67/33 50/50	67/33	4+3 M-F 3+2 w/e	4+2 M-F 3+2 w/e	2+1	**23.16**	9.01	**32.17**	24.06	9.36	**33.42**	19.5	6.82	25.39	9.87	**35.26**	28.3	**39.31**	23.6	6.6	24.61	13.25	**37.87**	No Change	No Change	**No Change**	25.2	4.83
			4 HOBS					100/00	100/00	100/00	1+0	1+0	1+0																						
CHH	C10	Colorectal surgery	17 +	18.32	7.55	**25.87**	Apprentice 1 Support Staff 1.80 **Total 28.67**	60/40 50/50 67/33	60/40 50/50 67/33	67/33	3+2 M-F 2+2 Sat 2+1 Sun	3+2 M-F 2+2 Sat 2+1 Sun	2+1	**21.28**	8.28	**29.56**	N/A	N/A	**N/A as none recorded**	14.2	6.39	22.09	8.59	**30.68**	NO CHANGE	NO CHANGE	17.7	8	21.73	9.31	**31.04**	No Change	No Change	**No Change**	18.4	5.27
			4 HOBS					100/0	100/0	100/0	1+0	1+0	1+0																						
CHH	C11		18 +	20.57	7.55	**28.12**	Apprentice 1 Support staff 2.51 **Total 30.03**	67/33 60/40 75/25	60/40 60/40 75/25	75/25	4+2 M-F 3+2 Sat 3+1 Sun	3+2 M-F 3+2 Sat 3+1 Sun	2+1	**21.99**	8.55	**30.54**	N/A	N/A	**No change**	16.1	6.52	24.47	9.52	**33.99**	24.63	**34.2**	20.7	6.6	22.41	9.61	**32.02**	23.10	9.90	**33.00**	19.4	5.75
SGH	28	Elective surg	16 + 2 esc	30.28	15.4	**45.72**		60/40	60/40	67/33	3+2 + CN	3+2	2+2	**23.7**	9.22	**32.92**	24	9.33	**33.33**	24.2	7.76	22.88	8.9	**31.78**	23.65	**32.85**	24.1	8.3	14.79	14.79	**29.59**	14.95	14.95	**29.91**	21.7	8.26
		HOBS	8 HOBS + 1 esc					75/25	75/25	60/40	3+1	3+1	3+0																						
SGH	29	Acute Surgery	25	19.44	19.9	**39.3**		50/50	50/50	50/50	4+4+CN	4+4	3+3	**24.66**	9.59	**34.26**	27.13	10.55	**37.68**	24.6	6.79	25	9.72	**34.73**	27.16	**37.73**	24.6	8.8	18.07	18.07	**36.14**	18.55	18.55	**37.10**	24.5	6.69
DPOW	B7	Elective Surgery	18 +	21.68	17	**38.68**		57/43	60/40	60/40	3+2+CN	3+2	2+1	**19.7**	7.66	**27.36**	N/A	N/A	No change	18	7.35	18.87	7.34	**26.2**	no change	no change	18.8	8.2	21.17	11.40	**32.57**	22.21	11.96	**34.17**	20.6	6.44
			4 HOBS					50/50	50/50	50/50	1+1	1+1	1+1																						
DPOW	B3	Emerg Surgery	20 +	27.92	17	**44.89**		50/50	50/50	60/40	3+3+CN	3+3	3+2	**24.17**	9.4	**33.57**	28.72	11.17	**39.89**	25.9	7.56	25.89	10.07	**35.95**	27.12	**37.66**	25.8	8.8	22.12	11.91	**34.03**	24.21	13.03	**37.24**	24.7	7.43
			6 HOBS					67/33	67/33	100/00	2+1	2+1	2+0																						
DPOW	C2	Gastro	27	19.55	18.3	**37.8**		50/50	50/50	50/50	4+4+CN	4+4	3+3	**29.97**	11.65	**41.62**	33.99	13.22	**47.21**	27	6.42	27.64	10.75	**38.39**	30.96	**43**	27	7.7	27.49	14.80	**42.29**	28.95	15.59	**44.54**	24.7	6.70

Family Services

Site	Ward	Specialty	Beds	RN & HCA Total providing direct patient care and measure against SNCT recommendation			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
HRI	H20 Woodland	Paediatrics	20+2 esc	22.08	7.02	**29.1**	2.47 Support staff Total **31.57**	80/20 rising to 83/17 at 0900	80/20	80/20	4+1 and B5 M-F 0900-1500 PLUS Nursery Nurse Mon-Thur 4+1 w/e	4+1 PLUS Nursery Nurse Mon-Thur	4+1				15.5	7.9	**23.4**	11.3	9.03	23.3	11.8	**35.2**	No changes	No changes	No changes	16.9	8	28.13	7.03	**35.16**	No changes	No changes	**No changes**	**13.5**	**7.54**
	H200	PAU	9	10.68	0	**10.68**		67/33	67/33	100/0	2+1 M-F (1200-2000)	2+1 M-F	2+0																							
	H200	PHDU	4+2 esc	11.66	0	**11.66**		100/0	100/0	100/0	2+0	2+0	2+0																							
HRI	H34 Acorn	Paed surg + ENT	18 + 4 DSU	19.31	6.36	**25.67**	0.75 x support staff Total **26.42**	80/20	80/20	100/00	4+1 Mon-Fri and 3+1 Sat-Sun plus 2 x B4 Nursery Nurse Mon to Sun	4+1 Mon-Fri and 3+1 Sat-Sun plus 1 x B4 Nursery Nurse Mon to Sun	3+0	15.1	7.7	**22.8**	14.7	7.5	**22.1**	11.3	8.53	14.1	7.1	**21.2**	No changes	No changes	No changes	11	14.3	15.99	5.33	**21.33**	No changes	No changes	**No changes**	10.7	8.02
HRI	H30 Cedar	Gynae	20 (9 emerg beds, 4 elective, 7 trolleys)	12.78	7.94	**20.72**	1.00 x support staff Total **21.72**	60/40 Mon to Fri and 50/50 Sat and Sun	60/40 Mon to Fri and 50/50 Sat and Sun	66/33	3+2 Mon to Fri 2+2 Sat and Sun	3+2 Mon to Fri 2+2 Sat and Sun	2+1	No changes	No changes	No changes	14.53	5.65	**20.18**	17	4.33	15.6	6.07	**21.67**	No changes	No changes	No changes	19.2	17	20.34	5.09	**25.43**	No changes	No changes	**No changes**	22	3.41
SGH	Disney	Paediatrics	12	21.56	9.39	**30.95**		50/50	50/50	67/33	2+2	2+2	2+1				10.3	5.3	**15.6**	7.8	15.96	14.5	7.4	**21.9**				9.9	17.5	21.1	14.06	**35.16**	No changes	No changes	**No changes**	9.2	11.97
		PAU	8					100/0	100/0	100/0	2+0	2+0	2+0																							
DPOW	Rainforest	Paediatrics	12	22.73	8.13	**30.86**		67/33	67/33	80/20	2+2	3+2+B6	2+1	No changes	No changes	No changes	14.2	7.2	**21.4**	10.8	11.59	16.1	8.2	24.2	15.1	7.7	**22.8**	11.7	15.3	22.85	12.31	**35.16**	No changes	No changes	**No changes**	11.1	11.08
		PAU	8					100/00	100/00	100/00	2+0	2+2	2+0																							

Head and Neck

Site	Ward	Specialty	Beds	RN & HCA Total providing direct patient care and measure against SNCT recommendation			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
CHH	C16	H&N, Breast, Plastics	28 M-F 16 F pm - M am (+2 x HDU beds + 28 S/Rms)	18.91	11.17	**30.08**	Support Staff 1.85 **Total 31.93**	62.5/37.5 60/40 67/33	57/43 57/43 50/50 67/33	60/40 67/33	4+3 M-F 2+2 Sat 1+1 Sun	3+3 M-T 3+3 Fri 1+2 Sat 1+1 Sun	2+2 M-T 1+1 Fri-Sun	29.12	11.32	**40.44**	30.34	11.8	**42.14**	22.7	5.18	31.38	12.2	**43.59**	31.45	12.23	**43.69**	21.7	7.1	29.35	15.80	45.15	No Change	No Change	**No Change**	**23.6**	**4.79**
		HDU	2								1+0	1+0	1+0																							

Major Trauma

Site	Ward	Specialty	Beds	RN & HCA Total providing direct patient care and measure against SNCT recommendation			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
Goole	NRC	Complex Rehab	14	12.46	16.02	**28.48**		33/67	33/67	50/50	2+4	2+4	2+2	16.67	6.48	**23.15**	19.65	6.48	**27.3**	12.9	8.79	16.95	6.59	**23.54**	18.65	7.25	**25.9**	13.2	20.2	12.59	12.59	**25.19**	13.40	13.40	**26.79**	13.7	8.56
CHH	C1	Complex Rehab	12	12.2	16.22	**28.42**	Support Staff 2.53 **Total 29.95**	50/50	40/60	40/60	3+3+PDA (1 RN 0700-1500)	2+3	2+3	14.64	5.69	**20.33**	17.32	6.74	**24.06**	12	9.38	14.45	5.62	**20.06**	17.84	6.94	**24.78**	11.7	9.4	7.36	11.04	**18.40**	9.20	13.80	**23.01**	11.7	9.79
HRI	H38	MT from 16.01.25	20 + 4 HOB								5+3	4+3	3+5																	22.83	15.22	38.05	26.1	17.4	43.51	22	6.48

TACC

Site	Ward	Specialty	Beds	Establishment			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
HRI	HICU1	Critical care	12	116.15	5.39	**121.54**	2.64 support staff **Total 124.18**	95/5	95/5	95/5	19+1	19+1	19+1							19.3									28.9								
	HICU2	Critical care	12	**ICU 1 & 2 have a joint establishment**							&B6 co-ord 24/7 in each unit																		29.4								
CHH	ICU	Critical care	22 (12 cardiac + 10 general)	88.25	4.62	**92.87**	Support staff 2.00 **Total 94.87**	86/14 88/12 93/7 92/8	88/12 93/7 92/8	100/00 100/00 100/00	12+2 Mon 17+2 T-F 15+1 Sat 14+1 Sun	15+2 M 17+2 T-F 15+1 Sat 14+1 Sun	17+0 M-F 14+0 Sat 12+0 Sun																	25.3								
DPOW	HDU	Crtitical Care	7	24.74	5.42	**30.16**		83/17	83/17	80/20	5+1	5+1	4+1								22.6								19.7								
DPOW	ICU	Critical care	6	38.4	5.46	**43.86**		88/12	88/12	87/12	7+1	7+1	7+1								42.8								29.4								
SGH	ICU	Critical care	8 Take 7 level 3 or 6 level 3 and 2 level 2)	43.74	2.72	**46.46**		89/11	89/11	100/00	8+1	8+1	8+0								24.4								25.1								
Goole	6	Ortho + urology surgery	15	19.09	6.24	**25.33**		67/33	67/33	67/33	3+1	3+1	3+1	14.31	5.56	**19.87**	14.31	5.56	**19.87**	8.1	9.54	12.28	4.78	**17.05**	no change	no change	no change	11.3	14.2	15.02	8.09	**23.11**	No Change	No Change	**No Change**	12.5	5.57

Cardiovascular

Ward	Specialty	Beds	RN & HCA Total providing direct patient care and measure against SNCT recommendation			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
			RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
C26	Cardiology	18	13.65	7.94	**21.59**	1 Apprentice 1.93 Support Staff **Total 24.52**	60/40	60/40	67/33	3+2+PDA	3+2	2+1	14.03	5.46	**19.49**	14.39 RN	5.59	**19.98**	18	7.39	15.26	5.94	**21.2**	19.35	7.52	**26.87**	17.8	5.9	10.58	9.77	**20.35**	14.03	12.95	**26.99**	18	4.82
C27	Cardiac Surgery	18 +	34.04	8.62	**42.66**	Support Staff 2.71 **Total 45.37**	75/25	67/33	67/33	3+1	2+1	2+1	30.76	11.96	**42.72**	No change	No change	**No change**	29.4	5.39	30.46	11.85	**42.31**	32.75	12.73	**45.48**	29.6	6.2	27.52	14.82	**42.34**	28.03	15.09	**43.12**	29.1	5.21
		16 HOBS								4+2	4+0	4+0																									
C28	Cardiology	17	37.98	7.94	**45.92**	2 Apprentices Support Staff 2.60 **Total 50.52**	75/25	75/25	66/37	3+1	3+1	2+1									24.66	9.59	**34.26**	28	10.89	**38.89**	24.8	8.1	15.35	3.84	**19.18**	15.69	3.92	**19.61**	16.8	4.39
	CMU	10								4+1	4+1	3+0																									
H39	Cardiology	16 + 4 SDEC (bedded)	16.37	10.67	**27.04**	Support staff x 3.00 **Total 30.04**	60/40	60/40	67/33	16 beds -3+2 SDEC 1+1	3+2 1+1	2+1 0+0	19.32	7.51	**26.83**	24.74	9.62	**34.36**	19.6	5.37	20.93	8.14	**29.07**	26.32	10.24	**36.56**	20	5.1	19.79	8.48	**28.27**	24.14	10.34	**34.48**	20.8	4.84
H7	Vascular surgery	26 +	24.09	10.67	**34.76**	2.67 x support staff 1 x apprentice **Total 38.43**	57/43	57/43	75/25	4+3 +B3 4/7 for pre-assessment	4+3	3+1	27.86	10.84	**38.7**	27.94	10.86	**38.8**	26	5.61	31.4	12.21	**43.61**	34.41	13.38	**47.79**	27.5	5.6	29.56	15.92	**45.48**	33.25	17.90	**51.15**	29.2	4.62
		4 HOBS					100/0	100/0	100/0	1+0	1+0	1+0																									
C1G	Cardiology	26	24.85	14.92	**39.77**		63/37	63/37	67/33	5+3+CN	5+3	4+2	25.55	9.93	**35.48**	26.77	10.41	**37.18**	25.3	6.49	28.66	11.14	**39.8**	30.04	11.68	**41.73**	25.7	7.3	23.54	12.67	**36.21**	No Change	No Change	**No Change**	24.3	6.52

Specialist Cancer

Site	Ward	Specialty	Beds	RN & HCA Total providing direct patient care and measure against SNCT recommendation			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed Days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
CHH	C29	Med Onc	15	11.75	7.72	**19.47**	Support Staff 2.5 Total **21.47**	50/50	50/50	67/33	3+2 M-F 2+2 w/e	2+2	2+1	16.13	6.27	**22.41**	16.21	6.3	**22.51**	14.6	5.66	16.48	6.41	**22.9**	17.1	6.65	**23.75**	14.7	7.4	13.73	9.15	**22.88**	No Change	No Change	**No Change**	14.4	5.91
CHH	C30	Oncology	26	19.47	10.63	**30.1**	Support Staff 2.5 Total **32.10**	60/40	60/40 67/33	75/25	5+2 M-F 4+2 w/e	4+2	3+2	26.56	10.33	**36.89**	27.38	10.65	**38.03**	24.9	5.25	29.1	11.32	**40.42**	30.27	11.77	**42.04**	25.5	5.7	29.12	9.71	**38.83**	31.05	10.35	**41.40**	25.4	5.34
CHH	C31	Onc inc. Head & neck	23	16.85	7.66	**24.51**	Support staff 2.50 Total **27.01**	60/40	60/40 67/33	75/25	4+2 M-F 3+2 w/e	3+2	3+1	22.99	8.94	**31.93**	24.93	9.69	**34.62**	21.7	5.8	25.36	9.86	**35.22**	25.52	9.92	**35.44**	21.4	5.5	19.08	10.27	**29.36**	21.93	11.81	**33.74**	19.1	6.05
CHH	C32	Onc - GI, CUP	22	16.85	7.69	**24.54**	Support Staff 2.50 Total **26.84**	60/40	60/40 67/33	75/25	4+2 M-F 3+2 w/e	3+2	3+1	22.7	8.83	**31.53**	24.34	9.46	**33.8**	21.5	4.84	27.26	10.6	**37.87**	27.8	10.81	**38.61**	21.2	4.9	20.70	11.15	**31.85**	24.55	13.22	**37.78**	20.9	4.97
CHH	C33	Haem, TYA and transplant unit	28	24.95	12.74	**37.69**	Support Staff 2.50 Total **40.19**	70/30 67/33	67/33	60/40	7+3 M-F 6+3 w/e	6+3	3+2	28.31	11.01	**39.32**	31.52	12.26	**43.78**	22.5	6.21	30.93	12.03	**42.96**	35.64	13.86	**49.49**	24.8	6.8	25.11	13.52	**38.63**	29.35	15.81	**45.16**	22.4	6.19
CHH	C7	IDU	12	10.93	7.94	**18.87**	Support Staff 1.91 Total **20.78**	50/50	50/50	67/33	2+2	2+2	2+1	10.7	4.16	**14.86**	18.01	7	**25.01**	10.1	7.25	11.87	4.62	**16.49**	13.82	5.38	**19.2**	10.01	7.6	7.50	5.00	**12.50**	7.63	5.09	**12.72**	9.1	7.76

AEM

Site	Ward	Specialty	Beds	Establishment			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			SNCT including levels 1c & 1d			SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
HRI	H36	Short Stay (neuro, gastro, resp, max fax + ENT clinics)	15	19.6	10.44	**30.04**	Support staff 3.6 (inc 2wte PDA)	66/33	66/33	60/40	4+2+PDA (7days)	4+2	3+2	10.9	4.24	**15.14**	14.34	5.58	**19.92**	15	9.4	18.91	12.61	**31.52**	20.08	13.39	**33.47**	14.9	8.2	20.60	11.09	**31.69**	No change	No change	**No change**	14.9	6.51
HRI	H38 (currently on Ward H1)	Acute Med	18	16.37	13.16	**29.53**	Support staff 1.53	57/43	57/43	50/50	4+3	4+3	2+2	14.81	5.76	**20.57**	15.25	5.93	**21.19**	14.3	??	17.95	6.98	**24.93**	18.65	7.25	**25.9**	18	11.4	22.83	15.22	**38.05**	26.10	17.40	**43.51**	22	6.48
HRI	H5	Gen med	26	11.66	15.66	**27.32**		50/50	50/50	60/40	Estab 2+3+PDA Use 3+3	2+3 3+3	2+3 3+2	27.45	10.67	**38.12**	35.92	13.98	**49.92**	26	5.18	26.9	10.46	**37.36**	30.83	11.99	**42.82**	26.8	5.4	19.57	19.57	**39.14**	No change	No change	**No change**	28.1	4.79
HRI	Amb Care Unit			1.8	0	**1.8**																															
HRI	AMU	Acute assess +	30	48.65	42.21	**90.86**		50/50	56/44	56/44	5+B6 co-ord +4+PDA	6+B6 co-ord +4	4+B6 co-ord +4	66.1	25.71	**91.81**	72.34	28.13	**100.47**	35.4 INCLUDES 8 HOBS	8.02 INCLUDES HOBS	54.84	21.33	**76.17**	63.11	24.54	**87.66**	38.3	9.2	50.79	33.86	**84.64**	53.63	35.75	**89.38**	38.2	6.95
		AMU HOBS	8								2+1	2+1	2+1																								
		SDEC (7am-1am)	50+pts/day								1+0	2 x T/L 1200-0100																									
SGH	5	Short stay	22	19.9	20.81	**40.71**		50/50	50/50	50/50	4+4+CN	4+4	3+3	34.85	13.55	**48.4**	35.17	13.68	**48.85**	21.9	7.51	31.2	12.13	**43.34**	34.42	13.39	**47.81**	22	7.2	21.41	21.41	**42.82**	22.69	22.69	**45.37**	22.1	7.26
SGH	IAAU/SDEC	Acute assess	24	43.92	31.2	**75.12**		55/45	43.92	60/40	6+4+CN	6+4	6+4	87.9	34.19	**122.09**	91.71	35.67	**127.38**	24	9.65	86.42	33.61	**120.02**	89.34	34.74	**124.08**	24.3	9.4	31.69	21.13	**52.81**	34.20	22.80	**57.01**	25.6	9.2
		Gynae assess in reach	2	15.03	6.59	**21.62**		100/0	100/0	50/50	2+0	2+0	1+1																								
SGH	23	ASS+ 4 cardiac mon.	26	27.9	20.81	**48.71**		56/44	56/44	63/37	5+4+CN	5+4	5+3	29.61	11.52	**41.13**	32.03	12.45	**44.48**	25.5	7.59	30.97	12.04	**43.01**	31.89	12.4	**44.3**	26	7.6	25.59	17.06	**42.65**	27.13	18.09	**45.22**	26.1	7.04
DPOW	A1	Medical Short Stay	18	22.02	22.93	**44.95**		50/50	50/50	50/50	4+4+CN	4+4	4+4	22.33	8.68	**31.01**	22.75	8.85	**31.6**	18	9.76	32.74	12.73	**45.47**	35.97	13.99	**49.96**	17.7	9.4	22.55	22.55	**45.10**	25.14	25.14	**50.27**	17.8	9.85
														23.16	9.01	**32.17**	23.55	9.16	**32.71**			34.89	13.57	**48.45**	37.91	12.73	**45.47**										
DPOW	IAAU/SDEC	Acute Assess	23	44.26	28.24	**72.5**		55/45	55/45	60/40	6+4+CN (CN 12 hours x 7 days)	6+4	6+4	31.99	12.44	**44.43**	34.49	13.41	**47.9**	22.9	10.43	37.96	14.76	**52.72**	39.87	15.5	**55.37**	22.7	9.9	33.29	22.19	**53.48**	32.14	21.42	**53.56**	22.6	9.36
		Gynae in SDEC		14.67	5.64	**20.31**					2 RN 8-8 1 HCA 8-8	2 RN 10-10 1 HCA 10-10																									
DPOW	C3	Short Stay	32	30.26	23.05	**53.31**		67/33	67/33	56/44	6+4+CN	6+4	5+4	34.23	13.31	**47.54**	38.78	15.08	**53.86**	32	6.75	36.44	14.17	**50.61**	37.14	14.44	**51.58**	32.2	6.5	29.33	19.55	**48.88**	30.55	20.37	**50.92**	35	5.99
HRI	ED	Emerg Med		95.77	20.19	**115.96**	Support Staff 13.53 Total 129.49										97.9	15.7	**113.6**						101.4	16.3	**117.7**						101.3	16.3	**117.6**		
HRI	ED Paeds	Emergency Med		13.32	0.76	**14.08**	N/A										24.4	3.9	**28.3**						19.8	3.2	**23**						19.6	3.1	**22.8**		
SGH	ED	Emerg Med		88.62	45.01	**133.63**											54.4	8.7	**63.1**						52.3	8.4	**60.7**						52.3	8.4	**60.7**		
DPOW	ED	Emerg Med		88.62	45.01	**133.63**											51	8.2	**59.2**						55.5	8.9	**64.4**						55.5	8.9	**64.4**		

Neurosciences

Site	Ward	Specialty	Beds	Establishment			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
HRI	H11	Stroke & neuro	28	21.59	11.44	**33.03**	Support staff 2.91 (inc 1 PDA)	67/33	37/33	60/40	4+B6 co-ord+2+ PDA	4+B6 co-ord+2	3+2	30.28	11.78	**42.06**	31.1	12.1	**43.2**	28	4.92	31.26	12.16	**43.42**	40.06	15.58	**55.64**	28	5.1	29.78	16.03	**45.81**	31.94	17.20	**49.13**	27.5	4.9
HRI	H110	Stroke	16 +	26.81	10.44	**37.25**	Support staff 3.21 (inc 1.21 PDA)	60/40	60/40	50/50	3+2+PDA	3+2	2+2	19.59	7.62	**27.21**	20.11	7.82	**27.93**	21.5	9.95	29.53	11.48	**41.01**	32.38	12.59	**44.97**	22.4	6.4	27.52	14.82	**42.34**	29.77	16.03	**45.81**	22	6.61
			8 HASU					100/0	100/0	100/0	2+Co-ord	2+co-ord	2+0																9.4								
HRI	H4	Neurosurgery	28	19.74	12.14	**31.88**	Support staff 1.8	62.5/37.5	71/39	60/40	5+3 M-F +PDA 4+3 w/e	4+2	3+2	25.39	9.87	**35.26**	28.75	11.18	**39.93**	26.9	5.08	28.67	11.15	**39.81**	30.67	11.93	**42.6**	27.3	5.9	27.37	14.74	**42.10**	31.79	17.12	**48.90**	27.6	5.02
HRI	H40	Neurosurgery	9 +	21.38	10.44	**31.82**	Support staff 3.04 (inc 1 PDA)	67/33	67/33	67/33	2+1+PDA	2+1	2+1	19.54	7.6	**27.14**	21.03	8.18	**29.21**	14.4	10.11	19.03	7.4	**26.43**	20.57	8	**28.57**	14.3	11.2	14.69	7.91	**22.60**	18.17	9.78	**27.95**	13.5	10.13
			8 HOBS								2+1	2+1	2+1																								
SGH	Stroke unit	Stroke	11 +	30.73	16.72	**47.45**		60/40	50/50	67/33	4+2	2+2	2+1	21.62	8.41	**30.03**	24.38	9.48	**33.86**	18.4	9.28	22.32	8.68	**31**	25.87	10.06	**35.93**	18.3	11.1	25.26	8.42	**33.68**	26.15	8.72	**34.86**	20	8.3
		HASU	6					67/33	67/33	67/33	2+1	2+1	2+0																								
		SAU	4					50/50	50/50	50/50	1*+1	1*+1	1*+1																								
DPOW	Stroke unit	Stroke	25	17.43	20.81	**38.24**		50/50	50/50	40/60	4+4+CN	4+4	2+3	28.55	11.1	**39.65**	29.29	11.39	**40.68**	25	6.07	28.07	10.91	**38.98**	28.76	11.18	**39.94**	25	6.5	24.61	13.25	**37.86**	24.82	13.36	**38.18**	25	5.99

Specialist Medicine

Site	Ward	Specialty	Beds	Establishment			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
HRI	H10	Endo	27	21.59	13.16	**34.75**	Support staff 3.8 (inc 2 PDA)	57/43	57/43	60/40	5+3+PDA	5+3	3+2	29.22	11.36	**40.58**	45.7	17.77	**63.47**	27.3	5.44	31.1	12.09	**43.19**	43.67	16.98	**60.66**	27.4	6.1	31.43	16.92	**48.35**	41.44	22.31	**63.75**	29.1	4.22
HRI	H70	Rheumatology + Gen Med	25	16.37	10.44	**26.81**	Support staff 3.7 (inc 1.7 PDA)	67/33	67/33	50/50	4+2	4+2	2+2	28.96	11.26	**40.22**	38.47	14.96	**53.43**	26.2	4.68	29.27	11.38	**40.65**	33.8	13.15	**46.95**	26.1	5.2	20.62	20.62	**41.24**	21.15	21.15	**42.31**	24.9	4.41
HRI	H50	Renal	19	14.86	8.94	**23.8**	Support staff 2.8 (inc 1 PDA)	50/50	60/40	67/33	3+2+ B6 co-ord M-F	3+2	2+1	22.17	8.62	**30.79**	23.21	9.26	**32.47**	19	5.34	21.97	8.54	**30.51**	26.81	10.43	**37.23**	19.1	5.4	21.34	11.49	**32.83**	21.76	11.71	**33.47**	19.3	4.8
HRI	H37	Respiratory	12 +	27.31	10.44	**37.75**	Support staff 3 (inc 1 PDA)	67/33	67/33	67/33	2+1	2+1	2+1	27.9	10.85	**38.75**	28.27	11	**39.27**	19.1	8.25	30.9	12.02	**42.91**	33.44	13.01	**46.45**	21.1	11.4	25.43	13.69	**39.13**	No change	No change	**No change**	19.1	7.97
		4 RSU + 4 HOB	8					75/25	75/25	75/25	3+1	3+1	3+1																								
HRI	H500	Resp/ Gen Med	24	21.59	10.44	**32.03**	Support staff 3 (inc 1 PDA)	71/39	71/39	67/33	5+2	5+2	3+2	25.01	9.73	**34.74**	25.76	10.02	**35.78**	25.7	4.69	26.08	10.14	**36.23**	28.63	11.13	**39.76**	26	5.7	24.28	13.07	**37.36**	No change	No change	**No change**	26.7	4.03
SGH	17	Respiratory	19 +	27.9	18.22	**46.12**		61/39	61/39	61/39	3+4+CN	3+4	3+2	29.37	11.42	**40.8**	31.69	12.32	**44.01**	22.8 inc. HOBs	8.36	31.15	12.11	**43.26**	34.54	13.43	**47.97**	22.9	8.8	23.70	15.80	**39.50**	26.98	17.99	**44.97**	22.5	8.19
		RHOBS	4								2+0	2+0	2+0																								
SGH	25	Endo	14	12.83	10.83	**23.66**		60/40	50/50	50/50	3+2	2+2	2+2	15.46	6.01	**21.47**	15.98	6.21	**22.19**	13.9	7.35	16.03	16.03	**32.06**	16.37	16.37	**32.75**	13.9	7.8	17.66	11.77	**29.44**	18.86	12.57	**31.43**	14	7.24
DPOW	C5	Respiratory	24	19.43	20.34	**39.77**		50/50	50/50	50/50	4+4+CN	4+4	3+3	27.01	10.5	**37.51**	28.53	11.09	**39.62**	24.1	6.67	26.1	10.15	**36.25**	26.64	10.36	**37**	24	7.7	18.45	18.45	**36.89**	18.93	18.93	**37.86**	22.1	7.08
DPOW	Amethyst	Endo	23	19.9	14.92	**34.82**		57/43	57/43	60/40	4+3+CN	4+3	3+2	32.87	12.78	**45.65**	34.06	13.24	**47.3**	22.9	6.44	33.68	13.1	**46.7**	37.68	14.65	**52.34**	23	7.4	27.55	22.54	**50.09**	27.76	22.72	**50.48**	17.2	5.65

Community, Frailty & Therapies

Site	Ward	Specialty	Beds	Establishment			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed Days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
CHH	C20	NCTR	26	11.41	15.66	**27.07**	Support staff 3.54 (inc 1.4 PDA)	40/60	40/60	40/60	2+3	2+3	2+3	27.24	10.59	**37.83**	45.44	17.67	**63.11 (high number of 1c recorded)**	11.3	4.74	26.51	10.31	**36.82**	**71.74**	27.9	**99.64**	25.2		20.39	20.39	**40.78**	30.88	30.88	**61.77**	25.6	4.25
CHH	H9	Frailty	30	18.87	13.16	**32.03**	Support staff 1.88	57/43	57/43	60/40	4+3	4+3	3+2	30.52	11.87	**42.39**	63.34	24.63	**87.97**	30.7	4.28	38.04	14.79	**52.84**	50.3	19.56	**69.86**	31.7	4.2	25.06	25.06	**50.12**	37.16	37.16	**74.32**	30.9	3.71
HRI	FAU	Frailty assessment	19 + 5 esc	20.17	13.16	**33.33**	Support staff 3.86 (inc 2.4 PDA)	50/50	50/50	60/40	4+3	4+3	3+2	32.97	12.82	**Adult Acute Assessment Tool used 45.79 WTE**	33.3	12.95	**Adult Acute Assessment Tool used 46.25**	22.6	6.06	30.89	12.01	**42.9**	No change	No change	**No change**	22.9		28.90	15.56	**44.46**	No change	No change	**No change**	23	5.62
HRI	H8	Frailty	27 + clinic	18.87	13.16	**32.03**	Support staff 1.88	57/43	57/43	60/40	4+3	4+3	3+2	33.24	12.93	**46.17**	39.81	15.48	**55.29**	28	4.01	33.56	13.05	**46.61**	40.65	15.81	**56.46**	27.9	4.9	22.41	22.41	**44.82**	31.46	31.46	**62.92**	28.2	4.12
HRI	H90	Frailty	29	18.87	13.16	**32.03**	Support staff 2	57/43	57/43	60/40	4+3	4+3	3+2	29.93	11.64	**41.57**	34.26	13.32	**47.58**	25.5		36.34	14.13	**50.47**	38.57	15	**53.58**	29	4.6	28.28	23.14	**51.43**	36.96	30.24	**67.20**	30.7	3.58
HRI	H80	Acute Frailty	27	16.15	13.16	**29.31**	Support staff 9.7 (inc 7.77 PDAs)	57/43	57/43	60/40	3+3 Use 4+3	3+3 Use 4+3	3+2	32.94	12.81	**45.75**	48.49	18.96	**67.45**	28.2	4.18	37.24	14.48	**51.73**	45.66	17.76	**63.42**	28.9	4.9	16.99	25.48	**42.47**	23.36	35.04	**58.40**	29	3.83
HRI	H130W	NCTR	22	11.41	13.16	**24.57**	Support staff 3.4 (inc 1.4 PDA)	40/60	40/60	50/50	2+3	2+3	2+2	25.62	9.96	**35.58**	41.01	15.95	**56.96**	22	5.28	28.03	10.9	**38.94**	33.97	13.21	**47.18**	22	5.3	18.63	27.95	**46.58**	18.88	28.33	**47.21**	23.7	4.37
HRI	H130E	NCTR	31	11.41	13.16	**24.57**	Support staff 3.4 (inc 1.4 PDA)	40/60	40/60	50/50	2+3 Use 3+3	2+3	2+3	34.47	14.4	**47.87**	57.15	22.22	**79.37**	31	3.95	32.57	12.67	**45.24**	66.26	25.77	**92.03**	31	4.1	17.17	25.75	**42.91**	19.78	29.67	**49.44**	32.7	3.45
SGH	22	Frailty	27	22.73	20.81	**43.54**		56/44	56/44	50/50	5+4+CN	5+4	3+3	34.58	13.45	**48.03**	34.95	13.59	**48.54**	27.1	6.46	35.14	13.67	**48.81**	37.79	14.69	**52.48**	27.2	6.4	25.38	25.38	**50.76**	28.81	28.81	**57.62**	28	6.21
SGH	16	Frailty	23	19.75	20.45	**40.23**		50/50	50/50	50/50	4+4+CN	4+4	3+3	23.67	9.2	**32.87**	29.56	11.5	**41.06**	19.9	8.17	29.79	11.58	**41.37**	33.64	13.08	**46.73**	22.9	7.3	19.74	19.74	**39.48**	23.70	23.70	**47.40**	21.7	7.3
Goole	Ward 3	Rehab	14 + 2 esc	13.31	9.89	**23.2**		33/67	33/67	50/50	3+3	2+2	2+1	14.44	5.61	**20.05**	14.51	5.64	**20.15**	12.9	7.6	15.67	6.09	**21.76**	15.74	6.12	**21.86**	14.3	7.7	13.92	11.39	**25.31**	14.10	11.54	**25.63**	14.8	7.78
DPOW	C6	Frailty	21	19.78	17.99	**37.77**		50/50	50/50	40/60	4+4+CN	4+4	2+3 (3+2 funded)	25.41	9.88	**35.29**	29.96	11.65	**41.61**	21.1	7.11	24.8	9.64	**34.44**	31.89	12.4	**44.29**	21.3	7.6	20.36	20.36	**40.73**	33.80	9.50	**43.30**	19.4	7.56

Specialist Surgery

Site	Ward	Specialty	Beds	Establishment			Total establishment including support staff and apprentices (HRI and CHH Only)	RN:HCA ratio			Roster numbers			Aug-24 SNCT excluding levels 1c & 1d			Aug-24 SNCT including levels 1c & 1d			Aug-24 SNCT aver. Occ.		Nov-24 SNCT excluding levels 1c & 1d			Nov-24 SNCT including levels 1c & 1d			Nov-24 SNCT aver. Occ.		Apr-25 SNCT excluding levels 1c & 1d			Apr-25 SNCT including levels 1c & 1d			Apr-25 SNCT aver. Occ.	
				RN	HCA	Total		E	L	N	E	L	N	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD	RN	HCA	Total	RN	HCA	Total	Bed days	CHPPD
CHH	C9	Elective orth & neuro	35	21.82	12.31	**34.13**	Support staff 2.8 (inc 1 PDA)	75/25 67/33 62.5/37.5 50/50	62.5/37.5 62.5/37.5 50/50	60/40	5+2 M 5+3 T 6+3 W 5+3 T 5+3 F 5+3 Sat 4+2 Sun	5+3 M-F 5+3 Sat 4+2 Sun	3+2	36.7	14.27	**50.97**	39.54	15.37	**54.91**	27.6	5	36.42	14.16	**50.58**	37.88	14.73	**52.62**	27.7	6.5	27.57	14.84	**42.41**	36.89	19.86	**56.76**	27.6	4.52
CHH	C15	Urology	34	23.29	15.66	**38.95**	Support staff 2.67 (inc 1 PDA)	66/33	62.5/37.5	50/50	26 beds: 5+2 34 beds: 6+3	4+2 5+3	3+2 3+3	30.24	11.76	**42**	N/A	N/A	**No change**	21.1	6.38	31.38	12.2	**43.58**	**No change**	**No change**	**No change**	30	6.3	30.75	16.56	**47.30**	31.37	16.89	**48.27**	29.6	4.72
HRI	H12	Trauma ortho	28	20.57	15.38	**35.95**	Support staff 2.4 (inc 1 PDA)	62.5/37.5	57/43	60/40	4+co-ord+3 Plus a nutritional assistant Monday to Friday	5+3	3+2	29.37	11.43	**40.8**	36.31	14.12	**50.43**	27.1	5.32	29.6	11.51	**41.12**	38.62	15.02	**53.64**	26.9	6.2	27.57	14.84	**42.41**	36.89	19.86	**56.76**	26.8	5.04
HRI	H120	Trauma, ortho, ENT & max fax	22	17.09	14.96	**32.05**	Support staff 2.4 (inc 1 PDA)	57/43	50/50	60/40	4+3	3+3	3+2 Mon-Fri 2+2 Sat and Sun and B5 TWL 1900-0100	23.44	9.12	**32.56**	34.07	13.25	**47.32**	21	7.26	24.73	9.62	**34.34**	33.82	13.15	**46.98**	21.1	7.6	15.58	15.58	**31.16**	28.80	28.80	**57.59**	20.5	6.88
DPOW	B6	Trauma ortho	22	27.92	22.04	**49.96**		50/50	50/50	50/50	4+4+CN	4+4	3+3	23.08	9.97	**33.05**	28.82	11.21	**40.03**	21.3	7.87	24.28	9.44	**33.72**	29.99	11.66	**41.65**	22	7.8	17.94	17.94	**35.89**	23.19	23.19	**46.38**	22	7.64
SGH	Ward 27	Ortho trauma	24	19.44	20.82	**40.26**		50/50	50/50	50/50	4+4+CN	4+4+CN	3+3	28.61	11.12	**39.73**	32.64	12.69	**45.33**	23.8	7.1	29.44	11.45	**40.9**	32.84	12.77	**45.61**	23.8	8.1	20.77	20.77	**41.55**	23.77	23.77	**47.55**	23.5	7.22

Appendix 2 2024/25 SNCT Establishment Review – initial prioritised recommendations January 2025

For NLAG, the cost of recommendations for ED and increasing ward manger time to lead can largely be offset by the recommended reductions outlined below.

RISK	WARD	RECOMMENDATION	COST	COST REDUCTION
Very high priority/ Immediate risk		NIL		
High	ED SGH	RN LD	-114	
	ED DPOW	RN LD	-124	
Moderate	Amethyst	HCA 24/7	-196	
	Disney - Paediatrics	RN 07.30-17.30 Friday for dental list	-57	
	DPOW Stroke	RN Night and then reduce late shift to 8pm from 10pm end	-102	
Low	SGH Stroke	HCA Night	-106	
	25 - Endo	RN Late	-57	
	29 - Acute Surgery	Replace B2 24/7 with B5 (60:40 skill mix)	-40	
	B3 - Emerg Surgery	B4 NA Early M-F	-52	
	C2 - Gastro	B4 NA 24/7	-208	
	SGH ICU	HCA Night	-106	
	SGH & DPOW ICU	Increase headroom to 9 study days (in line with HUTH)	-44	
		Increase B7 to 5 days supernumerary	-54	
	SGH Stroke	B3 Care Navigator 5 days	-30	
	25 - Endo	B3 Care Navigator 5 days	-30	
	22 - Frailty	HCA Night	-109	
	16 - Frailty	B4 NA 24/7	-208	
	C6 - Frailty	HCA Night	-106	
Cost saving/ cost neutral	28 - Elective Surgery	HOBS - Replace RN 24/7 with HCA 24/7	0	37
	Goole NRC	Increase RN and reduce RSW LD if cost neutral	-21	(18 offset by C1)
	DPOW ICU	Remove 1 WTE B2 as not required 7 nights	0	106
	A1	Remove RN Night	0	121
	SGH Stroke	Move RN early to late 7 days - immediate	0	
			-1682	**264**

Ward manager time to lead to 2 days 12/12 at £3k per ward – NLAG x 26 wards
26 wards Total £78k

As discussed, this is the first SNCT data for HUTH which has highlighted a gap and further work is required to quantify risks and prioritise recommendations for the Board.

RISK	WARD	RECOMMENDATION	COST	COST REDUCTION

Very high priority/ Immediate risk	C16 - H&N, Breast, Plastics	Increase RN M-Thur L, Sat L, Sun LD, night 7 days Increase HCA Sun LD, Mon- Fri Night	-300	
	H70 Rheum + GIM	HCA Night	-106	
High	ED - ECA	2 x RN + 2 x B3 CSW 24/7 + B2 HCA 24/7	-1054	
	H100 - gastro	RN 24/7	-236	
	H6 - acute surgery	RN 24/7	-236	
	H60 - acute surgery	RN Early	-71	
		RN Night	-124	
	C14 UGI & Max Fac	RN Night	-124	
	C10 Colorectal	HCA Night	-106	
	C11	HCA Night Mon - Fri	-66	
	C27 - Cardiac Surgery	HCA Late and Night for HOBS	-152	
	H39 - Cardiology	RN Night for SDEC beds (open since Nov 22)	-124	
	H7 - Vascular	HCA Night	-106	
	C30 - Oncology	B5 Tue for brachytherapy	-39	
		HCA LD 7 days	-93	
	C31 - Onc inc H&N	HCA Night 7/7	-106	
	C32 - Onc - GI & CUP	HCA Night for 7 days	-106	
	H11 Stroke & Neuro	HCA 24/7	-196	
	H110 Stroke	HCA 24/7 for HASU	-196	
	H4 Neurosurgery	RN Night	-124	
	H10 Endo	HCA Night	-106	
	H70 Rheum + GIM	RN Night + HCA LD	-214	
	H37 RSU	RN 24/7	-236	
	H9 Frailty	HCA 24/7	-196	
	FAU	RN Night	-122	
	H80 Acute Frailty	RN LD (being used) and HCA 24/7	-310	
	H130W	HCA Night	-106	
	H130E	RN LD (E currently used) and HCA 24/7	-310	
	C9 - ortho & neuro	HCA Night	-106	
	H12 Trauma ortho	HCA 24/7	-196	
		B7 Ward Manager 2 days supernumerary time	-3	
	H120 Trauma ortho	RN late and HCA on night	-106	
	H20 - Woodland/PAU/PHD	Uplift B5 to B6 so B6 on duty 24/7 across floor	-11	
Moderate	C29 - Med Oncology	HCA Night	-106	
	C31 - Onc inc H&N	RN Late M-F -to extend coordinator role	-47	
	C32 - Onc - GI & CUP	RN Late M-F -to extend coordinator role	-47	
	C33 - Haem, TYA & transplant	Increase B6 to 24/7 cover - uplift B5	-60	
	FAU	RN LD	-114	
	H100 - gastro	HCA Night	-106	
	H6 - acute surgery	HCA Late	-46	
	H60 - acute surgery	RN Late	-56	
	C14 UGI & Max Fac	HCA Night	-106	
	C10 Colorectal	4th RN M-F	-45	
		Don't drop at W/e other than RN on Early	-19	

	C11	HCA LD Sunday	-58	
		HCA N Sat & Sun	-40	
	H39 - Cardiology	HCA Night for SDEC beds (open since Nov 22)	-106	
	H4 Neurosurgery	HCA Late	-46	
	H12 Trauma ortho	RN Late	-57	
	H120 Trauma ortho	HCA LD	-93	
Low	H30 - Gynae	B7 to 3 management days - B5 backfill	-9	
	HICU1&2	1 HCA 24/7	-196	
	CHH ICU	1 HCA Night 7/7	-106	
	H7 - Vascular	RN 24/7	-236	
	C29 - Med Oncology	RN Early Sat & Sun	-26	
	C30 - Oncology	Uplift B5 to B6	-11	
	C7 - IDU	Increase B7 supernumerary time to 3 days	-9	
	AMU	Add headroom to PDA posts	-20	
	H50 - Renal	Increased B6 coordinator cover to 7am - 8pm Mon-Fri	-79	
	H11 Stroke & Neuro	HCA LD x 1	-93	
	H20 - Woodland/PAU/PHD	1 day management time for B6	-11	
Redutions/ cost neutral	C1 - Complex Rehab	Convert 3rd RN Early to B7 supernumerary for 5 days	0	18
To be reviewed	H60	Budget B6 24 hours short to cover roster	-72	
	H20 - Woodland/PAU/PHD	Establish unfunded HCA LD M-F	-55	
	H7 - Vascular	B3 07.00-17.00hours for 4 days (3 years)	-29	
Potential Business Case Requirement	C15 Urology	The ward is funded non recurrently in 24/25 for 35 beds	TBC	

First Draft Costs - SNCT Ward Reviews 24/25

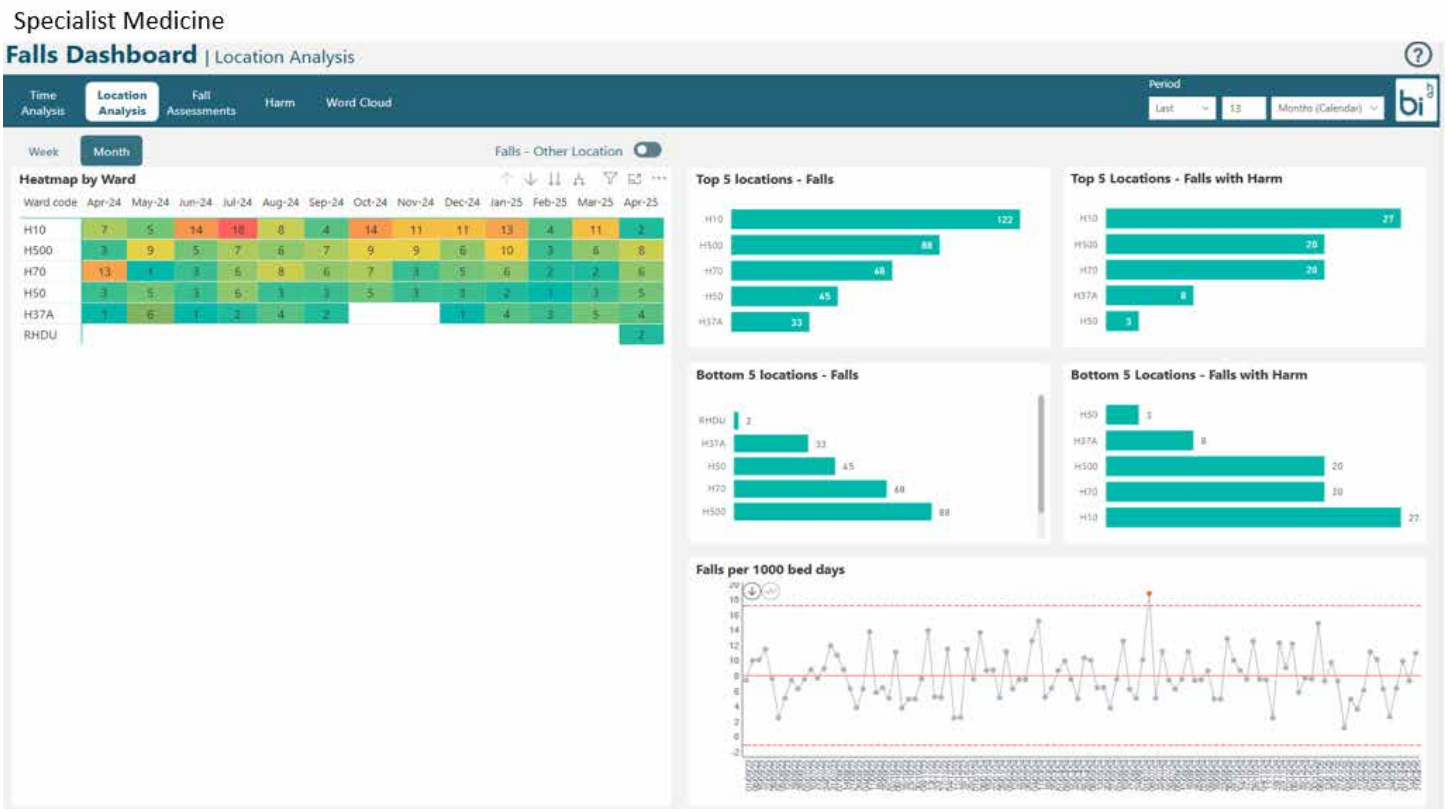
Caregroup	**Financial request £000s**
Digestive Disease	-1,786
Family Serives	-143
Head and Neck	-300
MT	-3
TACC	-210
Cardiovascular	-756
Specilist Cancer	-650
AEM	-1200
Neurosciences	-902
Specialist Medicine	-1036
Community, Fraility & Therapy	-1590
Specialist Surgery	-624
	-9,200

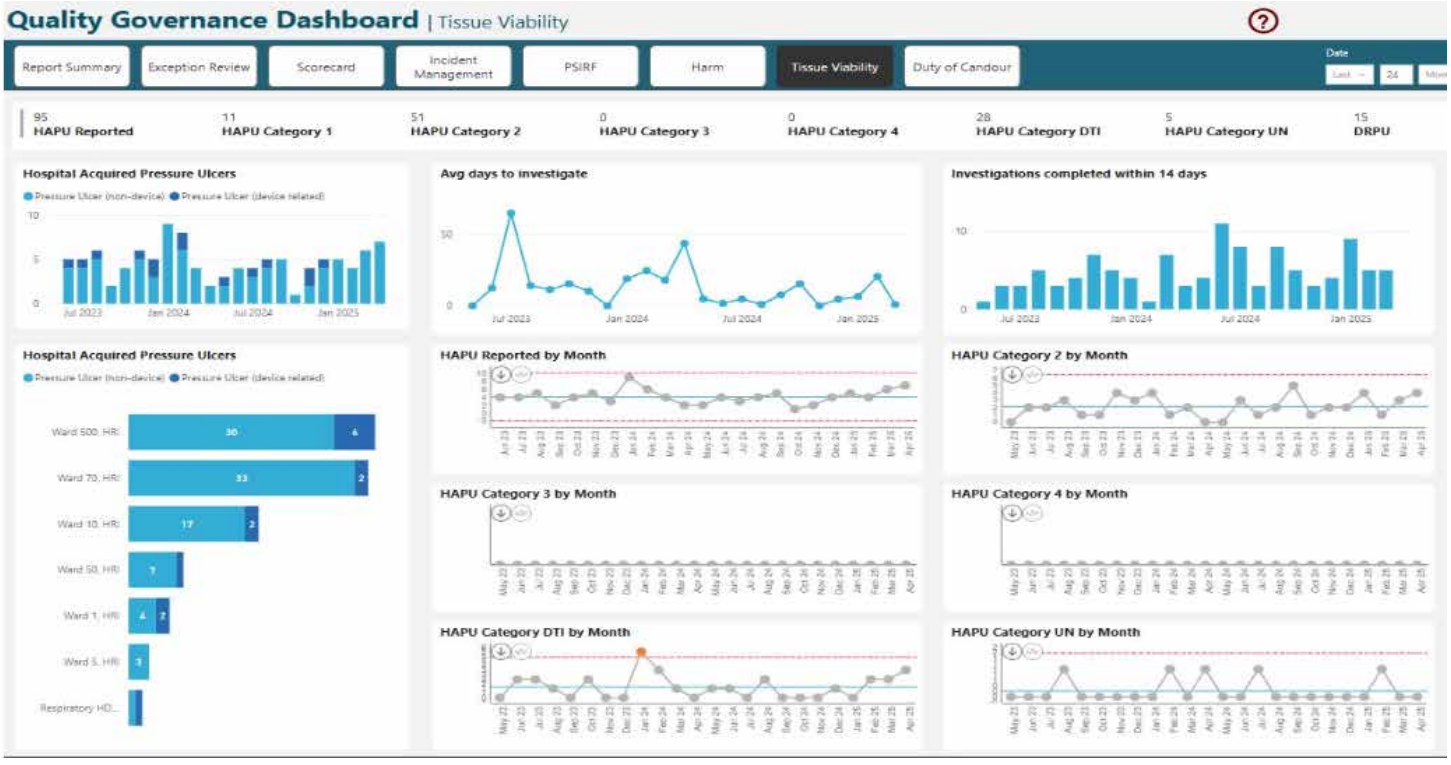
Appendix 3 2024/25 SNCT Establishment Review – re-prioritised recommendations April 2025

					Funding required	
NLAG	**Caregroup**	**Ward/Unit**	**Rationale**	**Site Nurse Directors Recommendations**	**Non recurrent**	**Recurrent**
Increased requirement	AEM	ED SGH	Currently using additional staffing. RN LD	Fund - currently staffing at this level	(114)	(114)
	AEM	ED DPOW	Currently using additional staffing. RN Night	Fund - currently staffing at this level	(124)	(124)
	Various	Mgt time NLAG	bring line with HUTH Ward Manager Days	Fund - to align HUTH and NLAG	(66)	(66)
Reduce requirement	TACC	28 - Elective Surgery	HOBS - Replace RN 24/7 with HCA 24/7	Agreed to skill mix	37	37
	Family Services	DPOW ICU	Remove 1 WTE B2 as not required 7 nights	Staffing not required	106	106
	AEM	A1	Remove RN Night	Staffing not required	121	121
				Total	**(40)**	**(40)**

					Funding required	
HUTH	**Caregroup**	**Ward/Unit**	**Rationale**	**Site Nurse Directors Recommendations**	**Non recurrent**	**Recurrent**
Issues picked up as part of the SNCT or via business plans where staffing is currently in place but not funded	Digestive Diseases	6th floor Coordinators (H60/H6)	Budget B6 - a additional B6, early shift to make 2x Long Days	Fund for 6 mths as already incurring spend, needs to be considered as part of SDEC Business Case.	(36)	0
	Family Services	H20 - Woodland/PAU/PHD	Establish unfunded HCA LD M-F	Funding already in place.	0	0
	AEM	H5	Funded currently as NCTR ward, using additional staff required as operationg as an Acute Ward. Additonal RN 2 x Long Day, 1 x Night. HCA reduce Night by x1.	Approved recently by Execs - budget to be allocated, but overall bed requirements to be reviewed and managed through efficiency workstream. Review CIP opportunity by end of Jun 25	(241)	(241)
	Cardiovascular	H7 - Vascular	B3 07.00-17.00hours for 4 days (3 years)	Fund based on staffing being in place. Review required on timings of shift (effectiveness).	(29)	(29)
	TACC	Obs/Gynae theatres	**Picked up outside Safer Sttafing establishment review** - Additonal staffing following Never event - impact to be reviewed and staffing to be reviewed.	Approved recurrently by Execs - but Business Case required to confirm resource requirements and any potential cost savings.	(515)	(515)
	Family Services	Maternity Specialist MW Roles	Realign budgets - funding required in part to fund maternity leave, then requirement will reduced (see briefing paper)	Approve - funding is being incurred.	(45)	(20)
				Total	**(866)**	**(805)**
Very High Priority from SNCT reviews - ranked	Specialist Medicine	H70 Rheum + GIM	HCA Night	Top 7 priority	(106)	(106)
	Head and Neck	C16 - H&N, Breast, Plastics	Increase RN M-Thur L, Sat L, Sun LD, night 7 days Increase HCA Sun LD, Mon- Fri Night	Top 7priority	(300)	(300)
	AEM	ED - ECA HRI	2 x RN + 2 x B3 CSW 24/7 + B2 HCA 24/7	Top 7 priority	(1,054)	(1,054)
	Community, Frailty & Therapy	H9 Frailty	HCA 24/7	Top 7 priority	(196)	(196)
	Community, Frailty & Therapy	H80 Frailty (not H90)	HCA 24/7	Top 7 priority	(196)	(196)
	Community, Frailty & Therapy	H130W	HCA Night	Top 7 priority	(106)	(106)
	Community, Frailty & Therapy	H130E	RN LD (E currently used) and HCA 24/7	Top 7 priority	(310)	(310)
	Digestive Diseases	H60 - acute surgery	RN Early	Top priority	(71)	(71)
	Neurosciences	H11 Stroke & Neuro	HCA Night	Top priority	(106)	(106)
		H11 & H110 HASU	HCA LD x 2 (1 per ward)	Top priority	(186)	(186)
	Specialist Surgery	H12 Trauma ortho	HCA 24/7	Top priority	(196)	(196)
	Specialist Surgery	H120 Trauma ortho	RN late	Top priority	(57)	(57)
			HCA Night	Top priority	(196)	(196)
				Total	**(3,080)**	**(3,080)**
				Total of both requirements	**(3,946)**	**(3,885)**

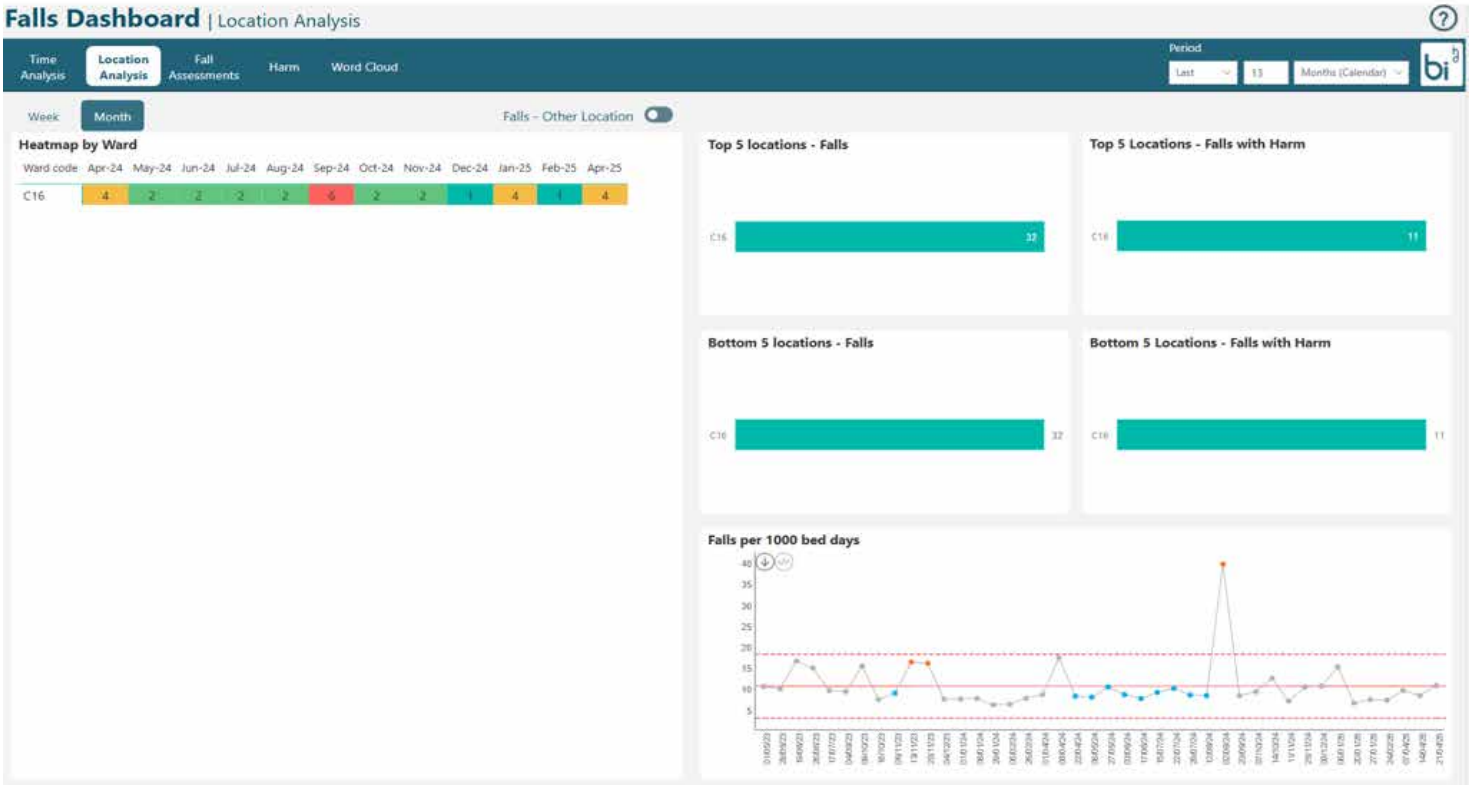
Appendix 4 Quality metrics for very high priority wards

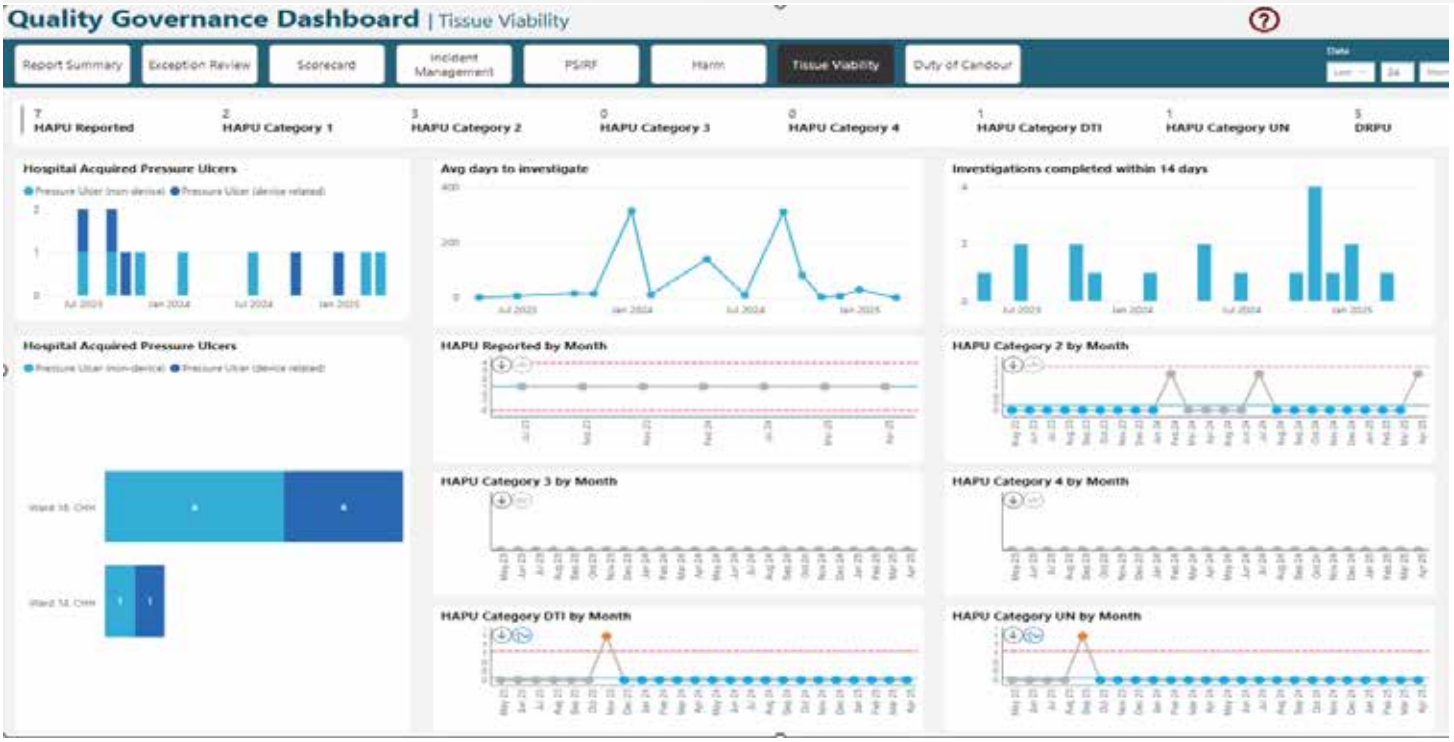




H70 is a 25 bedded rheumatology and general medicine ward (21 beds with 4 escalation beds open since January 2024). Lots of complex patients requiring 1:1 or 1:2 observation. Increased falls, particularly at night when staffing 2+2. Additional HCA on night a priority.

Head & Neck





Recommended increase is to ensure a safe patient: staff ratio, especially within HOB area. The HOB is a specialised 2 bedded area for patients with compromised airways following Tracheostomy surgery, these patients bypass ICU and come directly to the HOB on C16 post-surgery. The acuity of this area is high.

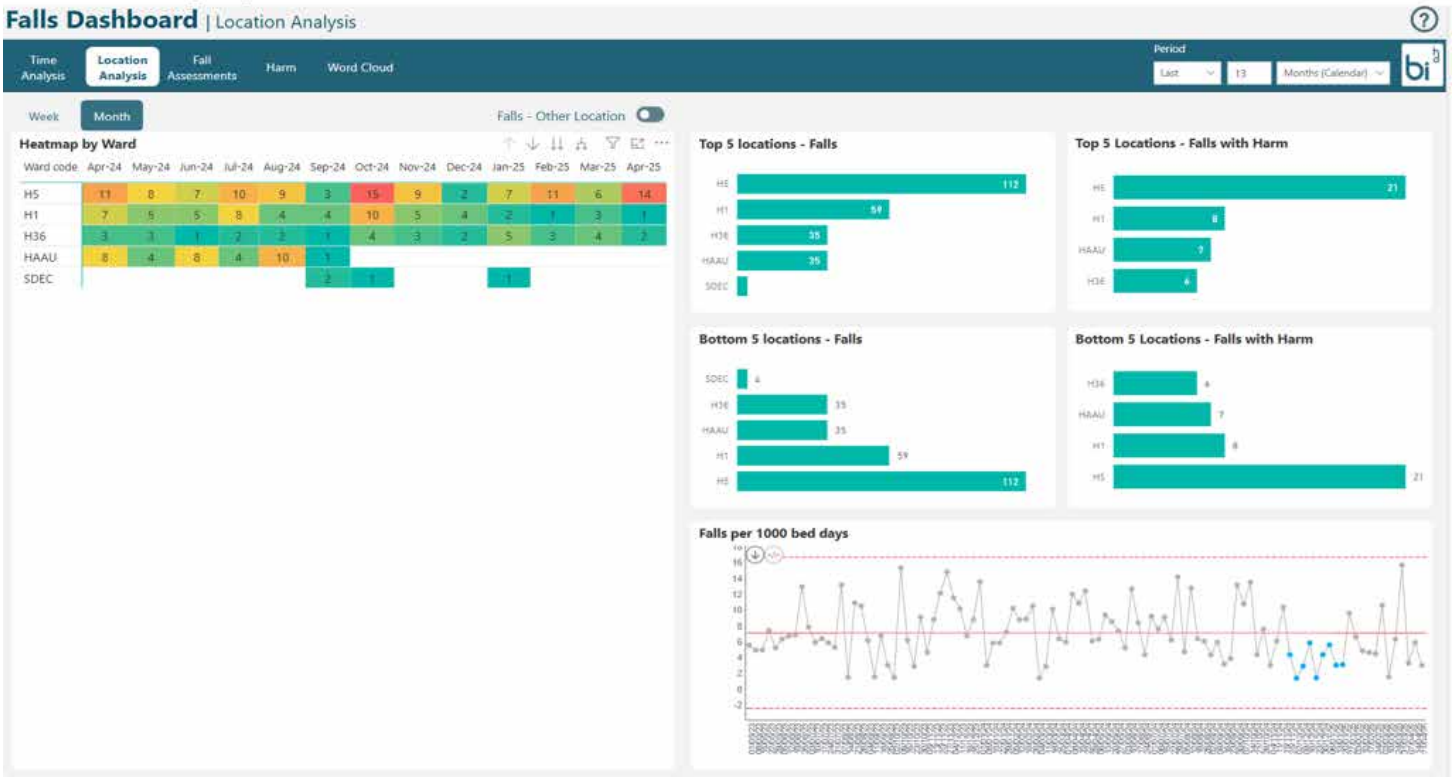
C16 also regularly take DIEP flap patients into this HOB area, which is mastectomy and reconstruction following all day breast cancer surgery. The HOB also regularly cares for patients post thyroidectomy, which is known to decrease the patient's calcium levels and they need a calcium infusion with continuous cardiac monitoring.

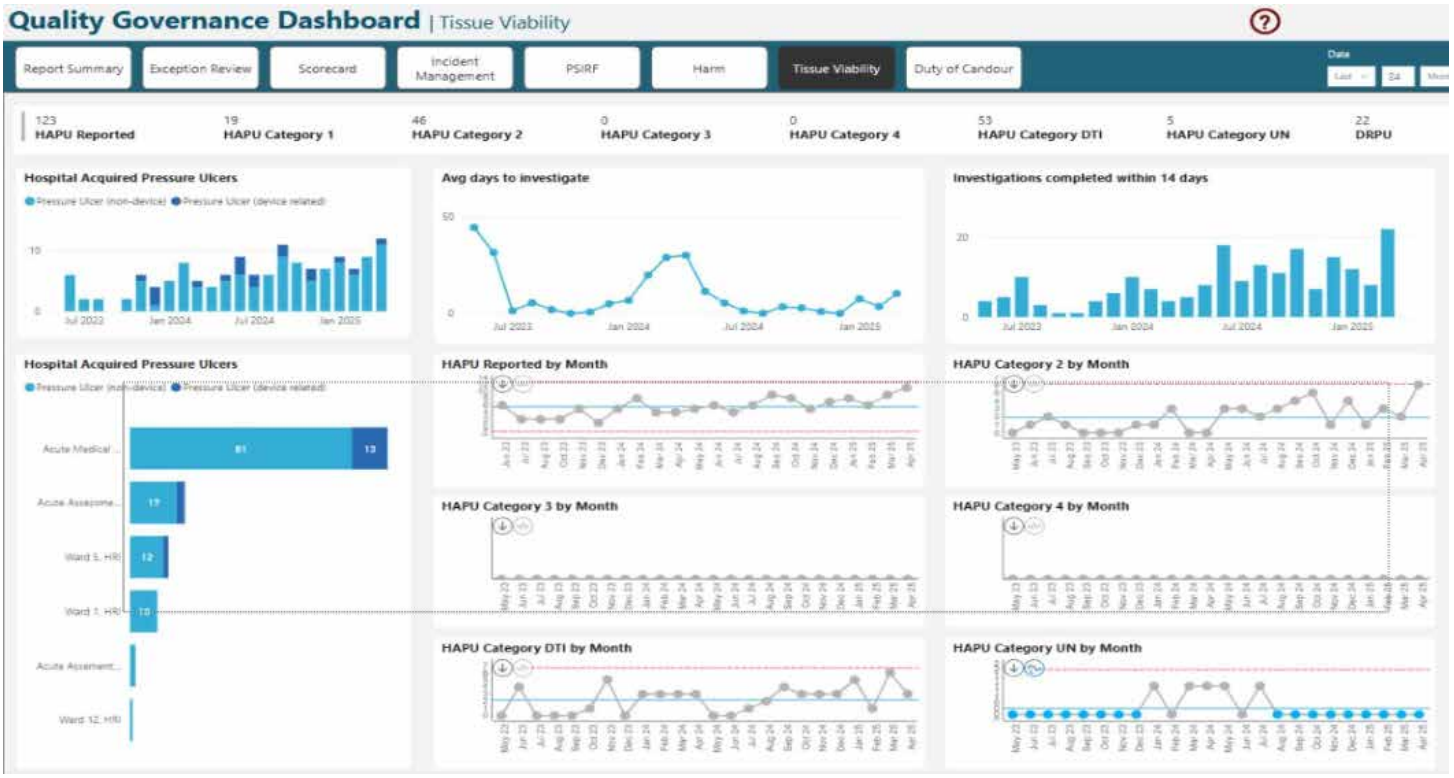
Following the above surgeries, there are also multiple complex wounds to care for.

These patients are at high risk of deterioration. Thus, requiring the additional registered nurses.

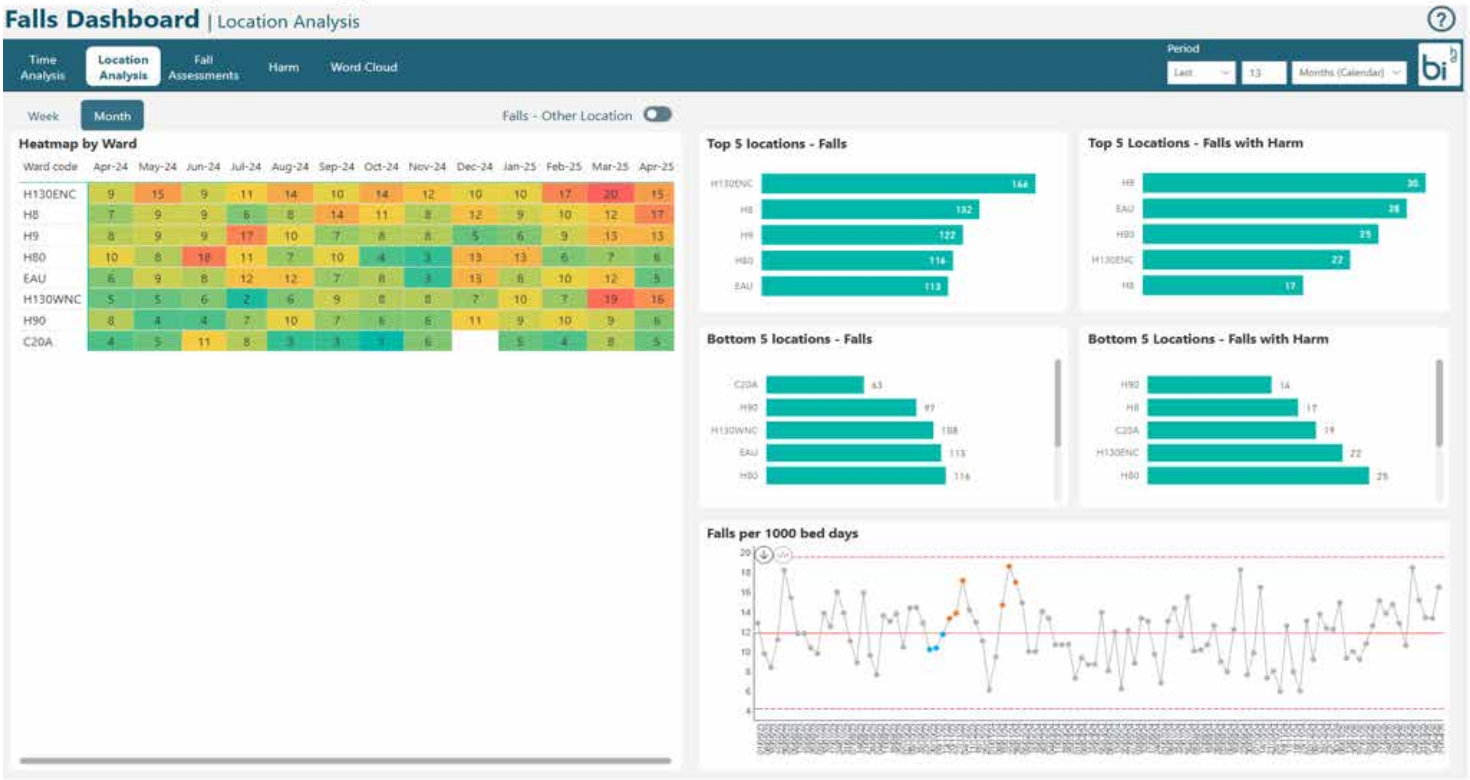
C16 is also a stand-alone building, regularly patients are required to go for MRI and X-ray where they need an escort with them. C16 is also set out with cubicles only and visibility of patients is limited.

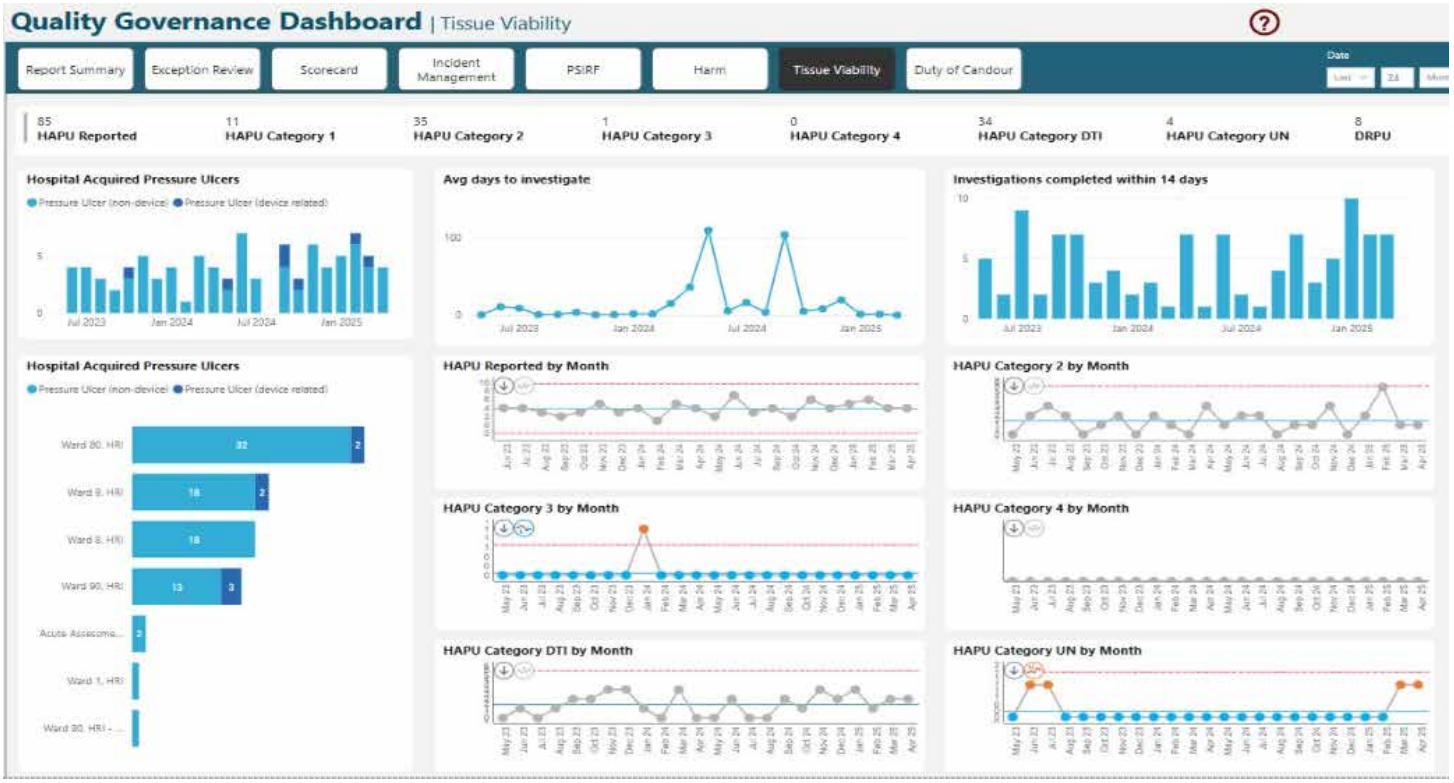
The additional HCA will assist with personal cares, activities of daily living, escorting patients and assisting the nurses.



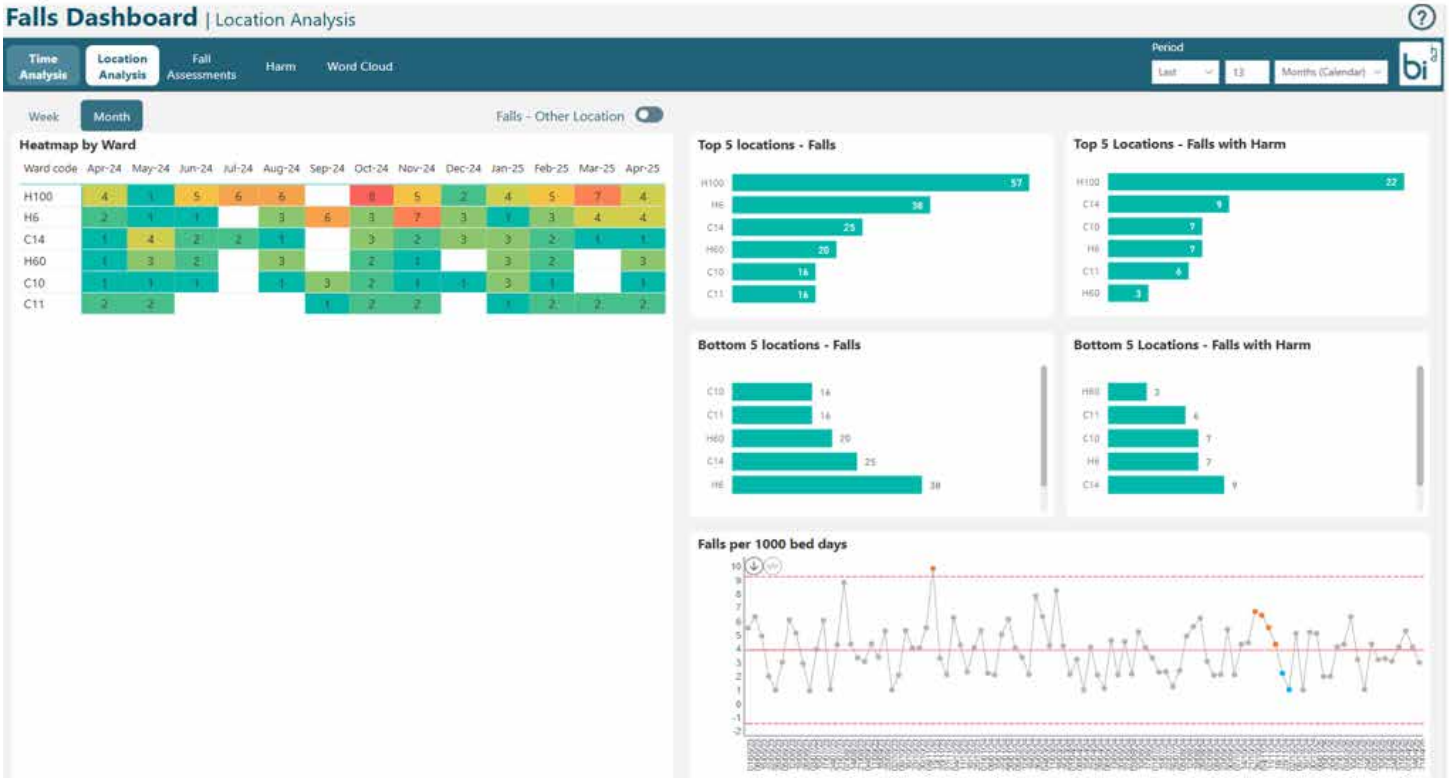


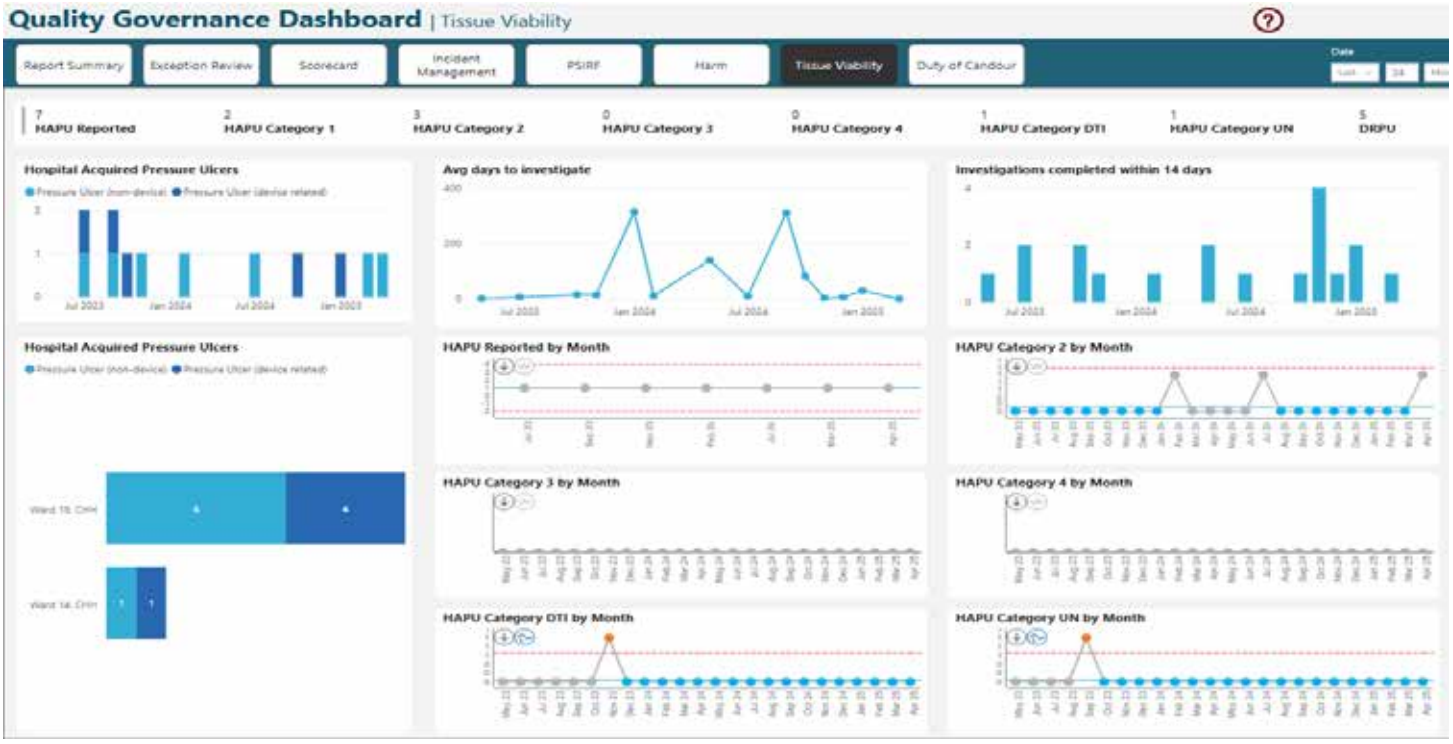
It is common for HRI ECA in ED to reach a patient number that averages between 40-80, inclusive of lodged patients. The current RN establishment can give a staff to patient ratio during peak periods that is too high to safely manage this number of patients, especially when factoring in caring for a cohort of patients waiting admission. There is also the added risk of having a large waiting area and the ability to safely observe this for patient deterioration. It is recommended, based on the occupancy and acuity that an uplift in RN hours is required to improve safety, quality and patient experience in the ECA. Based on the occupancy it is recommended to increase the staffing in the ECA by 2 Band 5 RNs and 2 Band 3 CSWs plus 1 Band 2 HCSW 24/7.





H9 is a 30 bedded frailty ward. High number of level 1c and 1d patients requiring 1:1 care but shifts infrequently filled. High number of patients at risk of falls and high number of falls with harm. High numbers of HA pressure ulcers.
H80 is a 27 bedded frailty ward. High number of level 1c and 1d patients requiring 1:1 care but shifts infrequently filled. High number of falls and falls with harm. High numbers of HA pressure ulcers.
H130E is a 31 bedded NCTR ward. High number of level 1c and 1d patients requiring 1:1 care but shifts infrequently filled. High number of falls and falls with harm.
H130W is a 22 bedded NCTR ward. High number of level 1c and 1d patients requiring 1:1 care but shifts infrequently filled. High number of falls.

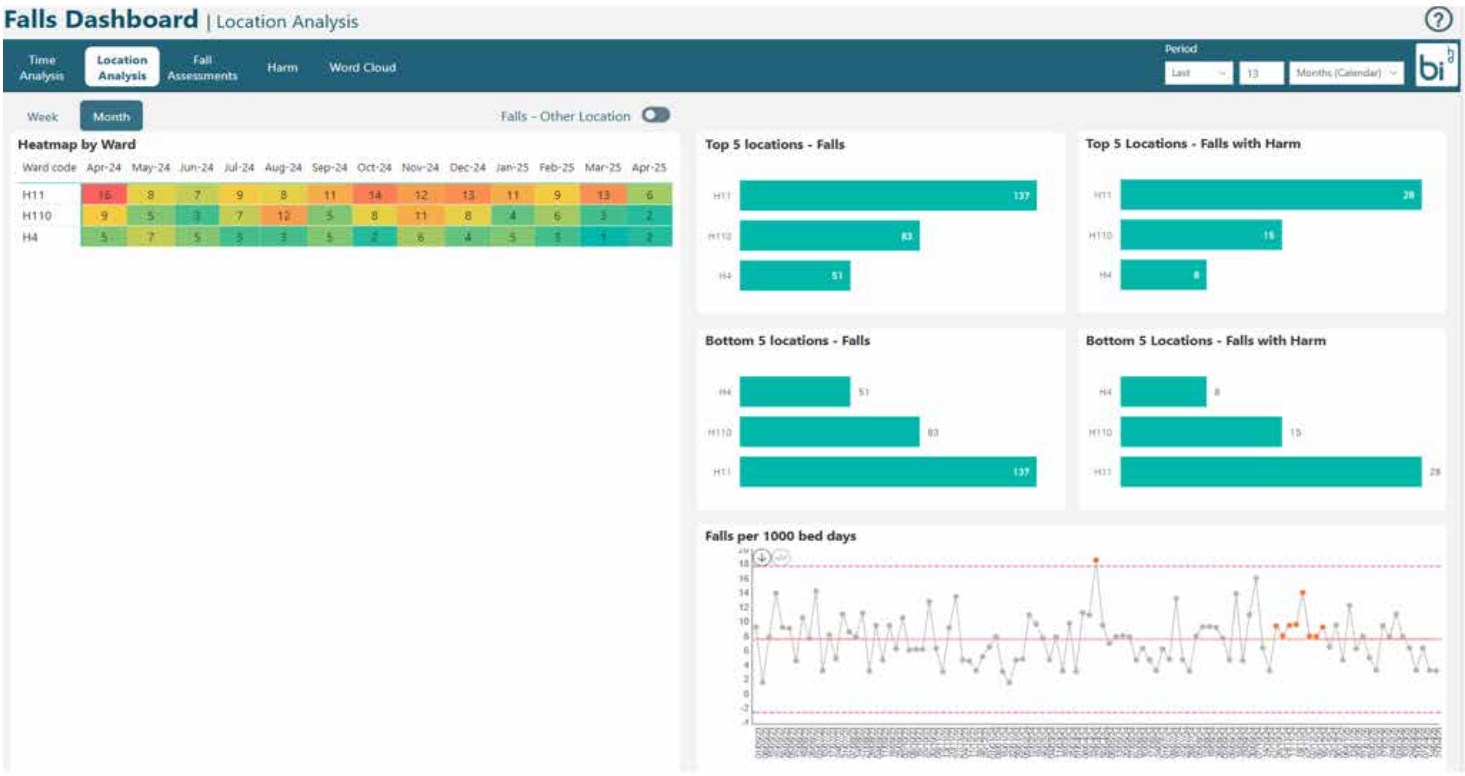


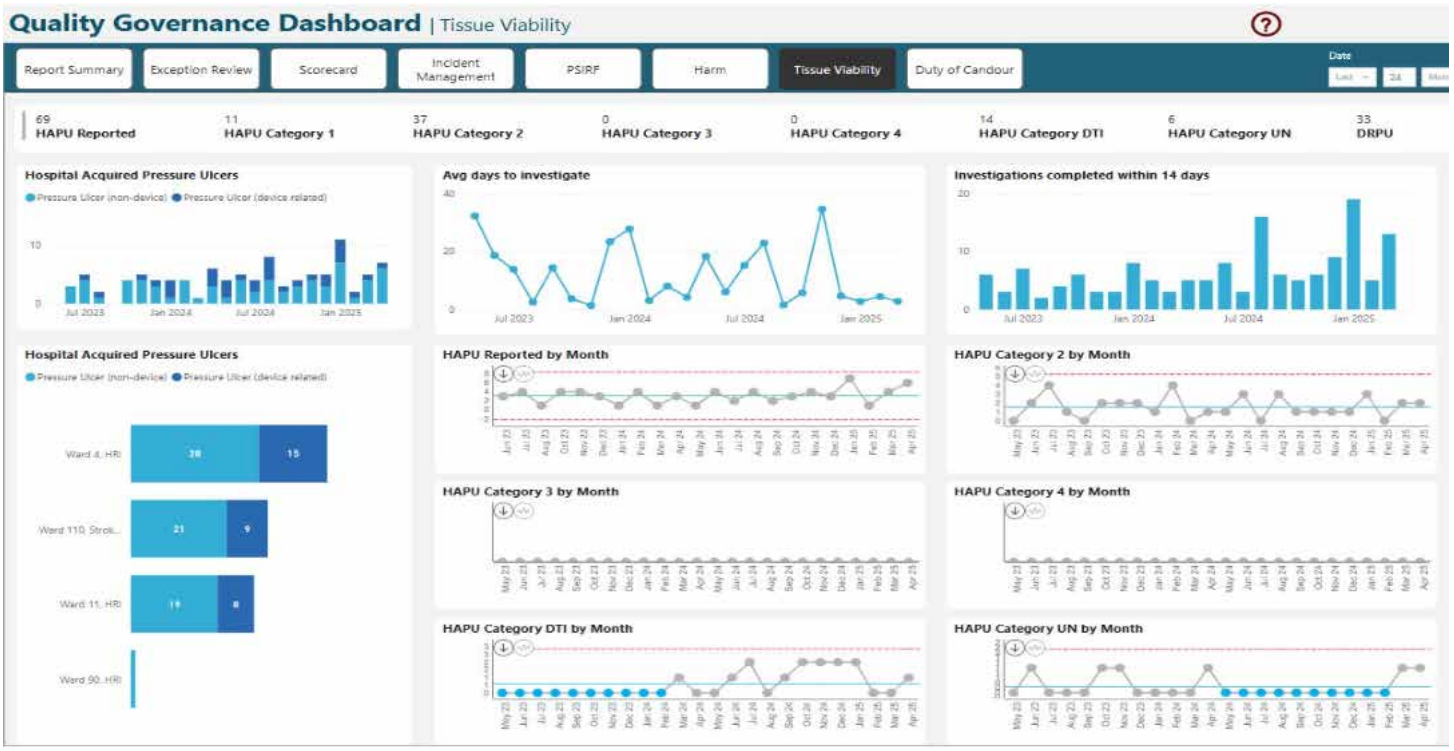


H60 is an acute surgical ward where patients arrive acutely unwell often requiring immediate lifesaving surgery or require numerous IV drugs and fluids to stabilise prior to surgery. The ward receives 2-3 patients from ICU a day who have usually had a laparotomy and are one day post op.

Patients can deteriorate quickly and post operative observations equate to the registered staff are as per policy, carrying out observations at least hourly and administering IV analgesia as well as caring for those on an IVPCA.

The ward has now secured access to a CPOD theatre daily 8-6pm which will allow more patients to access the ward and reduce length of stay but this will increase the turnover. The majority of activity is in the morning where there will be new admissions and discharges therefore this is where there is immediate need to ensure high quality care in preparing patients for theatre, discharging them safely, ensuring pain controlled and reduce the risk of sepsis by administering antibiotics in a timely manner.

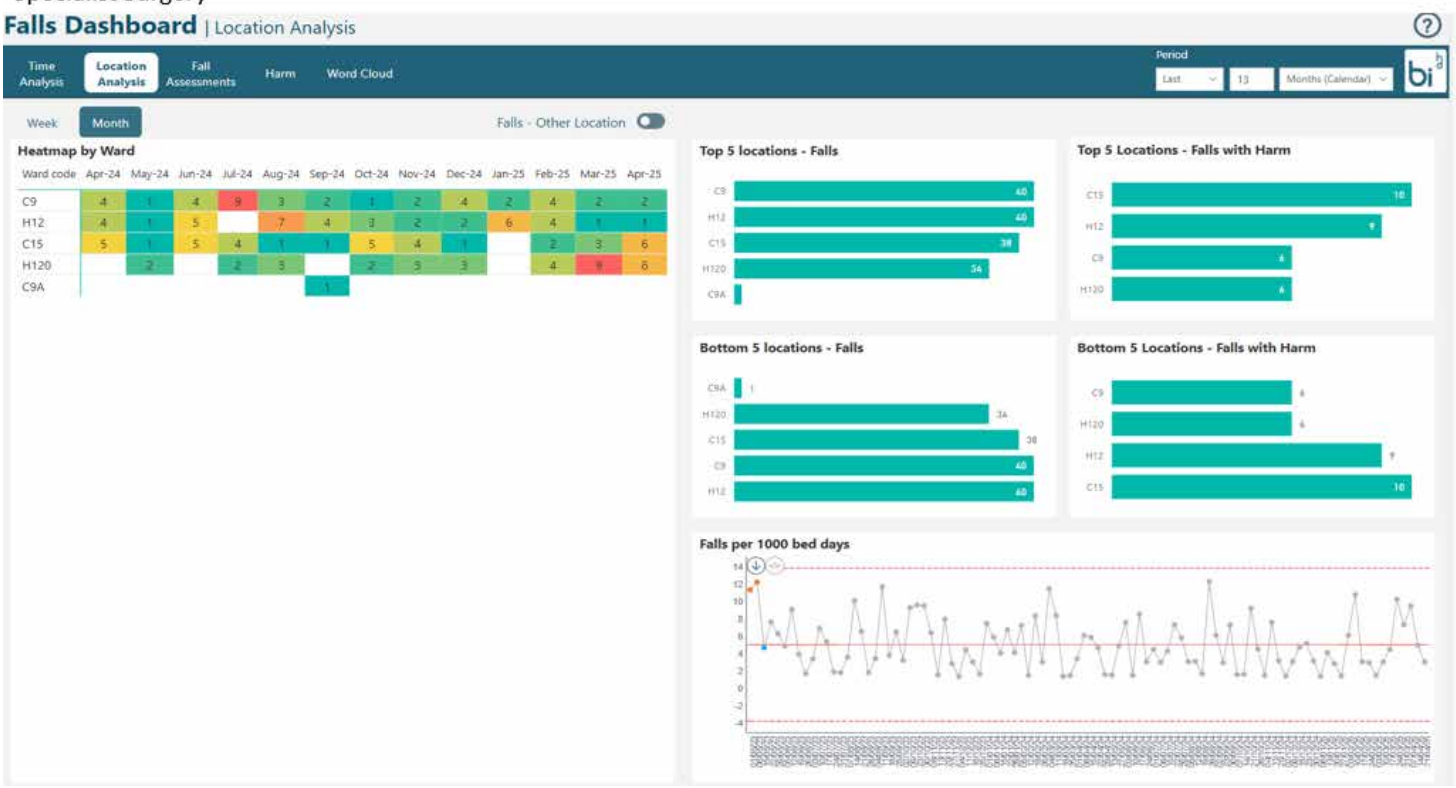


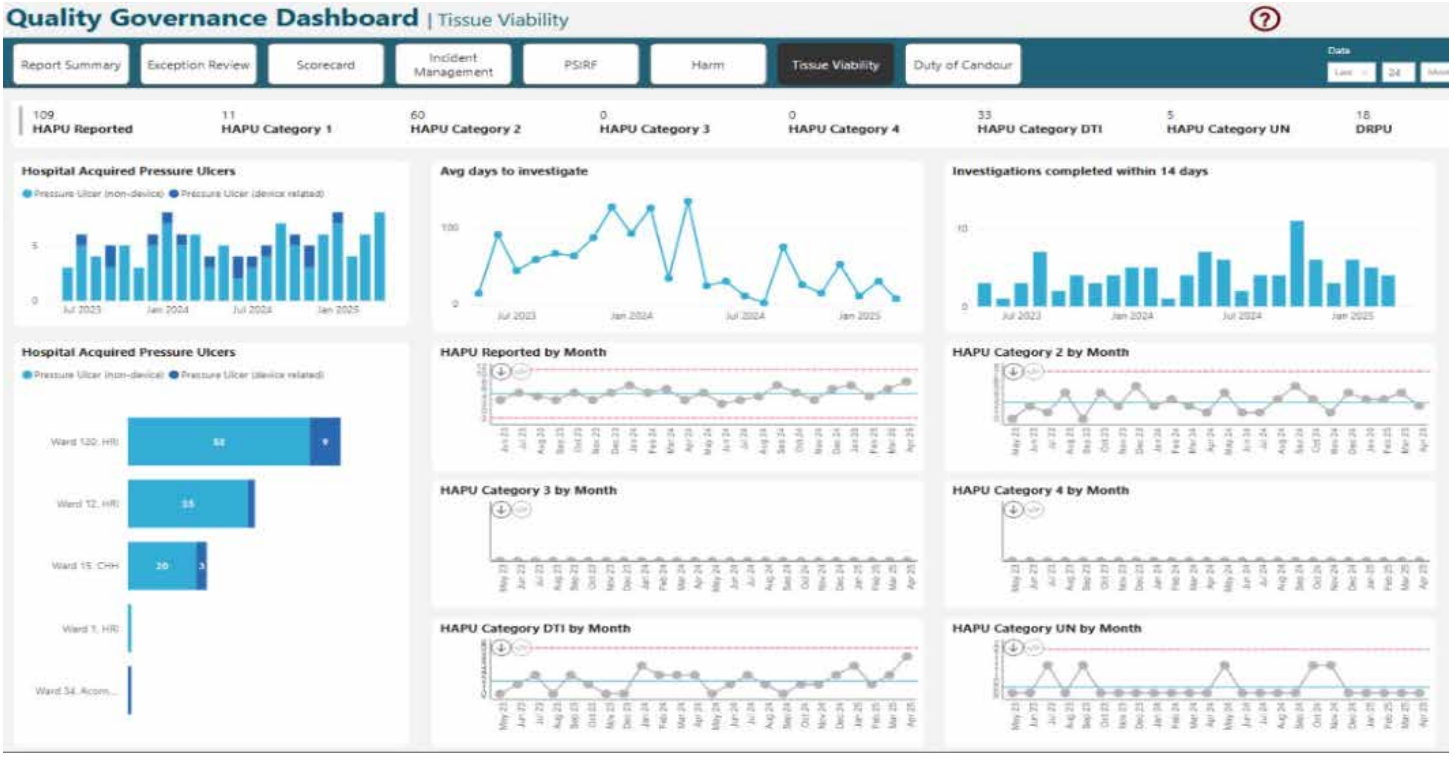


H11 in a 28 bedded neurology/ stoke ward, has extremely high acuity and dependency and generally has multiple patients who are high risk of falls. The number of unwitnessed falls has increased and increased numbers of falls are being seen overnight. The pathway from HASU is to H11. There are a high number of escorts required. The additional HCA is required to support with personal care and to increase oversight of vulnerable patients.

H110 has 16 stroke beds and 8 HASU beds. The ward layout is poor and bays are not visible. Many patients are a high falls risk and lots of escort duties are required. An HCA is required to support the 8 HASU beds 24/7 but with the priority being the long day.

Specialist Surgery





H12 is a 28 bedded trauma orthopedic ward. Ward layout poor. High acuity and dependency with multiple patients at risk of falls requiring 1:1 care. High number of falls and falls with harm.
H120 is a 22 bedded trauma orthopedic, ENT & maxillofacial ward. 10 cubicles. High number or level 1c and 1d patients requiring 1:1 care. Gaps in intentional rounding and increased incidents. There is also an Increase in the number of patients who fall and falls that result with harm. There is also high number of hospital acquired pressure ulcers.

Section 1 Bi-annual midwifery staffing oversight report Hull University Teaching Hospitals

Yvonne McGrath
Group Director of Midwifery
June 2025

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

1. Background

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

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

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

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

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

Maternity Services at Hull Royal Infirmary provide inclusive care for pregnant women and their families in Hull and the East Riding of Yorkshire and we provide care to over 5000 parents and babies every year. The Maternity Service operates a traditional model with intrapartum service provision delivered at Hull Royal

Infirmary (HRI). Despite the falling birth-rate both nationally and locally, the complexity of women and associated obstetric complications is rising, for example the number of safeguarding cases, the number of women with high BMI, diabetes and smoking in pregnancy. There is a midwife-led birth centre as well as specialist services for complicated pregnancies, fetal and neonatal care. Our service provides care for pregnant women and their babies throughout pregnancy, labour, and the postnatal period caring for pregnant women with pregnancy that are straightforward or highly complex.

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

2. Birthrate Plusâ Workforce Planning

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

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

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

This included a 21.6% uplift to cover annual, sickness and study leave has been included in the staffing calculations. The 2021 report identified that compared to data collated in 2018 the overall health needs of the local population have significantly increased than previously reported. This in turn has a direct correlation to the number of midwives required to deliver safe and affective care to women throughout their maternity journey. However, given the significant increased ask for midwifery training aligned to Core Competency Framework version, an increase in uplift from 6 days to 9.4 days is required and aligns with other specialist areas across the trust such as ITU.

Data has been collected for a full Birthrate Plusâ and this may impact the recommendations on numbers of midwives required across all areas of the service. The report has been received by the Trust; a further updated staffing report will be submitted in August 2025 to Trust Board detailing review of the recommendations.

3. Birthrate Plusâ Refresh November 2023

The refreshed report considered the implementation of the new maternity triage service and recommended a total clinical whole time equivalent of **197.48wte** registered midwives and band 3/4 maternity support workers.

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

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

Currently HUTH does not have all of the above roles. In addition to these posts, consideration should also be given to recommendations from national reports such as Ockenden 2022 with regards to new roles.

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

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

Table above shows the current funded establishment has a deficit of 13.46wte allocated for the non-clinical roles as usually required in all maternity services.

Results

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

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

The results indicate a negative variance of 20.13wte from the current funded establishment with 21% uplift. This is primarily in the Specialist posts so an increase in postnatal support staff will release midwifery hours to address the shortfall.

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

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

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

A number of Band 7 Manager Roles are also secondments causing uncertainty and instability across the team. The proposed approach would ensure that all Matron and Ward Manager roles were substantively appointed to which will support stability going forward.
As per the Diagnostic Report and the previously submitted Outline Business Case, urgent action is required to stabilise the midwifery leadership at Hull Royal Infirmary. Further funding is also required to reach Birthrate+ recommendations as detailed below.

Birthrate+ recommended establishment	221.17	
Funded establishment B3-B8	194.02	
Triage funding agreed (16.59 WTE B6 1 WTE B7)	17.59	
Current total	211.61	
Gap between BR+ and funded establishment	9.56	

Recommendation for B8/B7 Leadership roles in this	4.00	Community & MLU Matron (B8A) Labour Ward Manager (B7), Maple Ward Manager (B7), Community Manager (B7)
Unfunded B3s in post in community	4.92	Previously 1.66 WTE midwives removed from the community midwifery rotation budget to fund the band 2 to 3 uplift, currently 0.64 WTE funded establishment
New Band 3 post to support Diabetic team	0.64	In view of significant clinical risk-would help release midwifery time.
Total with new posts	221.17	

4. Current Midwifery staffing Issues and Risks

Recruitment and retention progress

Staff Group Summary

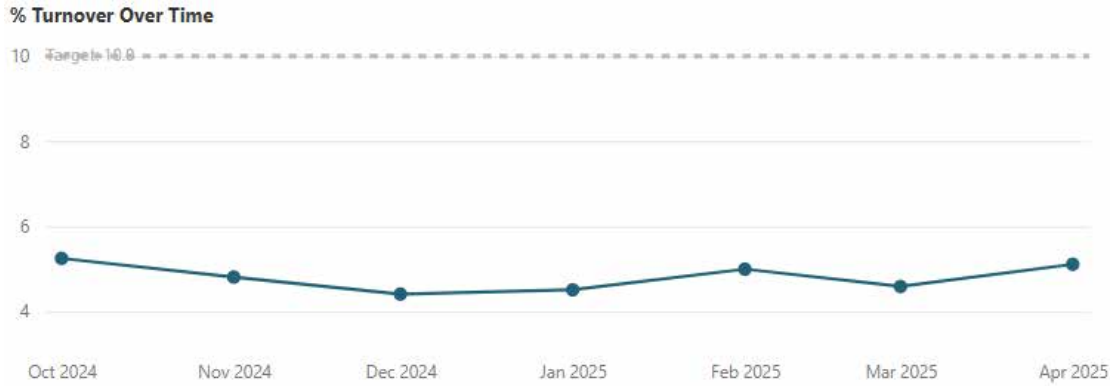
Staff Group	Headcount	Est FTE	SiP FTE	Vacancies FTE	% Vacancies	Agency FTE	Bank FTE	Adjusted Vacancies FTE	% Adjusted Vacancies
Nursing and Midwifery Registered	259	208.9	193.0	15.9	7.6%	0.0	2.8	13.0	6.2%
Total	**259**	**208.9**	**193.0**	**15.9**	**7.6%**	**0.0**	**2.8**	**13.0**	**6.2%**

Attrition

Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed. Turnover is 5.1% against a target of 10%

Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	5.1%	9.5	11.2	0.0	0.0%
Total	**5.1%**	**9.5**	**11.2**	**0.0**	**0.0%**



Maternity leave position

In October 2024, the maternity leave rate was 5.46%. This has gradually come down and is currently 4.01% of midwives in April 2025.

Sickness absence rates from October 2024 – April 2025:

Sickness levels remain stagnant over the last 6 months. The most common reason is mental health concerns.

Month	October	November	December	January	February	March	April
% of all midwives	5.4%	5.3%	5.2%	5.2%	5.3%	5.3%	5.2%

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

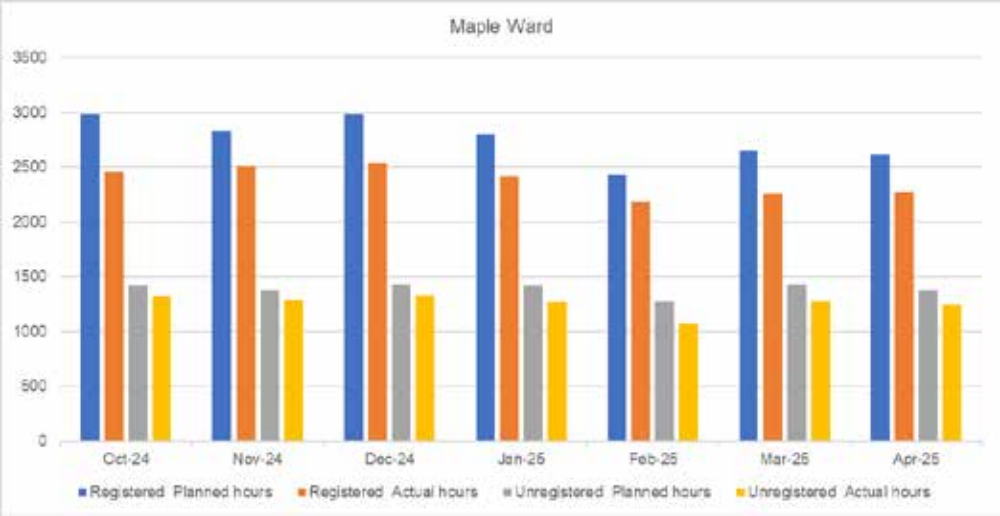
- Labour ward coordinator is not supernumerary for the whole shift
- Ability to provide a robust home birth service
- Cancellation of planned activity in community mainly booking appointments, potential to impact on targets for AN screening,
- Delay to induction of labour

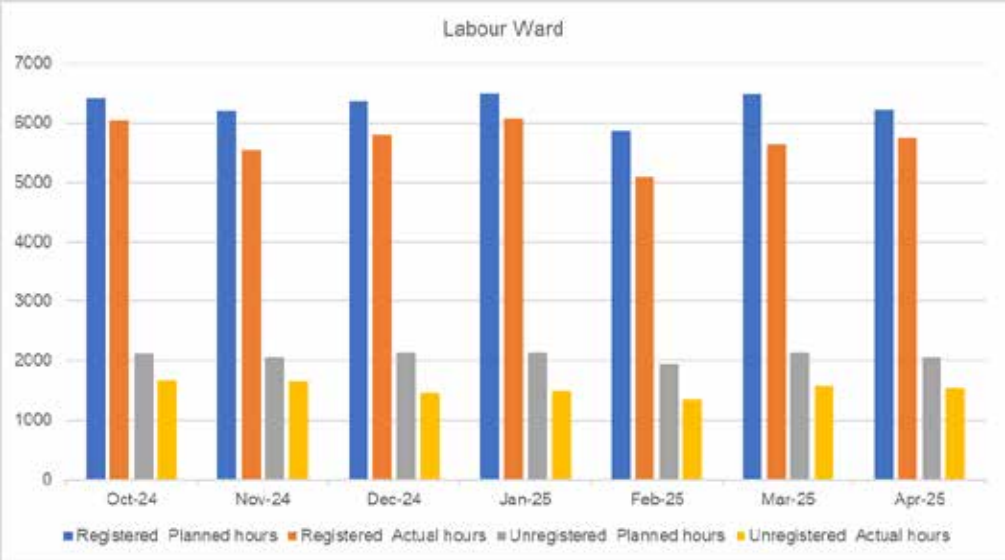
Actions taken to address attrition

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

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

5. **Planned Versus Actual Midwifery Staffing Levels (Inpatient Areas)**




Labour Ward
7000
6000
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Oct-24
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Dec-24
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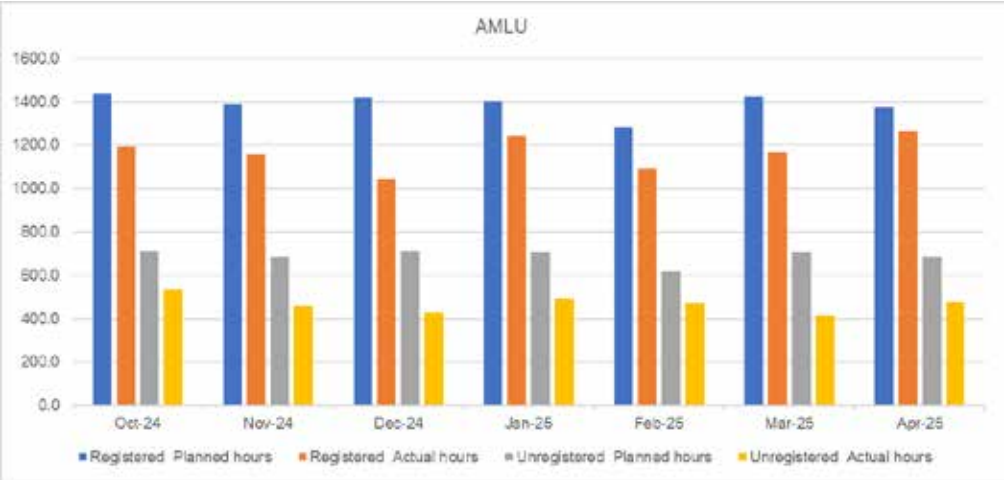
AMLU
1600.0
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Oct-24
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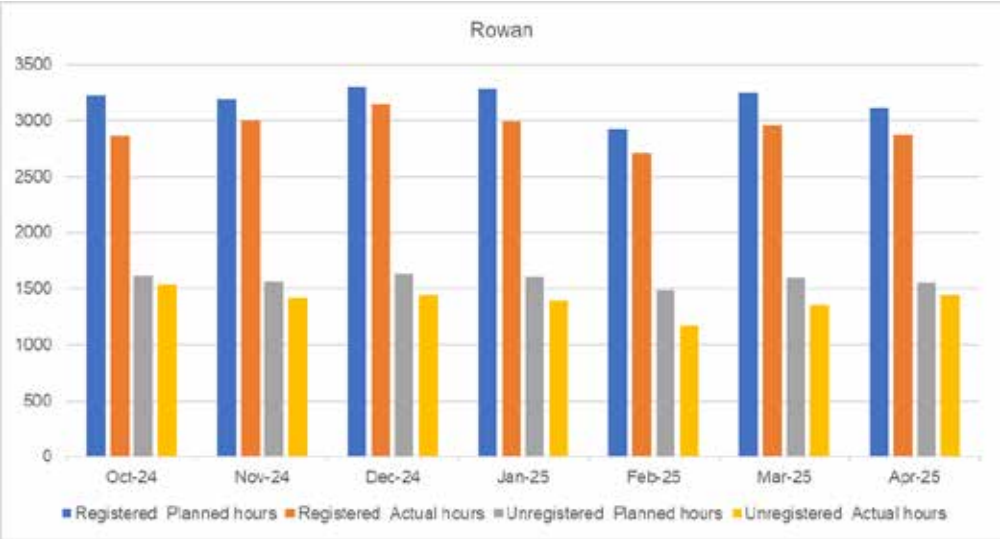
Apr-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours



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

6. **Specialist Midwives**

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

7. **Birth Rate Plus Live Acuity Tool**

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

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

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

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity. When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Activate the on-call midwives from the community to support labour ward.
- 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

There is an overall impact on deliver of CNST Year 7 safety action 5 – all workforce related, and despite the reductions in thresholds for compliance, this is still a significant risk.

Supernumerary Labour Ward Co-ordinator

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

The following table outlines the compliance by month:

Month	Number of days per month	Number of shifts per month	Compliance
October 24	31	62	98%
November 24	30	60	100%
December 24	31	62	100%
January 25	31	62	100%
February 25	28	56	98%
March 25	31	62	94%

There have been 6 incidents from October 2024 to April 2025 that the labour ward coordinator has not been supernumerary. On review of these incidents, it was a period of high activity on the labour ward, short term sickness, and the inability to fill vacant shifts.

As per the MIS Year 7 requirements, there should be a supernumerary coordinator allocated at the start of every shift. The 6 incidents above were reviewed and 5 occasions were throughout shifts and a temporary action following the escalation policy. There was 1 occasion where the coordinator temporarily allocated herself a postnatal woman/birthing person on the handover sheet whilst staff were relocated. The woman/birthing person was swiftly reallocated, and all cares provided by another midwife from handover, supported by patient documentation. Considering this, 100% compliance could be declared for this requirement.

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 reported by the Birth Rate Plus acuity tool by Month:

Month	Number of days per month	Number of shifts per month	Compliance
October 24	31	62	100%
November 24	30	60	100%
December 24	31	62	100%
January 25	31	62	98%
February 25	28	56	100%
March 25	31	62	100%

There has been 1 recorded incident from October 2024 to April 2025 where it was reported on the acuity tool that 1 midwife was not able to provide continuous one-to-one care and support to a woman during established labour. This was investigated further and when reviewing the records, the woman/birthing person that this was reported for did receive one-to-one care and at the time of the data inputting, the woman was then postnatal. Considering this, 100% compliance could be declared for this requirement.

Red Flag Incidents

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

The following tables demonstrate red flag events:

	1st October 2024 – 1st April 2025						
Delivery Suite	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**Total**
Delayed or cancelled time critical activity	39	25	16	22	24	17	143
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	2	3	0	0	0	7

Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes meds)	0	0	0	0	0	0	0
Delay in providing pain relief	0	0	0	0	0	0	0
Delay between presentation and triage	0	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0
Delay between admission for induction and beginning of process	33	36	33	32	33	36	203
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0	1	0	0	1
Labour Ward Coordinator unable to maintain supernumerary status – providing 1:1 care for a woman	0	0	0	0	0	0	0
Labour Ward Coordinator unable to maintain supernumerary status – NOT providing 1:1 care for a woman	1	0	0	0	1	4	6
TOTAL	75	63	52	55	58	57	360

8. Recommendations

It is recommended that:

- The contents of the Bi – Annual Midwifery Staffing Report are noted by the Trust Boards-in-Common.
- Full review the revised BR+ Report requirements is undertaken, reporting to Quality Committee-in-Common and Trust Board-in-Common to ensure compliance with MIS Year 7 requirements to demonstrate there is agreed plan to fund to BR+ recommendation including an agreed timescale.
- Further updated staffing report reflecting BR+ recommendations to be submitted to Trust Board in August 2025.

Section 2 Bi- annual midwifery staffing oversight report Northern Lincolnshire and Goole NHS Foundation Trust

Yvonne McGrath
Group Director of Midwifery
June 2025

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.

4. 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.

5. Birthrate Plusâ Workforce Planning

The only available workforce modelling tool for maternity services is the nationally recognised Birthrate Plus® (BR+). Birthrate Plusâ (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 Plusâ (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 Plusâ and this may impact the recommendations on numbers of midwives required across all areas of the service. This reported is expected by the end of June 2025

6. 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 Plusâ assessment is carried out every three years and that the midwifery staffing budget reflects the establishment as calculated by Birth rate plus.

7. 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	P
Clinical Facilitator	

8. 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. The predicted amount of new band 5's planned to join this year is 25 (head count) equating to 19.8 WTE.

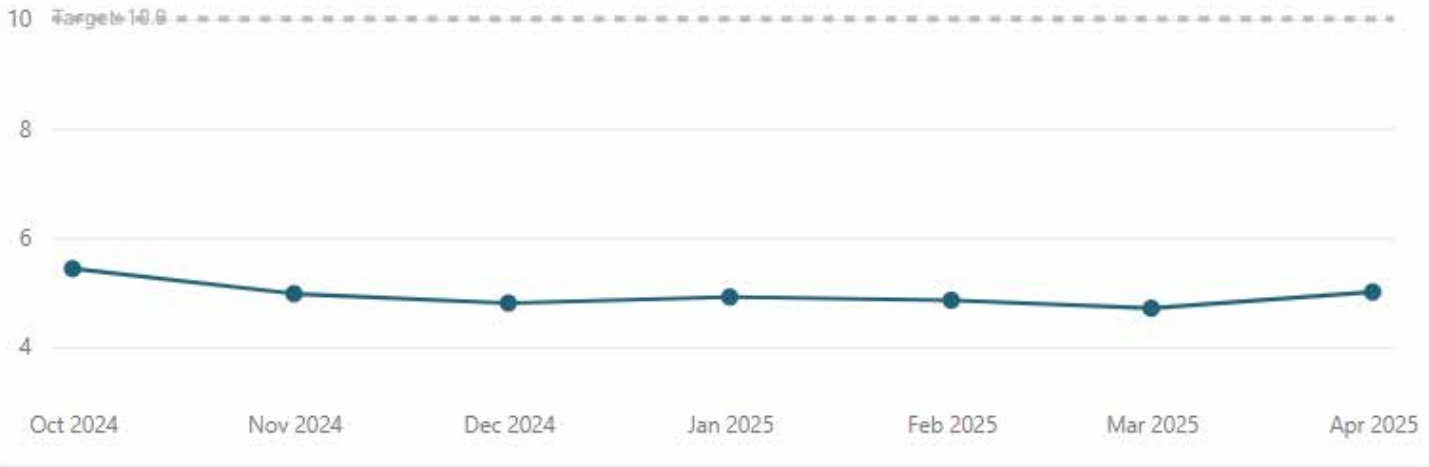
Attrition

Between October 2024 and March 2025 six midwives left. Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed.

Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	5.0%	17.9	20.1	1.4	8.0%
Total	**5.0%**	**17.9**	**20.1**	**1.4**	**8.0%**

% Turnover Over Time



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)

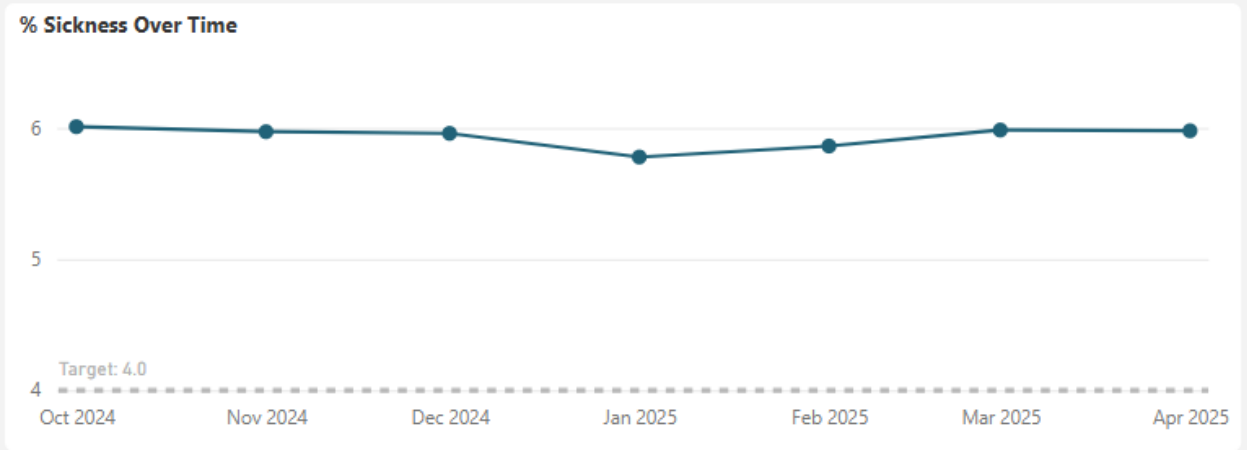
Maternity Leave position

In April 2025 the maternity leave rate was at 2.98% of our whole midwifery workforce, decreasing from 3.88% in October 2024.

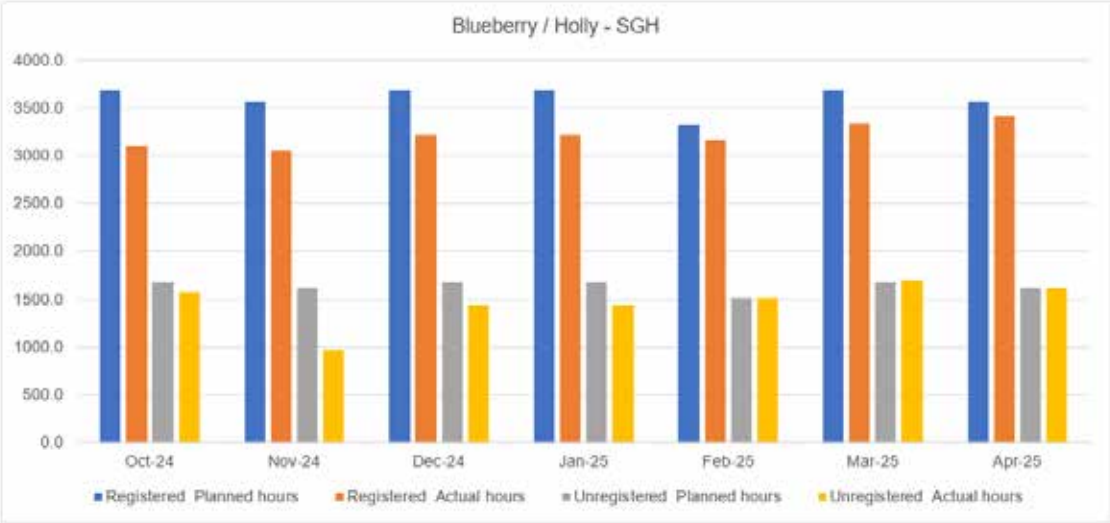
Sickness absence rates October 2024 to April 2025:

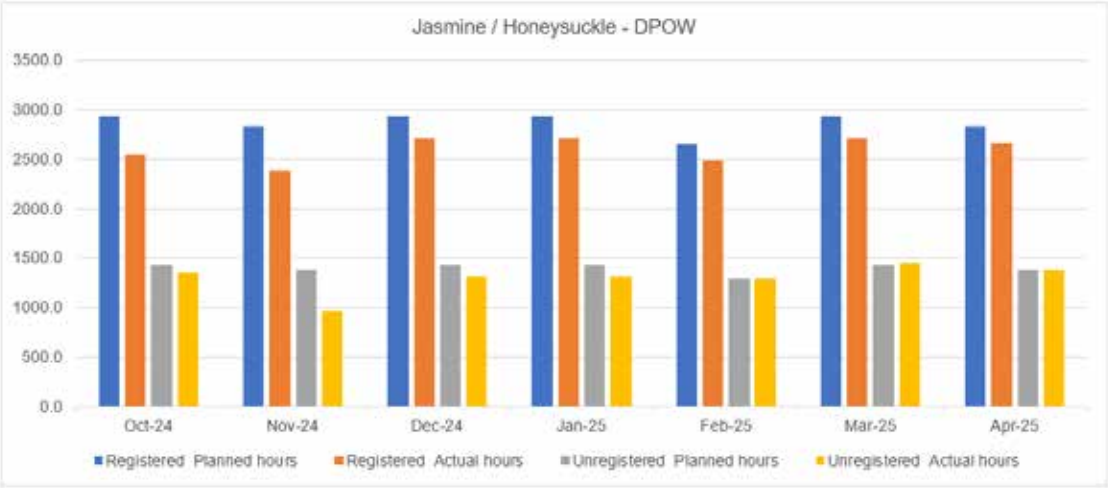
Sickness levels for Nursing and Midwifery Registered staff (short-term and long-term) have remained around 6% during this period:

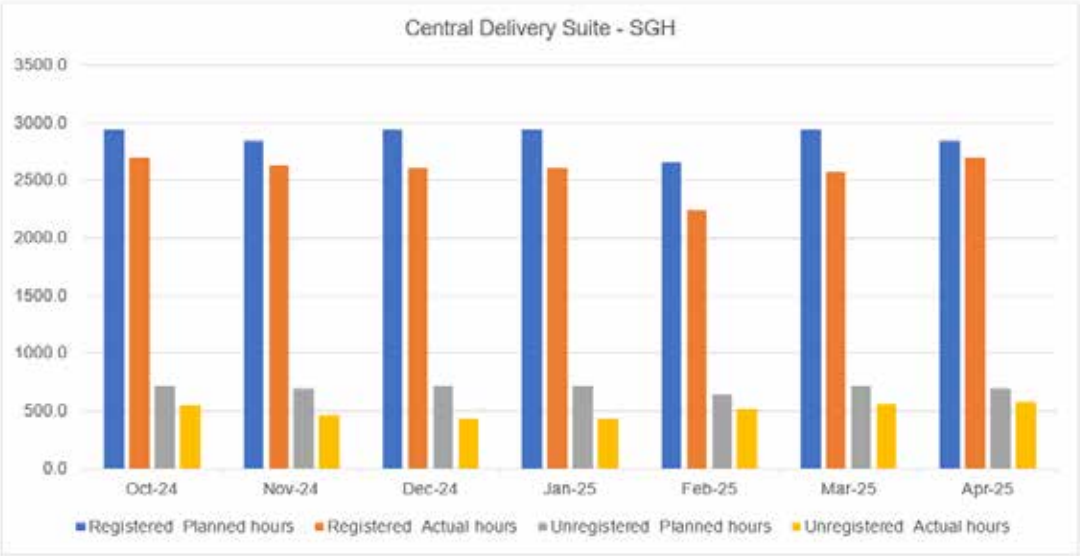
Month	October 24	November 24	December 24	January 25	February 25	March 25	April 25
% of all midwives	6.01%	5.97%	5.96%	5.78%	5.86%	5.98%	5.98%



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







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.

10. 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.

11. 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.

Month	Number of days per month	Number of shifts per month	Compliance
October 24	31	62	100%
November 24	30	60	100%
December 24	31	62	100%
January 25	31	62	100%
February 25	28	56	100%
March 25	31	62	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. 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 from October 2024 to March 2025:

Team	Indicator	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Trustwide Maternity	(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 ↘	0.0 ↘	1.0 ↗	0.0 ↘	0.0	1.0 ↗
	(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	1.0 ↗	0.0 ↘	2.0 ↗	1.0 ↘	3.0 ↗	0.0 ↘
	(c) Missed medication during an admission to hospital	0.0 ↘	1.0 ↗	1.0	0.0 ↘	1.0 ↗	1.0
	(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0
	(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0 ↘	0.0	0.0	0.0	0.0	0.0
	(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0
	(g) Delay of 2 hours or more between admission for induction and beginning of process	0.0 ↘	0.0	2.0 ↗	0.0 ↘	0.0	2.0 ↗
	(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	1.0 ↗
	(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
	(j) Community staff have been called in to work on the unit.	1.0 ↘	1.0	4.0 ↗	1.0 ↘	1.0	1.0

12. Recommendations

- Review the revised BR+ requirements against the new report once available via reporting to Quality Committee-in-Common and Trust Board-in-Common to ensure compliance with MIS Year 7 requirements and to demonstrate there is agreed plan to fund to BR+ recommendation including an agreed timescale.
- Further updated staffing report reflecting BR+ recommendations to be submitted to Trust Board in August 2025.

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(25)102

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 June 2025
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 – March 2025
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 29 March 2025
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 29 May 2025
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 27 March 2025 at 9.00am to 12.30pm at Boardroom DPoW

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)
Dr Kate Wood	Group Chief Medical Officer
Amanda Stanford	Group Chief Nurse
Clive Walsh	Interim Site Chief Executive (North)

In Attendance:

David Sharif	Group Director of Assurance
Yvonne McGrath	Group Director of Midwifery
Rebecca Thompson	Group Deputy Director of Assurance
Julie Beilby	Non-Executive Director (NLaG)
Murray Macdonald	Non-Executive Director (HUTH)
Tony Curry	Non-Executive Director (HUTH)
Ashok Pathak	Non-Executive Director (HUTH)
Michela Littlewood	Associate Director of Quality Governance (HUTH)
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Dr Simon Thackray	Chief of Service for the Cardiovascular Care Group
Wendy Magee	Cardiovascular Care Group Nurse Director
Zara Ridge	Head of Facilities
Damian Haire	Care Group Operations Director
Natalie Griffiths	Care Group Nurse Director – Head and Neck
Kevin Allen	Observing Governor
Jo Palmer	PA to the Non-Executive Directors (NLaG) – Minutes

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair welcomed those present to the meeting. Apologies for absence were noted from James Illingworth, Research and Development Manager.

1.2 Staff Charter and Values

The committee Chair reminded attendees that the meeting was being conducted in line with Trust values.

1.3 Declarations of Interest

There were no declarations of interest received in respect of any of the agenda items.

1.4 To approve the minutes of the meetings held on 27 February 2025

The minutes of the meetings held on 27 February 2025 were accepted as a true and accurate record.

A discussion took place on the clarity around the process of approving Minutes.

ACTION: David Sharif to clarify the process for the approval of Minutes across all assurance committees

1.5 Matters Arising

The committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.6 Review of Action Tracker

The following updates to the Action Tracker were noted:

24/10/24 Item 3.3 – on the Agenda therefore item to be closed
28/11/24 Item 1.8 – on the Agenda therefore item to be closed
28/11/24 Item 4.6 – on the Agenda for the time out session in April 2025
17/12/24 Item 5.1 – Sue Liburd raised with the L&D team therefore item to be closed
17/12/24 Item 6.4 – PEF CiC were made aware of the Legionella outbreak, therefore item to be closed
27/2/25 Item 1.7 – discussed at Trust Board and referred by WEC CiC, therefore item to be closed
27/2/25 Item 1.8 – to be discussed at the April time out session then item to be closed
27/2/25 Item 1. 8 – update to be provided at the May meeting
27/2/25 Item 3.2 – update to be provided at the May meeting
27/2/25 Item 3.2 – to be discussed at the April time out session therefore item to be closed

27/2/25 Item 4.1 – to be discussed at the April time out session therefore item to be closed
27/2/25 Item 4.7 – update to be provided at the September meeting

Yvonne McGrath joined the meeting

1.7 **Operational Pressures Update**

Clive Walsh provided an update on emergency flow, cancer, elective and diagnostics. Ambulance offload times continued to go well on the North bank and now also on the South bank. Yorkshire Ambulance Service (YAS) and East Midlands Ambulance Service (EMAS) recognised the safety contribution made by the Group. A capital investment was expected to enable the remodelling of the ground floor around the Emergency Department (ED) at Hull Royal Infirmary, which would improve the service to patients. There were still challenges caused by the outbreaks of CPE on the South bank and Norovirus on the North bank. Amanda Stanford went on to provide an update on the CPE outbreak; its impact on Infection, Prevention and Control (IPC) and the steps being taken to mitigate this, such as deep cleaning, Personal Protective Equipment (PPE), and hand hygiene. Unfortunately, there was continuing evidence of poor consistent IPC practice, however staff were being challenged with clarity on expectations of standards, clinical environments, bare below the elbow and so on. There was noted involvement from ICB colleagues, the UK Healthcare Security Agency (UKHSA) as well as an external expert in CPE containment and it was recognised that it would take some considerable time to get under control. There had been a request to implement a screening strategy, and this was currently being looked at. The subsequent impact on pathology colleagues was acknowledged in a business case for the release of funding to assist with the deep cleaning. David Sulch was pleased to hear that a strategy was being considered.

Improvements continued on the Faster Diagnosis standard for cancer pathways, but the 62-day standard was not meeting standard, with a large amount of patients at 63 days or more waiting for treatment. It was expected that it would be some time before capacity was available to improve the 62-day pathway. The Group were in the Tier 1 support system for cancer with NHSE.

Despite the increased risk due to the dispute with South bank consultants, it was expected that the number of patients waiting over 65 weeks would be in line with previous projections. The aim was to clear the over 65 weeks cohort by the end of June 2025 and to submit a plan that was compliant with the national standards around 52 weeks and the proportion of patients waiting over 18 weeks.

Dr Ashok Pathak questioned whether on the North bank, the 63 days or more cohort was linked to the lack of clinical workforce and asked which speciality was most affected. Clive Walsh responded to advise that the underperformance and good performance could be quite variable and individual cancer site improvement plans were in place. The main pressure area he believed was ENT in terms of capacity and demand, along with urology where the pathway was quite extensive. There were issues with histology being reported within the specified standard, which was being reviewed.

Murray Macdonald referred to the BAF and Risk Register and asked whether the Group were now at a point where the infection outbreaks were becoming a

strategic risk or were still at an operational level. Dr Kate Wood reassured him that it was still an operational risk as it was being managed as per other infection control outbreaks, but this would be kept under review.

Amanda Stanford added that there was a piece of work underway around the reduction in temporary escalation spaces, which were not safe spaces and were not beneficial to patient care and a visit was planned by a representative from NHSE.

2. MATTERS REFERRED TO THE COMMITTEES

2.1 Matters referred by the Trust Boards or other Board Committees

The committee Chair reported that the following item had been referred:

27/2/25 Item 1.7 – the issue of South Bank consultants not performing work outside of contract was raised to the CiC by the Workforce, Education and Culture CiC and was discussed at Trust Board on 13 March 2025. Dr Kate Wood provided a brief update on the situation to date, outlining that all immediate risks had been mitigated. New payment rates were to be implemented on the North bank as of 1 April 2025, despite some negative feedback. Dr Ashok Patel asked whether there was a risk of the North bank consultants following the same action as the South bank and Dr Kate Wood accepted there was always a risk of this. There was a large amount of work ongoing addressing activity during core work with a view to less reliance on additional activity.

Sue Liburd advised that there was an action from Board where there was to be some consideration around whether a Maternity Board was needed and whether the Maternity and Neonatal Assurance Group should become the Maternity Board. This was reflected in the action tracker to be reviewed in May following the publication of MIS Year 7.

3. COMMITTEE SPECIFIC BUSINESS ITEMS

3.1 Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, Incidents/MNSI)

Yvonne McGrath outlined this report, along with the Highlight Report, including the risks around training compliance, the ongoing work to address issues raised by the internationally educated midwives and updated the CiC on the recent incident involving a perimortem caesarian section, along with the positive debriefing session and provision of support to staff involved soon after the incident. MIS Y7 was awaited. Yvonne escalated the risk around high levels of sickness on the North bank, potentially affecting foetal monitoring, with a plan to provide cover from the South bank. The new additional Education Midwife was due to commence in June 2025. Sickness had also resulted in no governance support being provided on the North bank and there was a plan in place to cover this.

Sue Liburd asked Yvonne McGrath to outline the recent deep dive into diabetes as noted in the Highlight Report. It had been noted that a large proportion of stillbirths were due to diabetes, and work was also ongoing into other outcomes related to diabetes. This required more resources, and a Band 3 support worker was to be

advertised who would liaise with the team, freeing up the midwives and assisting in streamlining clinics. Work was also underway in what needed to be done to address inequality. Sue Liburd noted that the matter had been added to the maternity services risk register.

Dr Ashok Pathak asked for clarification that more Type 2 gestational diabetes were being diagnosed and whether it was site specific. Yvonne McGrath responded that the increase had been noted in all locations and was now at a rate of approximately 20% of women, rather than the 5% referenced within the literature.

Tony Curry referenced the issue of racist and discriminative behaviour which had been discussed at the WEC CiC the previous day and asked for assurance around the potential impact of psychological safety and patient safety and whether staff felt able to speak up. Yvonne replied, saying it was important that conversations were held where staff asked themselves whether they were communicating within the Group value framework. Amanda Stanford felt that the Group had a lot of work to do to get this right and Yvonne added that perhaps focus could be made on any themes and trends appearing that could be addressed. Sue Liburd explained that the CiCs would enable a comprehensive and multi-layered approach to the subject, in terms of patient safety and the impact on staff and patient health and patient experience.

Simon Thackray joined the meeting.

Amanda Stanford informed the CiC that the NGO National Conference have advised they were to publish a ‘speak up’ review for overseas workers in the next few weeks which would go some way to assisting in the Group’s approach.

David Sulch raised the issue of NMPA outlier data, to which Yvonne McGrath replied that it was a data issue. Case notes had been pulled, and the organization was within the thresholds. This would be briefed at the next MNAG meeting.

Amanda Stanford advised the CiC that there had been an engagement meeting with CQC at DPoW and there had been a discussion around the Section 31 notice where they felt that the Group were now in a position to provide evidence that the conditions set out in the Section 31 letter were being met, but Amanda’s concern was that the outstanding maternity business case had not yet been approved and this was pivotal to fully meeting the requirements of the enforcement action. Yvonne McGrath added that triage was now funded but recruitment to the posts was ongoing, until fully recruited it would not be possible to move to a full 24-hour service.

Yvonne McGrath left the meeting.

3.2 **External Agency Visits Quarterly Report Q3**

This item was deferred to the May meeting.

3.3 **Deep Dive – Audiology adult and paediatric service**

Damian Haire and Natalie Griffiths introduced themselves and gave a presentation outlining the risks and challenges, along with the improvements made and future

plans. For HUTH, there were three high risks of physical accommodation, paediatric audiologist shortfall and performance and one moderate risk in adult accommodation. For NLaG there was one high risk in paediatric audiology service. The appointment of a new Band 7 paediatric audiology clinical lead, the possibility of some space within CDC, the promotion of shared learning via Group wide audiology governance meetings and a positive meeting with ICB colleagues was highlighted for HUTH. For NLaG, Dr Kate Wood explained to the CiC the background to the SI cluster. The organisation had been regionally and nationally praised for the approach take to recover from this, had met with families affected by the SI, patients involved in the SI had been reviewed and appropriately managed. Funding had been secured for a new hearing booth at DPoW and there had been positive movement in recruitment and training. There were plans to recruit a Head Audiologist post at HUTH, continue with time out days to increase morale, focus on the physical accommodation issues at both HUTH and NLaG, a business case had been submitted to address the right size capacity versus demand and work towards IQIPS for NLaG and HUTH paediatrics.

Tony Curry thanked the team for the presentation and was encouraged to hear of the steps being taken. He asked about how much of the investment was around providing the minimum service that should be expected compared to providing a better service. Damian Haire replied that the majority, if not all, of the investment would get the organisation to the standard it should be.

Clive Walsh added that there needed to be effective pathway management across the whole system for audiology and ENT, with a plan to introduce local guidelines.

Dr Ashok Pathak commented on the training and accommodation issues, to which Natalie Griffiths responded that better training was in place now and the British Society of Audiology was better structured than it had been. Damian Haire added that the team felt it was important to do the accreditation training and was encouraged by the positive ICB visit.

Amanda Stanford believed that the organisation could learn from this, but it was important to know how. Dr Kate Wood responded that the issues had originated before the Group was formed but the new structure had brought its own challenges. Damian Haire added that since the Group operation began, the team had set up the Group Wide Governance Group for audiology which was helping to align the service on all sites, and he believed that the ongoing involvement of the regional experts on the SI was continuing to be very supportive to the service.

Richard Dickinson added that all the screening services had been reviewed and were part of the Group model governance arrangements which enabled open discussions on any issues and share learning.

David Sulch hoped that Care Groups were confident to request investment if they believed it necessary, despite the cost improvement plan underway. He thanked Natalie Griffiths for the presentation and felt it would be useful to have a discussion at the April time out session on how to hear about how other services were performing across the Group.

Clive Walsh left the meeting.

Limited assurance was agreed.

3.4 **Deep Dive – TAVI**

Dr Kate Wood explained that TAVI had been brought back to the CiC following a cluster of further deaths. Dr Simon Thackray gave a background to the service, including the national and local mortality data, the governance structure and the measures taken to improve the service and address issues raised in previous reviews.

Wendy Magee advised of the improvements in the governance structure within TAVI and how the incidents and deaths were processed following reporting via Datix. The team were looking at setting up its own Care Group mortality meeting, as well as linking into the Trust Mortality Improvement Group. Open and honest discussions were encouraged within the whole team and Duty of Candour applied within Datix as well as face to face with relatives. A record of such conversations was saved onto Lorenzo.

Dr Ashok Pathak thanked the team for the presentation and asked for some assurance that now a full complement of nursing staff and a consultant anaesthetist was on board, that the service was running to full potential. He also asked as to what was being done to increase staff morale. Dr Simon Thackray responded to advise that the staff complement was because of the recommendations from the Royal College Review. Another recommendation was to look at the culture within the department and it was clear that this had become a lot more positive over the last few years.

David Sulch asked whether there had been any new learning from the most recent cluster of deaths and Dr Simon Thackray responded positively, giving a change in the blood thinning protocol as an example.

The meeting stopped for a break of 15 minutes at 11.10am.

3.5 **Integrated Performance Report (IPR): quality & safety metrics**

The paper was taken as read. There was discussion, initiated by David Sulch, on the VTE compliance on the North bank, linking it to regular performance meetings with Care Groups. Work needed to continue with co-ordination and prioritisation and Dr Kate Wood advised there had been an improvement in compliance on the North Bank, which was due to being a standard agenda item at the performance meetings with the Care Group ensuring good focus.

Tony Curry questioned the high number of pressure ulcers reported in ED. Michela Littlewood responded to advise there was a large amount of work relating to pressure ulcers and for many of the patients, they were not hospital acquired.

Julie Beilby asked for a glossary of the acronyms and Richard Dickinson agreed to action this.

ACTION: Richard Dickinson to provide a glossary on the acronyms within the IPR report

Amanda Stanford advised that there was due to be a focus on complaints, in respect of responding to them mindfully and learning from them, with the aim to reduce the number going forward.

3.6 **Quarterly Patient Safety Report Q3 (themes and analysis including PS11, PSIRF & CLIP)**

The report and its format were well received.

No assurance rating was given on this paper.

3.7 **Patient Experience Report Q3 (including learning from complaints)**

Michela Littlewood asked if the CiC found the paper to be sufficient and the Executive Summary to be succinct.

Dr Ashok Pathak questioned the reference to the catering department and the quality and nutritional value of the food being provided. Michela Littlewood responded that work was being done to make improvements.

Tony Curry stressed it was important to review the feedback and take the necessary actions to minimise complaints. Amanda Stanford agreed and believed that initial contacts with the PALS service were not acted upon quickly enough before they escalated to a complaint. From April 2025, the QI team would be assisting the Deputy Group Chief Nurse in addressing the communication issue.

Murray Macdonald believed it important to set the objectives but also note where the organisation aimed to be so progress could be monitored. The Executive Summary on papers needed to be clear on the main issues.

Amanda Stanford added that it was important to ensure that the key strategic priorities were in place.

Sue Liburd was pleased to see the section on Group Development and Learning but believed it would be beneficial to record ongoing issues until the next report.

No assurance rating was given on this paper.

3.8 **Patient Led Assessment of the Care Environment (PLACE)**

Amanda Stanford gave an introduction on the Group's approach for this paper and noted the clear differences in the reporting across the Group, which would be addressed via the operational groups going forward.

Zara Ridge presented the report and noted the positive results, particularly as the Group were largely performing above the national average. The assessors would be reviewing the feedback and be involved in any improvement work and revisit areas to provide assurance that any action had been taken. Zara was pleased to advise that there had been improvements in all areas apart from combined food. There would be actions to address food quality and overall consistency across the sites, using the strong links with IPC, patient representatives, Estates & Services and clinical teams.

David Sulch commended the team on the results compared to last year's findings and the national average. He questioned how these improvements would be maintained in the current financial position. Zara responded that the team would continue to push for continued funding, and it was important to liaise with the capital team around investments.

Julie Beilby commented on the slight variations in the scales on the reports and that they could be misleading.

Zara Ridge also highlighted the effective information sharing between the two Trusts currently and believed this would become evident in the Group report next year.

A discussion took place around the process of assurance. The CiC were significantly assured with the HUTH report but were unable to give an assurance rating for NLaG.

3.9 **Clinical Effectiveness Report Q3 (including clinical audit work programme, NICE compliance & deviations, PROMS etc)**

The report was accepted.

4. STRATEGY

4.1 **Quality Strategy**

This item was deferred to the April time out session.

5. ANNUAL REPORTS

5.1 **Research, Innovation & Development Annual Report (including quarterly update)**

Dr Ashok Pathak questioned whether any of the 520+ publications had been peer reviewed, and Dr Kate Wood replied that she would check with the team.

Edit post-meeting: Dr Kate Wood updated that all the publications had been published through peer reviewed journals and were PubMed and Medline indexed.

The report was approved. Dr Kate Wood asked that the CiC recognise the excellent work undertaken by the Research & Development team during the transition to the Group structure.

5.2 **Annual PROMS Report**

This item was deferred to the May meeting.

6. HIGHLIGHT REPORTS

6.1 Patient Safety and Learning

This report was taken as read. Amanda Stanford drew the CiC's attention to the risk within ED and conversations were ongoing with the Care Group in terms of excess deaths. This would be highlighted at the Mortality Improvement Group.

6.2 Patient Experience and Learning

This report was taken as read.

6.3 Maternity and Neonatal Assurance Group

This item was discussed under Item 3.1.

6.4 Risk and Compliance

This report was taken as read.

7. ANY OTHER URGENT BUSINESS

7.1 Any Other Urgent Business

There were no items of any other business raised.

8. MATTERS TO BE REFERRED BY THE COMMITTEES

8.1 Matters to be Referred to other Board Committees

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

8.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board in the Committees' highlight report:

- 62-day cancer pathway remains under pressure
- Temporary escalation spaces remain under close review by NHSE
- CPE and Norovirus outbreaks remained an operation risk but mitigations were in place
- Issues experienced by the internationally educated midwives escalated to WEC CiC and a comprehensive review is to take place
- Emerging risk of increasing levels in diagnosis of Type 2 gestational diabetes which has been added to the maternity services risk register
- Audiology and TAVI deep dives
- As expected SHMI at HUTH, but to note that March 2025 was the first month that HUTH have been in the expected range for 18 months
- Significant assurance given for the HUTH PLACE report but unable to give assurance for NLaG. Evidence of good information sharing between the two Trusts
- Clinical Effectiveness report accepted

- Research, Innovation & Development Annual Report approved. Excellent work noted from the R&D team during the transition to Group structure
- PSLG - Excess deaths to be highlighted to the Mortality Improvement Group

9. DATE AND TIME OF THE NEXT MEETING

9.1 **Date and Time of the next Quality & Safety CiC meeting:**

The next meeting will be a time out session on Tuesday 29 April 2025 at 9.00am to 12.30pm in the Boardroom, Hull Royal Infirmary.

The committee Chair closed the meeting at 12.26 hours.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2024/2025

Name	Title	2024/2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
David Sulch	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Sue Liburd	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y		N	Y
Dr Kate Wood	Group Chief Medical Officer	Y		Y	Y	D	Y		Y	D		Y	Y
Amanda Stanford	Group Chief Nurse	Y	Y	Y	Y	D	Y	Y	Y	D		Y	Y
Julie Beilby	Non-Executive Director (NLaG)	N	N	N	N	N	N	Y	Y	Y		Y	Y
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	Y	Y	Y	Y	Y	Y		N		Y	Y
Rebecca Thompson	Deputy Group Director of Assurance	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Michela Littlewood	Associate Director of Quality Governance (HUTH)	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y
Dr Pete Sedman	Deputy Group Chief Medical Officer		Y		Y	Y	N	Y		N		Y	N
Mel Sharpe	Deputy Group Chief Nurse	Y			Y	Y	N			Y		Y	N
Yvonne McGrath	Group Director of Midwifery				Y		N	Y	Y	Y		Y	Y
Clive Walsh	Interim CEO (North)						N		Y	Y		Y	Y

Corrin Manaley	Quality Improvement Facilitator	Y		Y	Y		N	Y		Y		Y	N
Tony Curry	Non-Executive Director (HUTH)	Y		Y	Y	Y	Y	Y	Y				Y
Dr Ashok Pathak	Non-Executive Director (NLaG)	Y		Y		Y	Y		Y				Y
Kevin Allen	Governor		Y				N		Y				Y
Jonathan Lofthouse	Group Chief Executive		N	Y	Y	N	N	Y	N	N		N	N
Sean Lyons	Group Chair		N	N	N	Y	N	N	N	N		N	N

***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(25)103

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12th June 2025
Director Lead	Helen Wright / Gill Ponder, Non-Executive Directors / Chairs of Performance, Education and Finance Committees-In-Common
Contact Officer / Author	Karena Groom, Interim Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common meeting held on Tuesday 01 April and Tuesday 06 May 2025.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	**The minutes attached are for information.**
Prior Approval Process	Performance, Estates and Finance Committees-in-Common in May and June 2025.
Financial Implication(s) (if applicable)	**N/A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

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Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 1st April 2025
at 09:00 to 12:30 hours in The Nightingale Room, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) – Chair
Helen Wright	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer
Clive Walsh	Interim Site Chief Executive - North
Emma Sayner	Group Chief Finance Officer
Simon Parkes	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Philippa Russell	Deputy Director of Finance
Tom Myers	Group Director of Estates

Observers

Wendy Lawtey	Public Governor

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. Apologies for absence were noted for Ivan McConnell, Group Chief Strategy and Partnerships Officer Adam Creeggan, Group Director of Performance and Sarah Tedford, Interim Site Chief Executive - South

1.2 Staff Charter and Values

Gill Ponder noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 04 March 2025

The minutes of the meeting held on 04 March 2025 were accepted as a true and accurate record.

1.5 Matters Arising

No items were raised.

1.6 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
3.3.1	Finance Strategy	Brian Shipley to include a finance strategy update within the finance report section at future meetings, to update on current position, the challenges anticipated in the next five years and when a financial strategy will be available.	**The refresh of the wider strategy work would include the reason to why the date has changed to June.**
4.3	Performance Update / Deep Dive: Diagnostics (October Data) including update on Audiology Data Quality	Clive Walsh to conduct a review to understand why the assurance level for 65-week waiters was inaccurate and present the lessons learned at the next meeting.	**Clive sent the draft report to participants asking for comments on accuracy prior to distribution to the PEF CiC.**
4.3	Performance Update / Deep Dive: Diagnostics (October Data) including update on Audiology Data Quality	David Sharif to check if the ERF funding process was logged on the risk register.	**A Group-wide income expenditure risk and cash risk was drafted. Taken to Risk Corporate Committee last week for comment and they need to be put onto the system. Action closed.**

			Philippa Russell to bring a recommendation for the risk level to the next PEF CiC.
1.4	To approve the minutes of the meeting held on 04 February 2025	An additional business case for medical staffing to be shared with the Board in February 2025.	**Medical staffing will be reviewed as part of the 2025/26 plan.** **Action closed.**
1.4	To approve the minutes of the meeting held on 04 February 2025	Adam Creeggan to send Karena Groom the accurate wording around UTC to include in February's minutes.	**Karena Groom to obtain accurate wording from Ivan McConnell in Adam Creeggan's absence and include in February's minutes.**
4.1.1	Operational Planning Update	Emma Sayner to distribute the slide pack on the financial position to the CiC following the meeting.	**Slidepack distributed.** **Action closed.**
4.2	Integrated Performance Report: Operational Performance Metrics	Adam Creeggan to provide assurance to the CiC on the impact of using AI to validate waiting lists on patient care at a future CiC.	**Picked up within the Elective Care Deep Dive on the agenda.** **Action closed.**
4.2	Integrated Performance Report: Operational Performance Metrics	Clive Walsh to share the ambulance handover recovery plan with Helen Wright.	**The overall UEC improvement plan developed as part of the Tier 1 process has been shared.** **Action closed.**
4.2	Integrated Performance Report: Operational Performance Metrics	Adam Creeggan to bring a summary of the revised Urgent and Emergency Care plan to this CiC.	Deep Dive on Urgent and Emergency Care. Share as an appendix for the next meeting. **Karena Groom to get Urgent and Emergency Care plan from Sally Campbell and circulate prior to May meeting. Share as an appendix in next agenda.**
4.4	Estates and Facilities - General	Tom Myers to re-assess UPS work at SGH with Simon Tighe and	Main risk was IT server which has been replaced, revised and reduced risk. Further

	Update including Risks	ensure that is reflected within the risk scoring for the next CiC.	work around replacing UPS and ICU batteries is being carried out. **Action closed.**
4.5.3	Contract Approval - 3No Tender Awards for Roof Replacement at Scunthorpe General Hospital	Tom Myers to provide the third paper and further information with regards to the contract approval before the papers go to Board.	Further information provided to PEF, Lots A and B approved to send on to Board for approval and approved at Board development session on 13 March 2025. **The team were reviewing Lot C tender clarifications that had increased the price, and the Foster Roofing performance. Lot C would go to the Capital and Major Projects Committee for approval in June.** **Action closed.**
4.5.3	Contract Approval - 3No Tender Awards for Roof Replacement at Scunthorpe General Hospital	Gill Ponder to refer Lot C of the Roof Replacement contract approval to the June Capital and Major Projects CiC.	Referred to Capital and Major Projects CiC. **Action closed.**
4.5.4	Contract Approval - Battery Storage System report	Tom Myers to gather further information to answer the CiC questions. Following this the CiC would review and, if satisfied, provide email endorsement.	Further information provided by Tom and endorsed via email. Approved to send on to Board and was approved by Board at 13th March development session. **Action closed.**
7.1	Matters to be Referred to other Board Committees	Helen Wright to refer a medical costs discussion to Audit, Risk & Governance Committees-in-Common.	HW referred to Audit, Risk & Governance Committees-in-Common. **Action closed.**

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.2 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Financial Plan 2025/26

Emma Sayner provided an update and explained that a breakeven position was submitted last week into the Centre. The cost improvement and transformation programmes remained the greatest area of risk for 2025/26. Additional income negotiated through the system was positive and showed the Group's commitment to live within its means and the spirit of the planning guidance. The Cost Improvement Programme (CIP) showed the breakdown of the efficiency plan between the level of development and risk. This showcased the level of work to take place with the Care Groups to ensure the Group engage in delivery. A 3-hour session would take place to review cost pressures and service developments with the ambition to enact a level of de-risking linked to the CIP. Emma emphasised the importance of a focus on productivity and transactional inefficiency. A productivity opportunity across the Group of £88 million had been identified. The CIP programme outlined £130 million of improvement was required.

Jane Hawkard noted that without Elective Recovery Fund (ERF) to drive income through it was just a cost reduction programme. Emma Sayner shared that there was speculation that the CAP on elective recovery would be lifted however this had not been confirmed. She explained that it was a cost reduction and the Group anticipated a challenge of how to deliver activity with no extra cost. She also mentioned opportunities within the waiting list initiatives (WLI) and the independent sector.

Jane Hawkard further queried whether the Day Case Surgery Unit at Castle Hill Hospital would reduce waiting list initiatives (WLIs) due to the extra capacity. Clive Walsh confirmed that WLIs would reduce if the Day Case Surgery Unit was operated efficiently and that was currently a challenge. Emma Sayner shared that repatriation from the independent sector was a significant opportunity and that the Group's ambition and strategy would need to align to that.

Philippa Russell commented that there were limitations and recruitment challenges from a medical staffing capacity within Theatres and Anaesthetics. She explained that Agency was still utilised to backfill gaps in specialties and queried whether there

was capacity within Care Groups to deliver the requirements for 2025/26 despite having theatres accessible.

Helen Wright mentioned the £130 million of improvement required and queried how much wastage was included within cancellations. She praised the delivery on the CIP but noted that productivity delivery was not achieved.

Clive Walsh noted an improvement in bed availability compared to the previous winter's lost elective activity. He highlighted improvement in the reduction of cancellations particularly in relation to Neurosurgery. Assurance was provided from Specialist Commissioners who recognised that the Group were not cancelling as many patients. However, ITU capacity remained a concern in relation to cancellations.

Emma Sayner shared that transformational work would need to be delivered with a focus on areas that make a significant difference. Helen Wright mentioned that conversations previously took place around the Group requirement to release savings and investment and the skillset to achieve this.

Gill Ponder recognised the need to focus on delivery from the start of the year, avoiding the traditional approach of finding savings later in the year. She suggested the importance of a cultural mindset shift to achieve the financial plan.

Helen Wright queried whether a significant amount of the breakeven position included ICB support and further queried if breakeven versus £43 million deficit would give even more risk to the plan. Emma Sayner explained that the Group ensured that the ICB understood that system support would be required to deliver £130 million. She emphasised the importance of the Group drawing decommissioning to a close.

Simon Parkes proposed that it would be helpful to have a series of milestones when decisions were expected to be taken in order for the benefits to be delivered. He explained that this would provide an earlier sight of position against the plan for assurance purposes.

Emma Sayner explained that work was ongoing to track against the CIP.

Action: Emma Sayner and Philippa Russell to provide a milestone profile, highlighting where decision making was required in the planning timeframe at the next meeting.

Philippa Russell noted that the CIP delivery profile was less 'hockey-stick shaped' than in previous years and would meet the external challenge of providing breathing space for the Group to conform rather than face external scrutiny. She shared that the financial plan was developed to over-deliver ahead of time.

Clive Walsh queried a possible opportunity for £2 million dependent on changes at Goole Hospital within the financial recovery plan for 2026. This was based on an assumption of remodelled utilisation, subject to a number of external factors as no decisions on the future use of Goole Hospital had been reached yet.

Clive Walsh proposed a discussion in terms of what assurance means relating to cost improvement programmes for the next CiC.

Action: Emma Sayner, Gill Ponder and Helen Wright to have a discussion in terms of assurance requirements around cost improvement programmes for the next CiC.

The Committees-In-Common agreed reasonable assurance and endorsed the plan for Board approval. The challenges for 2025/26 were noted as was the importance of the Group to focus on delivery. The level of investment in transformation and cultural risks of achieving change were acknowledged. The Finance and Operational teams were commended on getting a plan in place much earlier in the year than normal, enabling focus to be on delivery against the plan from Month 1 of the new financial year.

4.2 Group Finance Report – Month 11

Emma Sayner shared that the cash position was as anticipated, and no major issues were expected. The Group were not expecting any material risks for the forecast position and were working towards finalising the position on Working Day 10. No issues were anticipated from an Estates, Capital and Digital capital perspective.

Gill Ponder proposed spending allocated funding earlier in the year to release pressure from the Group. Emma Sayner recognised the amount of delivery to be achieved. She mentioned that last minute spending of some funding awarded to the Group late in the year was unavoidable and suggested monitoring core allocations to ensure the Group work in a more timely fashion.

Helen Wright queried whether an administrative aspect contributed to the delay of spend that was reflected within the report. Philippa Russell clarified that an activity perspective attributed to the spend delays.

Simon Parkes proposed forecasting on a monthly basis to encourage a more disciplined frequency of reviewing forecasting. Emma Sayner shared her confidence in Capital expenditure and mentioned reviewing revenue forecasting. Simon Parkes added that reviewing the decision points alongside the forecasts would be advantageous.

Philippa Russell shared that further income allocations from the Integrated Care System (ICS) was achieved to close the mitigated gap. This included additional non-recurrent income and a portion of repayable support. She explained that some of the income was accounted for in the financial plan.

Dr Kate Wood joined the meeting at 10:09 hours.

Emma Sayner highlighted that the financial strategy needed to maximise the amount of external income and the Group needed to think very differently to ensure they avoid operating a PbR based arrangement with Care Groups.

The Committees-In-Common agreed reasonable assurance.

4.3 Group Integrated Performance Report: Operational Performance Metrics

Clive Walsh took the report as read and provided an update.

Diagnostics

Steady improvement was seen within Diagnostics between January and February 2025. Clive Walsh shared that challenges continued with longer waits in cystoscopy, some activity was moved to Goole and the Group expect the wait lengths to reduce. He mentioned a challenge on the South Bank in relation to availability of equipment and rooms due to refurbishment for barium examinations however this was expected to resolve within a month. Clive Walsh shared a further issue around non-obstetric ultrasound in relation to independent sector contractors leaving the market during a tendering process. Community Diagnostic Centres (CDCs) would provide some missing capacity. He had discussed the issue with the ICB which led to an unresolved outcome. He assured the CiC that the Group had sight of this issue and work was taking place for a resolution.

Jane Hawkard queried clarification on the targets. Clive Walsh shared that the original pre-pandemic target was 1% of patients waiting over six weeks. Nationally the target was 5% and although not achieving target, the Group's Diagnostics position was comparatively better than others.

Simon Parkes queried how much Community Diagnostic Centre (CDC) improvement the Group had seen. Clive Walsh confirmed that the Group were yet to achieve anticipated improvement and the benefit would be visible within the post-project review. Gill Ponder noted that the Group should be able to see a correlation of movement towards the Group target from when the CDCs opened to patients and that the improvement trajectory graphs should evidence improvement from the availability of the additional capacity the CDCs would provide.

Cancer

The Group had entered a Tier one process with the ICB and NHS England, and Tier one meetings were ongoing. Clive Walsh mentioned a reality check that was undertaken between December 2024 to January 2025 and noted consistent reviewing of cancer performance against the reality check rather than the original plan. Deterioration was seen in performance associated with absence of capacity over the Christmas-New Year period. February and March 2025 showed that the Group was near the target for the faster diagnosis 28-day standard however had not made improvement on the 62-day standard. The number of patients awaiting the 62-day standard remained between 220 and 240. When that number reduced, it would be a sign of progress in reducing the backlog, but would worsen the 62 day performance.

The Group was reasonably confident that no excess patient harm was caused. Clive Walsh explained that the Group would not submit a plan for next year in line with the

national framework of 75% standard and aimed to achieve 63% which was realistic but not near the target pre-pandemic.

Helen Wright queried if there was an opportunity to request additional support through the Tier One process. Clive Walsh confirmed that additional support would be requested.

Action: Clive Walsh to update the CiC regarding additional support following the Cancer Tier One meeting.

Gill Ponder queried the deterioration at NLaG in compared to the previous month. Clive Walsh explained the comparison between the variation of patients at NLaG and HUTH. NLaG saw a greater variation of patients while more cancer patients were seen at HUTH which contributed to a more stable picture.

Dr Kate Wood queried whether the deterioration included impact on the 62-day cancer as a direct result of the extra contractual pay issues. Clive Walsh clarified that it would be reflected in the report for March.

UEC

Clive Walsh provided an update on the Urgent and Emergency Care performance for February 2025. HUTH were near target to achieve the plan of 63%, which was reasonably low in comparison to performance pre-pandemic. He explained that a supportive Tiering process was taking place with the ICB, providing the Group with external visits and advice. The Group anticipated a significant £8 million capital allocation to support a remodel of the ground floor at HUTH. NLaG were 3% below the target but the target was higher in comparison to HUTH. Type 3 performance at NLaG remained outstanding despite an increase in volume.

Clive Walsh shared that a viable plan was in place for improvements on UEC with a headline figure being closer to the national requirement. He highlighted a significant improvement in ambulance handover times; HUTH were operating at an average time for 45 minutes and this week moved to a target time of 30 minutes. NLaG operated at 45 minutes with EMAS and would focus on achieving a target of 30 minutes in the future. HUTH were commended for good practice and rapid improvement in ambulances handovers.

Helen Wright shared concerns around the time in department for patients over 65 years. Clive Walsh confirmed that patients over 80 were treated on a frailty pathway. He explained that the capacity of the Frailty Assessment Unit was not substantial and a department similar to the Acute Medical Unit (AMU) was being considered for frailty patients.

Gill Ponder mentioned the following 3 key enablers to improving ED performance that were discussed previously:

- The time in department for patients over 65
- The mean time to treatment
- Non-admitted total time in department.

She recognised that those enablers were not improving and queried whether they were suitable enablers. Clive Walsh explained that those enablers were indicative of the effectiveness of ED and he noted that congestion was the key risk. However, the Group had prioritised ambulance handovers and flow to reduce risks to patients in the community. Dr Kate Wood explained that the Group needed to change their focus to enable ED performance improvement.

The Committees-In-Common agreed limited assurance due to lack of signs of sustainable improvement but highlighted the improvements in diagnostics and the Group ambulance handovers. The CIC remained concerned regarding UTC performance and the impact on ED flow of restricted UTC opening hours.

4.4 Deep Dive: Elective Care

Clive Walsh shared that no material changes were expected from the projected elective outturn. NLaG were on target to achieve the plan and HUTH were 3% over plan. This provided the Group a surplus of £4.6 million in Elective Recovery Funding (ERF). The Group did not have confirmation for 2025/26 ERF funding and the implication of that was factored into the productivity and financial implication.

The Group had agreed to deliver the National plan of achieving 1% of patients waiting over 52 weeks by March 2026 and would work with the ICB to ensure the waiting list position would be improved more than originally anticipated towards the end of the 2025/26 financial year. Clive Walsh suggested the ICB implement effective demand management schemes and a similar discussion had taken place last year but had not come to fruition. He shared that less risk was anticipated for 2025/26 and emphasised the importance of holding the ICB accountable to work with the Group on ways to ensure reduction on the total waiting list over the year.

Emma Sayner mentioned that working alongside the ICB was significant to implementing change, noting the arising opportunities. Single point of referral was crucial and could have a material impact. Local enhanced services were negotiated with General Practice which would embrace change and result in improvement. She further mentioned the ongoing work around validation.

Clive Walsh highlighted a national programme (FF20) run by Professor Tim Briggs and GIRFT which could provide a potentially significant impact with associated minimal funding of £60k in 2024/25. 20 areas were selected across the country, including both HUTH and NLaG. The Group had no detail regarding how the programme would look in 2025/26 but anticipated it would be significant, particularly regarding associated government concerns around welfare reforms and getting the working age population back into paid employment.

Gill Ponder asked how the Group would track progress with FF20 and how the competing priorities of working age adults and clinical need would be balanced, without worsening health inequalities. Clive Walsh responded that it was anticipated that the FF20 activity would be achieved with additional funding and capacity beyond current plans, so it would not disadvantage any other individual or groups of patients.

The Group had agreed to invest in an artificial intelligence (AI) tool which would provide a significant opportunity in validation, reduction in patients on waiting lists and identifying patients at risk. Clive Walsh emphasised that the AI tool would not make the final decisions and human intervention would take place to ensure accuracy.

Clive Walsh mentioned a National scheme which would pay the Group £33 per clock stop on the waiting list achieved through validation.

The Group anticipated improvements in productivity would be significant in the Elective and Emergency pathways. Opportunities presented in Advice and Refer for Consultants to make decisions on pathways in a faster and more efficient way rather than bringing every patient to clinic. Clive Walsh mentioned that the Day Surgery unit at Castle Hill Hospital was not fully operational, with 6 of the 10 theatres available. He emphasised the importance of forward planning to ensure the unit runs efficiently.

Opportunities had presented in reducing several additional payments made for WLIs and bringing patients back from the independent sector. The Group anticipated a maximum of 170 patients waiting over 65 weeks at HUTH, and 20 patients at NLaG. The Group currently had 135 patients waiting at HUTH, and 32 patients at NLaG. Overall, the Group expected to meet the elective target.

Simon Parkes queried what the Group needed to ensure they did not lose sight of. Clive Walsh advised that the focus would be on patients waiting for major elective surgery as presently they were being cancelled due to ITU capacity. He mentioned connections between elective and cancer patients and assured the CiC that the Group had oversight. Clive advised that undertaking the validation exercise would provide assurance around patients with unknown risk.

Dr Kate Wood highlighted that this was the first year that Neurosurgery did not close to admissions and maintained flow.

Jane Hawkard queried what would happen if demand exceeded expectations. Clive Walsh mentioned the growth and demand 2025/26 plan and the estimated 8% elective demand on the Patient Tracking List (PTL). The ICB challenged the over-estimation on the amount of demand. He explained the cautious position taken in the plan which projected growth in demand.

Helen Wright shared that it would be useful to understand the criteria of removal from the waiting list. Clive Walsh replied that the criteria would harmonise the current Access Policy and advised that no patients would be removed from the waiting list without skilled human intervention.

Action: Karena Groom to circulate the Access Policy to the CiC.

The Committees-In-Common agreed reasonable assurance, highlighting plans to use AI to validate waiting lists, demand management and possible ICB single point of referral and ITU patient flow requiring help and intervention to avoid elective cancellations.

4.5 Contract Approvals

4.5.1 Contract Approval: Contract for the Provision of Volumetric Pumps and Associated Consumables

Emma Sayner explained that the contract would replace Volumetric Pumps and Associated Consumables at NLaG with a view to take it through procurement. The Group would expect to procure the Contract through the supply chain framework through a low risk and standard route. She noted that savings would be delivered through the life of the contract and explained that work was ongoing to understand upcoming expectations.

Helen Wright queried harmonisation across HUTH and NLaG and a view to consolidate at the end of the contract. Emma Sayner confirmed that harmonisation was being reviewed.

Gill Ponder scrutinised awarding a 7-year contract when the HUTH contract would expire in 2029. Emma Sayner shared the Group had an exit clause that would provide an opportunity to harmonise in 2029.

Gill Ponder further highlighted that the paper lacked sufficient information on the alternative supplier's relative costs and what would generate the savings. Emma Sayner advised that she did not have that level of detail available. She suggested a standardised procurement template to draw that information out and advised that work was ongoing to devise a template.

The Committees-In-Common endorsed the contract for Boards in Common approval.

4.5.2 Contract Approval: Smile Contract to run Health Tree Foundation (HTF)

Emma Sayner shared that a further discussion at April Board would take place on how to administer the Health Tree Foundation (HTF) due to the comparison of approaches in Charity administration at both NLaG and HUTH. She shared that the HTF was currently administered by Smile and the structure was reassuring but the Group were not seeing the level of funds raised, income generation and donations expected in the Charity's financial plan. The cost of living and economic crisis had been a factor in the reduced level of income.

Emma Sayner mentioned that a more targeted approach with an incentive to do more had been discussed and was still a work in progress. She explained that the ask was for a year-long contract extension whilst this work concluded. She would discuss costs to achieve best value and to ensure delivery on the 2025/26 plan with Smile.

Jane Hawkard noted that the costs did not bear out the income and queried what proportion of the income was legacy and what proportion was generated by Smile. Emma Sayner explained that the proportion of income was undetermined.

The Committees-In-Common approved a year-long extension of the contract to enable the work described to take place and would review progress and conclusions drawn at the meeting in October 2025.

Action: Karena Groom to include Charitable Funds on the PEF Workplan for October 2025.

4.6 Directorate of Estates, Facilities and Development Update

Tom Myers mentioned that Digital and Clinical strategies were progressing well and work was ongoing with Linsay Cunningham to understand when they would complete. An Estates strategy would follow and act as an enabler for all the strategies developed across the Group. He shared the need to review the condition of the Estate, looking at a 6-facet survey process and then going out to tender. He recognised the need to harmonise a Group 6-facet survey under the same specification and company.

Conversations had taken place with NHS England around an opportunity for national survey funding.

The Capital plan started at £18 million at NLaG and £22 million at HUTH, and due to additional capital received had risen to £31 million at NLaG and £32 million at HUTH. NLAG had been allocated £32m and HUTH £30m for 2025/26. This allocation was much earlier in the year, so it was hoped that there would be less need for last minute spend and that spend could be focused on areas of highest risk or areas to support the evolving Group strategies.

91 schemes were ongoing and work was taking place to review whether the team could deliver the demand with the level of resources available.

The Group secured further funding through sustainability work. £8.2 million was allocated through NEEF3 and would support rooftop PV, solar car ports at Hull Royal Infirmary and resurfacing works. Further PV at Scunthorpe General Hospital (SGH) would assist in meeting the extra electrical demand expected due to electric boilers.

The Green Plan would be refreshed and return to the CiC next month in draft form for verification.

Work was ongoing around car parking harmonisation, review of security and car parking contracts and staff parking charges. A paper would go through Cabinet in April with a recommendation on how to move forward.

Tom Myers mentioned a CPE outbreak was ongoing at Diana, Princess of Wales Hospital (DPoW). The Group were reviewing cost elements and exploring the use of HPV cleaning. A further update would be provided at the next CiC when more information was available.

Simon Parkes mentioned the dedicated bays created for electrical parking spaces and lack of charging points at DPoW. Tom Myers responded that this would be further followed up.

Tom Myers briefed the CiC around the subsidiary issues mentioned by Sir Jim Mackey in terms of all corporate services, particularly Estates and Facilities. He shared that the team were trying to understand the impact and ongoing discussions were taking place with NHS England. Options would be reported back to the CiC.

Gill Ponder noted the possible use of an external consultant to support the development of the Estates strategy. She suggested an in-house secondment of a senior member of the team that would provide a development opportunity and noted a potential risk of missing an in-house understanding of issues. Tom Myers explained that external expertise was expected to take a high-level view to assist with harmonising the Group's different approaches and that an external consultant could bring an external perspective on the level of under-utilised estate across the system and opportunities to utilise that in shifting work away from acute hospitals and closer to people's homes. He advised that the internal team would be heavily involved in supporting the development of the Estates strategy. Emma Sayner explained that connecting different parts of the system would provide a better planned strategy.

Helen Wright suggested referring the Estates Strategy to the Capital and Major Projects Committees-in-Common to review Capital and maintenance for 2025/26 and how it was split across the Group.

The Committees-In-Common agreed significant assurance, highlighting the plans to develop the Estates strategy and the fact that the capital allocation for 2024/25 had nearly doubled in year, but had still been spent by the end of the year. The teams involved were commended for this achievement.

4.7 Emerging Issues

No issues were raised.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

- Charitable Funds to be added to the Workplan for October 2025.

5.2 Planned Care Board Meeting Draft Minutes

Clive Walsh mentioned that the Planned Care Board Meeting did not take place in March due to a critical point in terms of the planning cycle. He noted that the next meeting would be held on 24 April 2025.

Helen Wright queried the sense of value from the meetings. Clive Walsh shared that discussions had taken place and it was decided to take the meeting towards a more assurance-driven approach.

5.3 Unplanned Care Board Meeting Draft Minutes

No issues were raised.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the 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:**

Tuesday 06 May 2025, 9:00am to 12.30pm in The Boardroom, Hull Royal Infirmary.

The meeting closed at 12:14 hours.

Cumulative Record of Attendance at the PEF CiC 2025/2026

Name	Title	2025											
		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								
Helen Wright	Chair / Non-Executive Director (NED -HUTH)		Y	Y	Y								

Emma Sayner	Group Chief Financial Officer		Y	Y	Y								
Jane Hawkard	NED (HUTH)		Y	Y	Y								
Simon Parkes	NED (NLaG)		Y	Y	Y								
Clive Walsh	Interim Site Chief Executive North		D	Y	Y								
Sarah Tedford	Interim Site Chief Executive South		Y	D	D								
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y								
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y								
Andy Haywood	Group Digital Information Officer		N	N	N								
David Sharif	Group Director of Assurance or deputy		Y	Y	Y								
Philippa Russell	Deputy Director of Finance		Y	Y	Y								
Ian Reekie	Governor Observer (NLaG)		D	Y	D								

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 6th May 2025
at 09:00 to 12:30 hours in The Boardroom, 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)
Dr Kate Wood	Group Chief Medical Officer
Sarah Tedford	Interim Site Chief Executive - South
Emma Sayner	Group Chief Finance Officer
Simon Parkes	Non-Executive Director (NLaG) (Virtual)
Jane Hawkard	Non-Executive Director (HUTH)

In Attendance:

Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Philippa Russell	Deputy Director of Finance
Tom Myers	Group Director of Estates
Leah Coneyworth	Head of Quality Compliance and Patient Experience - HUTH (item 3.1)
Jackie Railton	Deputy Director of Planning and Performance - Virtual (item 4.3)
Jackie France	Operations Director for Patient Admin (item 4.4)
Catherine Sowerby	Patient Services Programme Manager (item 4.4)
Edd James	Procurement Director (items 4.5, 4.7.1)
Marc Beaumont	Head of Sustainability and Social Value (item 4.8)

Observers

Ian Reekie	Lead Governor – NLaG (Virtual)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Helen Wright, welcomed those present to the meeting. Apologies for absence were noted for Rebecca Thompson, Deputy Director of Assurance (HUTH), and Clive Walsh, Interim Site Chief Executive - North

1.2 Staff Charter and Values

Helen Wright noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 01 April 2025

The minutes of the meeting held on 01 April 2025 were accepted as a true and accurate record.

Helen Wright noted that approval layers were causing delays for distribution of the minutes. The CiC would have a separate look at the approval process for the minutes.

1.5 Matters Arising

No items were raised.

1.6 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
3.3.1	Finance Strategy	Brian Shipley to include a finance strategy update within the finance report section at future meetings, to update on current position, the challenges anticipated in the next five years and when a financial strategy will be available.	**Item owner changed to Emma Sayner. Agreed to create a more consolidated financial strategy and plan to be concluded by the end of Q1 in June 2025. Carry forward to July.**
1.6	Review of Effectiveness Outcome	David Sharif to propose at the December Board to have a repeat of the	**David Sharif will send out a questionnaire to review**

		Committee effectiveness review in 6 months' time.	**effectiveness following this meeting.**
4.3	Performance Update / Deep Dive: Diagnostics (October Data) including update on Audiology Data Quality	Clive Walsh to conduct a review to understand why the assurance level for 65-week waiters was inaccurate and present the lessons learned at the next meeting.	Clive Walsh confirmed those available to respond had done so and the report will be available at the meeting. **Feedback from participants was incorporated into the report. Karena Groom will distribute the report as a draft to the PEF CiC which will close this action.**
4.1	Presentation on the PA Consulting work	Ivan McConnell to bring a verbal three-month PMO review update to the PEF CiC in May 2025.	**Update provided in Agenda item. Action closed.**
4.2	Integrated Performance Report: Operational Performance Metrics	Adam Creeggan to bring a summary of the revised Urgent and Emergency Care plan to this CiC.	**Karena Groom circulated revised UEC plan and included on May agenda for information. Action closed.**
4.3	Deep Dive: Length of Stay and Beds	Adam Creeggan to provide an update with clarity on bed modelling progress for the May CiC.	**ECIST are supporting the Care Groups with identifying their bed requirements. Sarah Tedford is currently looking at the overall bed modelling.** **Carry forward to June.**
4.1	Financial Plan 2025/26	Emma Sayner, Gill Ponder and Helen Wright to have a discussion in terms of assurance requirements around cost improvement programmes for the next CiC.	**A discussion took place on 30 April 2025.** **Action closed.**
4.1	Financial Plan 2025/26	Emma Sayner and Philippa Russell to provide a milestone profile, highlighting where decision making was required in the planning timeframe at the next meeting.	**Discussed within Agenda item. Action closed.**

4.3	Group Integrated Performance Report: Operational Performance Metrics - Cancer Section	Clive Walsh to update the CiC regarding additional support following the Cancer Tier One meeting.	**Clive Walsh updated that HHP is in discussion with NHSE about the operation of the tiering meeting.** **No further meeting scheduled, Clive Walsh will discuss next steps with NHS England. Carry forward to June.**
4.4	Deep Dive: Elective Care	Karena Groom to circulate the Access Policy to the CiC.	**Policy shared with the CiC. Action closed.**
4.5.2	Contract Approval: Smile Contract to run Health Tree Foundation (HTF)	Karena Groom to include Charitable Funds on the PEF Workplan for October 2025.	**Included on workplan. Action closed.**
1.6	Committees-in-Common Action Tracker	**Philippa Russell to bring a recommendation for the risk level with incorporation of ERF to the next PEF CiC.**	**Update provided in Agenda item. Action closed.**

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 CQC Actions Report – Group

Leah Coneyworth joined the meeting at 09:20 hours.

Leah Coneyworth provided an update. There were 2 open actions for HUTH. 4 actions were open for NLaG, 2 of which were rated red and in relation to outpatient performance. The patient follow up initiatives backlog had increased since the previous inspection undertaken in 2022. The Group escalated this to the Planned Care Board for further action. The 62-day cancer waiting times remained on the risk register with a score of 16 and did not meet the plan to be achieved by March 2025. All other actions were progressing to closure and the Group would expect 2 actions to be closed over the next couple of months.

Gill Ponder queried the action around clinical and financial strategy addressing delivery of safe and sustainable services. She noted that the action was rated green from February 2025 however that was not accurate as work had not completed.

Action: Leah Coneyworth agreed that as no progress was made the action rating would need amending.

Jane Hawkard noted the impact that red rated actions had as it did not reflect progress made but could not be amended until revisited by the CQC. David Sharif proposed writing to the CQC to query their plans for the actions and suggested closing the actions and writing back to national standards.

Sarah Tedford mentioned that having oversight of activities and working towards trajectories would provide support to pinpoint cancer patients.

The CiC wished to highlight to the Board that triangulation was not working and the Group were not receiving real time information for the CQC actions. A revisit of CQC actions would take place within the internal audit plan to review how to close and deliver those actions, noting trajectories, particularly the operational plan targets, how to get there and what the actions are.

Leah Coneyworth left the meeting at 09:25 hours.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 Group Finance Report – Month 12

Philippa Russell provided an update on the month 12 position. The underlying run rate deficit going into 2026/27 was £120 million which was significantly impacted by the level of non-recurrent CIP identified. She clarified that the underlying position for 2026/27 was the financial starting position for that year. There was £49 million non-recurrent income within the plan which included deficit funding and risk sharing from the ICS. Emma Sayner shared that the Group commenced the external audit process and had received no feedback which indicated a positive picture.

Gill Ponder queried how the underlying position going into 2026/27 would have changed from 2025/26 and whether the position had improved. Philippa Russell explained that the position was similar however it had not reduced due to the level of non-recurrent CIP. Emma Sayner shared that work on transformation would

contribute to improving the position and the underlying financial position would be kept under review.

Gill Ponder enquired whether there was possibility of an improvement in the monthly run rate from the first financial month of 2025/26. Philippa Russell explained that additional income was identified and would be included in the 2025/26 financial plan. The Group expected to see a slightly improved run rate but not to the level required. Emma Sayner mentioned that it was critical to not see a deterioration in CIP profiling.

4.2 Financial Plan 2025/26 including CIP Profile and Decision Timetable (to include PMO Status Update)

Emma Sayner shared that the financial plan for 2025/26 was a developing picture and the bottom-line position remained unchanged from previous submissions. The Group would re-review profiling and the approach to risk within the plan whilst aiming to keep core CIP ambition low to ensure as much recurrent business-as-usual CIP was delivered. A small level of turnover was reflected within the plans which should be deliverable on a business-as-usual basis. Big areas of transformation would be where reductions in spend would be delivered.

The Group received significant pressure from regional and national colleagues around mitigations to ensure all CIP activities are identified and to ensure they were delivered. The weekly grip and control through the CIP Programme Board and Financial Planning Improvement Board would be crucial to aid this.

Helen Wright mentioned transformational and pathway changes particularly around repatriation of independent sector activity. She queried the steps in place to ensure that was delivered. Emma Sayner explained that key factors with the independent sector were to establish minimum waiting times, procedures of limited clinical value and use of high-cost drugs. There were big themes around restraint on contract management.

Emma Sayner assured the CiC that the Group would not minimise patient choice but encourage primary care to divert patients into NHS capacity, corralling the wider capacity in the ICS to make that happen.

Gill Ponder noted a track record of some areas not delivering CIP plans with little accountability for non-delivery. She queried what the Group would do differently to encourage focus on delivery from the beginning of 2025/26. Ivan McConnell explained that the Group had taken a tactical financially driven approach and had shifted the dialogue of previously driving against a money target which was detrimental and would take time to embed.

Sarah Tedford shared that the transformation CIP programme should work towards delivery and the Group were clear on the deliverables and the need to deliver them. She shared that accountability was a concern due to culture within the Group and response when challenged was met with Freedom To Speak Up cases or grievances which slowed down the process. Helen Wright suggested that the Group needed to be aware that responses on the staff survey would differ through difficult periods of transformation.

Action: Helen Wright to refer the expectation of increased FTSU activity and potential downturns in the staff engagement survey to WEC.

Jackie Railton joined the meeting at 10:06 hours.

Ivan McConnell provided an update on the PMO status. The Group would report against a gateway process and were starting to phase it through. The strength of the Equality Impact Assessment (EQIA) process would be monitored and a live power BI dashboard was built internally. The Quality Improvement (QI) process was strengthened and would continue to be monitored. Sustainability would be a key driver. Ivan McConnell noted the need to shift the non-recurrence to recurrence and emphasised the need to recognise the top risks to non-delivery. He added that although the greatest risk was Diagnostics from an engagement point of view as action follow-up was slow, he was confident that the Group would put a plan in place to accelerate this.

Gill Ponder proposed that the Group should focus more on what people were doing to remove barriers to delivery rather than focusing on risks and issues. Ivan McConnell emphasised that the way people engaged in conversations needed to change within the Group.

Gill Ponder queried the EQIA policy commencing at Gateway 5. Ivan explained that the Group were trying to commence it as early as possible however it was a complex process. Dr Kate Wood explained that the Group were unable to create an EQIA until they understood the work required. She shared that there was a greater focus on EQIA and the process was beginning to flow.

Jane Hawkard noted the resourcing issue. Sarah Tedford explained that the whole team would need to be involved in part of the delivery as part of the day job and provided assurance that herself and Clive Walsh were reviewing this. Ivan McConnell advised that conversations were taking place and the message would need to be reinforced that transformation should be a priority for everyone.

The Committees-In-Common agreed reasonable assurance due to the focus on delivering sustainable financial performance, strengthening of the EQIA process, and better governance in place around PMO. Focus on non-recurrence versus recurrence. There remained a concern as to whether the Group was investing enough in transformation and had the digital capability to deliver the plans.

4.3 Group Integrated Performance Report: Operational Performance Metrics

Jackie Railton took the report as read and provided an update.

RTT

The Group had seen slippage in RTT long waiters and improvements were made to rectify this. RTT Delivery Group had reinforced a greater focus on delivery within 18 weeks and 40 weeks. Work around validation commenced on 06 April 2025 and had delivered positive benefits in clearing the PTL which contributed to ensuring the Group were clear about legitimate waiters. The previous review revealed an increased removal rate of 18% for HUTH and 29% for NLaG.

Sarah Tedford shared that independent sector work would have an impact on the numbers. The transformation work to take place in Theatres would be key going forward as the Group had in excess of 50 theatres and were not utilising these effectively. Business cases were in place to increase trauma sessions and hip and knee day-cases.

Diagnostics

The Group were in a better position in comparison to 2024/25 however there were deteriorations within neurophysiology, echo, sleep studies, CT at HUTH and endoscopy modalities, audiology and non-obstetric ultrasound due to ceasing the independent sector contract. The Group were looking to fill vacancies within neurophysiology. There were potential opportunities within Community Diagnostic Centres (CDCs) to improve activity. The Group would review and triage referrals on the waiting list to look at making better use of CDCs.

Sarah Tedford mentioned that the NLaG position around endoscopy affected the number of cases within diagnostics and the Group expected this to resolve moving forward.

Cancer

February's cancer position at NLaG revealed improvement. There was slippage around the 62-day performance and concerns around the 104-day backlog being above trajectory at HUTH. The Group were reviewing surgical capacity within Urology and LGI screening for diagnostic delays. Work was ongoing to review how to manage people and undertake diagnostics earlier. Although performance was not as expected, the Group delivered 10% more cancer treatments than planned in 2025 and treated 10% more patients under 62-days.

ED

The 4-hour standard performance was below target. Combined type 1 and 3 performances revealed that HUTH achieved 58.5% and NLaG achieved 70.9% against a target of 78%. Differences were noted across the Group. Increases were seen in type 1 attendances but not to the same levels as planned for type 3 attendances. The South Bank had an increase in type 3 attendances and reduction in type 1 attendances.

Jackie Railton apologised that the type 3 graphs within the report were not accurate and she would send an updated version to the CiC following the meeting.

Sarah Tedford updated that the Group were managing IPC issues taking place at Diana, Princess of Wales Hospital (DPoW). Changes were made to systems at HUTH due to not seeing the benefit of reduced waiting times in ED. The Group were looking to set up a Short Stay ward and review the general medical rota.

Jackie France and Catherine Sowerby joined the meeting at 10:38 hours.

Gill Ponder noted that the Diagnostics narrative did not seem to change from month to month and inquired about the accuracy of information provided regarding the current system for addressing issues. Jackie Railton shared that the CDC were

delivering off-site as earlier accelerator activity. She mentioned that the data around what was included within the 2024/25 activity and what was due in 2025/26 would provide clarity.

Gill Ponder further noted a significant reduction in 2WW patients at HUTH within the last 3 months and queried whether there was a reason.

Action: Jackie Railton to look into the reason for 2WW cancer reduction at HUTH

Gill Ponder mentioned the increase in ED attendances across the Group. Sarah Tedford advised that it was flagged to the System and meetings were taking place to review this.

The Committees-In-Common agreed limited assurance due to performance not improving as anticipated and trajectories not in place in line with the operational plan. A key focus was on improving diagnostics to improve the overall performance and focusing on the right patients within cancer. Clear plans and changes to the ways of working within ED, cleansing of the PTL to achieve targets and opportunities within CDCs were noted.

4.4 Deep Dive: Outpatient Transformation

Jackie France provided an update on the significant changes that took place across the Group over the last 12 months. There was a focus around CIP savings and creating capacity to increase new appointments that had an impact on the follow up list increasing. Lorenzo and changes in the data warehouse had an impact and it had taken time to embed those changes. Support in place across the Care Groups had started to have an impact and the Group had seen a healthy steering group with good input and ownership around the programme.

Significant improvements were seen within patient initiated follow up (PIFU) due to targeted work with 3% across the Group, a national target of 5% was in place until 2029. Ophthalmology saw improvements in March at 1.5% from a previous 0.3%.

Catherine Sowerby updated that missed appointment rates had reduced to 7.5% across the Group which was nationally around the median quartile. The Group rates were higher in comparison to Harrogate and York which was likely a consequence of demographic variations. The Access Policy was revised and targeted clinical training was undertaken to further reduce the rates.

Opportunities had arisen through DrDoctor for patients to book appointments online and the DrDoctor business case identified a potential 30% reduction in missed appointments. The Group experienced delays with commencing online booking due to two key pieces of functionality requiring development by the DrDoctor suppliers.

Work on outpatient procedure coding had recovered approximately £230k for 2024/25 and would continue into 2025/26 to ensure accuracy.

A gap analysis across 16 specialities for GIRFT Further Faster was undertaken and the Group were currently achieving 73% with a target of 80% compliance for 2025/26.

National guidance was consolidated around outpatients and the Group had developed an outpatient strategic plan from 2025/26 to 2028/29 with an aim to support Care Groups in identifying key objectives for patients. The plan was approved at the Outpatient Steering Group and Planned Care Board.

Jackie France mentioned that a connected health model in place on the South Bank revealed that 70% of patients did not require a first appointment. A similar model was adopted on the North Bank called 'Advice and Refer' based on the same principle of patients routed through a single point of access for assessment by a consultant. Results revealed that 77% of patients within Cardiology could be managed without a first appointment. The model was trialled in Neurology and Gastroenterology and revealed that 50% of patients could be managed without a first appointment. The model would provide rapid expert clinical opinions at the beginning of the pathway, improved waiting times, and enable conversations to start imminently between primary and secondary care.

Plans were in place to develop a locally enhanced service which would enable primary care colleagues to see patients where needed. This was the greatest enabler to achieve delivery.

3 key areas of focus were around the efficiency programme, digital transformation and moving ongoing projects into business-as-usual.

A Groupwide contact centre would provide additional support to patients navigating appointments through the system. Jackie France anticipated the challenge and significant change in moving towards a digital record and emphasised the importance of supporting teams and patients through delivering that which would expect to be a 2 to 3 year programme.

A key part of job planning for 2025/26 saw the need to reflect the shift to single point of access working. Focus on reduction of the follow up list and a different approach were crucial in terms of how the Group managed follow up lists.

Gill Ponder queried whether an analysis was carried out on missed new appointments in comparison to follow ups. Catherine Sowerby shared that analysis revealed similar rates between missed appointments for new and follow up patients. She explained that Care Groups routinely overbooked clinics to minimise the loss of core capacity.

Gill Ponder further queried whether Advice and Refer would cause an impact on ED if patients were unable to be seen by their GP when managed within primary care. Emma Sayner explained that the Advice and Refer model would direct patient care into available capacity and capable resource, which may include pharmacists rather than just GPs.

Ian Reekie left the meeting at 11:30 hours.
Edd James joined the meeting at 11:31 hours.

Helen Wright queried whether there was a top initiative to deliver 4% improvement. Jackie France explained that the key area was around the Advice and Refer model.

The Group were not yet fully aware of the opportunities within outpatients due to lack of data and digital systems.

Jackie France and Catherine Sowerby left the meeting at 11:40 hours.

The Committees-In-Common agreed reasonable assurance due to clear Care Group ownership and Digital being a clear enabler. Main areas of focus were Advice and Refer, validation using AI, and cleansing of the waiting list. A need to review the programme fully to ensure there was no overlap in other areas was noted.

4.5 Procurement Improvement Plan / KPIs / Expired Contracts

Edd James updated that the Group continued to work on savings, identification and delivery. Delivery for 2025/26 had commenced and the Group were building a workplan for years moving forward. Work was ongoing across the ICS with community and mental health colleagues which had paved the way for further work with ICS colleagues and further savings for the Group. A social value model was agreed with York Council which would be used as a framework to engage with Hull City Council. The Group were invited to Parliament to talk about the work ongoing in procurement and provide advice for how other parts of the country could learn from the work and benefits delivered.

Helen Wright noted the savings position against business case and queried whether the Group were performing under business case. Edd James clarified that years one and two were performing above business case and that the charts were only showing savings already realised as opposed to future savings and activity.

Edd James shared that the Group were on target to clear expired contracts by October 2025.

The Committees-In-Common agreed significant assurance. The need to influence the wider procurement Group to deliver savings in radiology was noted and Edd James would lead on this.

4.6 Bed Management – Command Centre and Electronic Bed Management System

Sarah Tedford shared that the current bed management system provided challenge to track patients and understand patient data. She explained that a centralised bed management area would allow the Group to monitor patients and produce effective data to show how patients were managed.

Helen Wright queried whether the Group were an anomaly by not having a centralised bed management area. Sarah Tedford confirmed the Group were an anomaly.

Emma Sayner shared that technological capability would enable data to track behaviours which would be a key enabler to focus on productivity and efficiency. There was a discussion around No Criteria To Reside patients and the inability to monitor this data in real time delays actions being taken to increase capacity. The new system would provide this information.

Gill Ponder queried whether there was opportunity to implement Artificial Intelligence (AI) to further automate routine tasks once the system was introduced. Sarah Tedford explained that more information would be available when driving the business case.

4.7 Contract Approvals

4.7.1 Contract Approval: Routine Radiology Reporting Services to include Out of Hours

Edd James explained that the Contract contained cumulative value and the request was to extend under a compliant NHS supply chain Framework. Work was underway within the imaging network to look at a single contract across the whole of the imaging network which would provide £400k in savings. Work needed to be finalised to ensure that the extension would lead the Group to that point.

Helen Wright noted previous delays and queried whether the Group were confident on harmonisation and delivery of the savings. Edd James confirmed that the Group were not confident due to the imaging network working as two separate networks however meetings were taking place to bridge the gap.

Helen Wright further queried if there was an escalation method. Edd James clarified that escalation was previously raised through the Procurement Board and Andy Bertram would review this as the imaging network sat with York and Scarborough.

Marc Beaumont joined the meeting at 11:54 hours.

Gill Ponder queried how the Contract aligned strategically with the in-house additional activity to report outside of standard hours and queried if the total value of the contract was beyond the approval limit of the CiC.

Action: Edd James to provide clarity around the additional in-house activity savings.

Action: Edd James to review whether the Contract value exceeded the £5 million Board threshold.

The Committees-In-Common renounced the Contract for approval, noting needing further information around additional in-house activity savings and confirmation on the Contract value.

Marc Beaumont joined the meeting at 11:54 hours.

Edd James left the meeting at 11:58 hours.

4.8 Directorate of Estates, Facilities and Development Update (to include The Green Plan)

Tom Myers informed the Group that work would commence on the pit car park at Scunthorpe General Hospital (SGH) which was expected to cause disruption over

six months. A series of options to try and minimise disruption would be discussed in the Group Executive meeting.

Marc Beamount presented The Green Plan. A national target was in place for 80% reduction in carbon footprint by 2028-2032. New guidance was published in February 2025 which provided the Group with a short timescale to ensure the plan aligned with other Trust documentation. The Group had achieved £68.4 million of external funding and delivered a significant cost avoidance of £4.7 million. A £370k cost avoidance was achieved through anesthetic gases. There were 13 key areas of focus which all had deliverables and KPIs to enable the Group to monitor progress against them. Further meetings and six-monthly updates to Trust Board would take place to ensure accountability and progress was made against the strategy.

Gill Ponder queried whether the Green Plan was required to go to Trust Board twice a year and proposed that it would be received at PEF CiC twice a year and Trust Board once a year.

Helen Wright queried what the key initiatives were across the next 2 to 3 years. Marc Beaumont clarified that the delivery plan aligned with the strategy which set out the key initiatives with the intention that the delivery plan would be used as a primary agenda at the Sustainability Committee to ensure delivery on key initiatives.

The Committees-In-Common agreed significant assurance.

Marc Beaumont left the meeting at 12:09 hours.

4.9 Cleaning Harmonisation

Tom Myers shared that following discussion in December, the Group had moved into a position to harmonise cleaning services across the Group. He added that external support would help drive that forward.

Action: Karena Groom to ensure the workplan is updated to align with Estates and Facilities documents coming to the PEF CiC.

4.10 Risk Level Recommendation

Philippa Russell shared that one revenue, and one cash risk were identified. The proposed risk was rated a level 16 which aligned with Board Assurance Framework (BAF) and would be reviewed on a regular basis. The Group expected to see the risk reduce with a target of level 9 by the end of the year.

Gill Ponder noted that the wording within the report on the cash risk did not articulate clearly that cash support could be refused. Philippa Russell clarified that the risk describes the fact that in order to be able to access cash support the Group would be required to demonstrate that all cash management opportunities had been maximised by working with very low levels of cash and stretching payment terms for creditors as far as possible.

Action: Philippa Russell to rephrase wording around cash support within the report.

Gill Ponder asked whether there were delays in raising invoices for debtors and queried if a control could be put in place to ensure invoices were issued in a timely manner to avoid late invoice raising leading to an increase in the risk of bad debts. Philippa Russell confirmed that deep dives into balance sheets had commenced and the Group were reviewing accrued incomes regularly, therefore this risk is being mitigated.

Action: Philippa Russell to include mitigations in place around late invoices within the report.

Helen Wright noted that whilst risk levels at 16 are high, that this does not appear to reflect a low confidence level at this stage in the new financial year and emphasised the importance of understanding that difference when reporting.

4.11 Emerging Issues

None to note.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This item was shared for information.

5.2 Unplanned Care Board Meeting Draft Minutes

This item was shared for information.

5.3 Revised Urgent and Emergency Care Plan

This item was shared for information.

5.4 Performance Assessment Framework 2025/26

This item was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

Helen Wright to write to the Workforce Committee to share concerns that when moving to transformation and pushing everyone hard to deliver plans there may be

fall out in terms of staff survey and Freedom To Speak Up to manage and be aware of.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the 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:**

Tuesday 03 June 2025, 9:00am to 12.30pm in The Boardroom, Castle Hill Hospital.

The meeting closed at 12:21 hours

Cumulative Record of Attendance at the PEF CiC 2025/2026

Name	Title	2025											
		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							
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y							
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y							
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y							
Simon Parkes	NED (NLaG)		Y	Y	Y	Y							
Clive Walsh	Interim Site Chief Executive North		D	Y	Y	D							
Sarah Tedford	Interim Site Chief Executive South		Y	D	D	Y							
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y							
REQUIRED ATTENDEES													

Tom Myers	Group Director of Estates		Y	Y	Y	Y							
Andy Haywood	Group Digital Information Officer		N	N	N	N							
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y							
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y							
Ian Reekie	Governor Observer (NLaG)		D	Y	D	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(25)104

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12th June 2025
Director Lead	Tony Curry, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common & Julie Beilby Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Karena Groom, Interim Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-In-Common held on Wednesday 26th March and Wednesday 30th April 2025.
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 Wednesday 30th April and Wednesday 28th May 2025.
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 Wednesday, 26th March 2025
at 09:00 to 12:30 hours in the Boardroom, Diana, Princess of Wales Hospital, Grimsby

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) - Chair
Julie Beilby	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Amanda Stanford	Group Chief Nurse (Virtual)
Simon Nearney	Group Chief People Officer
Kate Wood	Group Chief Medical Officer
Sue Liburd	Non-Executive Director (NLaG)
Laura Treadgold	Non-Executive Director (HUTH) (Virtual)

In Attendance:

Karena Groom	Personal Assistant (Minute Taker)
Rebecca Thompson	Deputy Director of Assurance (HUTH)
David Sharif	Group Director of Assurance
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement
Ashok Pathak	Associate Non-Executive Director (HUTH)
Murray MacDonald	Non-Executive Director and Vice Chair (Virtual)
Lucy Vere	Group Director of Learning and Organisational Development
Myles Howell	Director of Communications & Engagement

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees in Common Chair welcomed those present to the meeting. No apologies were noted.

1.2 Staff Charter and Values

Tony Curry noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meetings held on 26th February 2025**

The minutes of the meeting held on the 26th February 2025 were accepted as a true and accurate record subject to the following amendment:

- Dr Kate Wood noted a point of accuracy on page 3 – amend minutes to state that extra contractual payments last year were £12 million, not £3 million.

1.5 **Matters Arising**

The Committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda.

Amanda Stanford provided an update around the Pharmacy cover on the South Bank. NHS benchmarking showed NLaG Pharmacy Services were at the bottom of the benchmark staffing levels per 100 beds and HUTH was around the midrange of that benchmarking. NLaG had struggled to recruit historically and were looking to be fully recruited to the low baseline, which still did not provide sufficient resource to the level of ward cover required. A business case was in place for more resource and progress had been made around putting support into emergency departments.

Tony Curry mentioned the mitigation approach around an extra tier of technicians to provide a level of cover. He queried the effectiveness of the mitigation measures and advised that if they did not resolve the issues then the CiC would require a deeper understanding of the situation.

Action: Amanda Stanford to work with Jo Goode to provide a Deep Dive of Pharmacy Staffing across the Group to the CiC.

1.6 **Committees-in-Common Action Tracker**

Updates to the Action Tracker were provided within the agenda items.

1.7 **Emerging Issues**

Simon Nearney provided an update on the Extra-contractual Consultant Pay issue. He shared that himself and Dr Kate Wood emailed the North Bank Consultants implementing the revised on-call payments as of 01 April 2025. The Group awaited a formal response from the South Bank Consultants as they had previously declined the offer and remained in dispute. The Group had proposed working with Acas (Advisory, Conciliation and Arbitration Service) for resolution as part of the dispute process.

Ashok Pathak queried the HUTH rate position. Simon Nearney clarified that the on-call rates had improved significantly from what was currently in place.

Amanda Stanford highlighted that concerns were raised by Internationally Educated Midwives at DPoW around lack of career progression. A meeting took place with the Midwives which raised further concerns regarding racism. She advised that detailed work was ongoing. Amanda met the Regional Chief Nurse and the Region had oversight of the issues. A review was taking place around every Midwives' career progression and then a wider look at the Group's approach to Internationally Educated colleagues would be undertaken.

Ashok Pathak queried whether the Midwives concerned were recruited directly from other countries. Sue Liburd explained that concerns most specifically raised were from directly overseas Internationally Educated Midwives however this issue was not specific to the Internationally Educated Midwives.

Tony Curry advised that this issue appeared much wider than DPoW and mentioned that similar concerns had arisen on the North Bank in relation to Filipino Nurses. Sue Liburd emphasised that the concerns were not directly about career progression but also serious direct discrimination was taking place.

Julie Beilby proposed the Committees-in-Common take a no tolerance approach to racism and escalate this issue to the Board for awareness. Tony Curry shared that the CiC needed to understand how deep this issue was. Sue Liburd highlighted the deterioration in the care and support NLaG provide Internationally Educated Nurses in comparison to 18 months ago and shared that substantial cultural work would need to take place.

David Sulch proposed looking at the working dynamics and relationships within the Maternity team.

Lucy Vere recognised the issue of white fragility in terms of 'All lives matter' and the further challenge of social media presence around this.

David Sharif reminded the Group to seek assurance that these issues were being dealt with as 'business as normal' through existing Governance channels which was crucial to embedding cultural change.

Tony Curry highlighted that when reading the EDI Steering Group minutes there was no real recognition/assurance that the Group have real issues or challenges across the hospitals. The minutes contained little issue, debate or action. Amanda Stanford recognised that the EDI Steering Group needed to be clearer on their focus throughout the year.

Murray MacDonald mentioned the lack of diversity breakdowns within the staff retention reports. He advised that we must know the diversity of our staff and proposed asking the Data Quality team for that data as a leading indicator for these conversations. Simon Nearney explained the workplan covered various EDI reports such as the WRES and WDES, Gender Pay etc and statistics were included within those reports, but Simon agreed to add some EDI statistics to the workforce IPR going forward.

Tony Curry questioned the information received and requested further assurance around the plans and systems across the Group. Simon Nearney and Lucy Vere assured that plans were in place including a full review of recruitment, talent and succession planning with a focus on EDI. They explained that it would take time to

ensure the Group address issues properly and ensure they were pro-active rather than reactive.

The CiC Chair shared that the CiC required greater assurance on planning and actions underway, triangulation, gaps in plans, and timescales.

Action: Following maternity issues at DPoW, Lucy Vere and Amanda Stanford to have a conversation around resource and assurance, and Amanda to update WEC.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate

None to note.

3.2 Review of Relevant External Reports, Recommendations & Assurances as appropriate

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Registered Nursing & Midwifery Staffing

Amanda Stanford took the paper as read and provided an update. Work was still ongoing around recruitment for the Registered Nurse vacancies on the South Bank. She explained that she was working with Jo Ledger to see what that plan looked like. The Group were in the process of recruiting newly qualified students from Hull University. Amanda provided assurance that the Group were sighted and working on the accommodation and travel challenges on the South Bank. She highlighted a challenge with unregistered Nurses which would drive temporary spend and explained that assurance around plans to recruit had been requested.

The Group were working to recruit into Band 2-3 posts. Discrepancies between both Organisations saw Hull Royal Infirmary and Castle Hill Hospital at the lower end when benchmarked nationally across Care Hours Per Patient Day and further work was ongoing. The safer staffing paper business case would be reviewed.

The Group planned to roll out an approach to apprenticeships on both sites. This presented a challenge due to the change in levy financially and the Group would review how to optimize the use of tariff. Work was underway to ensure Clinical Educators were in place to support newly qualified Nurses, Midwives and provide opportunities for development. Amanda Stanford mentioned that Workforce teams had agreed their plans, priorities and KPIs for 2025/26.

Action: Amanda Stanford to bring a summary of the Workforce plans back to WEC CiC.

Sue Liburd recognised the Legacy Mentor post had made an impact but noted the post coming to an end and queried an indication of the post continuation. Amanda Stanford shared confirmation of CPD funding for this year and the Legacy Mentor role would continue as the post was supported by that funding.

Sue Liburd further noted the staff retention challenge across the Group and queried if the Group were supporting Leaders and Managers to manage a diverse working pattern. Amanda explained that Jo Ledger was the Lead on the flexible working and a discussion had taken place around work life balance. Simon Nearney advised that the Group needed to get managers into a more positive position to manage differently.

Julie Beilby noted the absence of HUTH data within the report. Amanda Stanford advised that the lack of data would be reviewed as there was a recognised gap.

Action: Amanda Stanford to review unavailability of the HUTH data and ensure it is included in future reports.

Paul Bunyan recognised the technicality of data within both organisations as a result of difference in technology and how data was collected and managed. He shared that IT purchased a data warehouse at a group level which would enable data to be reported in the same place. Paul advised that work was ongoing to agree data parameters to ensure harmonised reporting of data.

The Committees-in-Common agreed limited assurance for this item due to the lack of HUTH data, recognising the ongoing process work.

4.2 **Workforce Integrated Performance Report**

Paul Bunyan shared that recovery was starting to show following winter pressures. Due to this there had been a decrease in temporary staffing usage, but there was an increase in sickness due to seasonal illnesses such as cough, cold and influenza. The vacancy position had decreased and the recruitment position was within the expected target range for performance and metrics although slightly high around shortlisting. Appraisal was within the target range. Role specific training compliance had increased at 82.5%, particularly in Medical and Dental staff which reflected a 1.7% improvement from December. This was still 2.5% below target and specific programmes were being worked through to review role specific training and the Group's approach to it.

The Corporate Planning guidance required the Group to:

- Reduce agency spend by 30% in year
- Reduce bank spend by 10% in year
- Reduce corporate staffing levels to April 2022 levels

Paul Bunyan explained that the Group were currently working with PA Consulting and Care Group colleagues to realistically review the workforce programme to enable CIP savings and still be able to deliver services. This would be presented to Cabinet by the end of April 2025.

Murray MacDonald praised the report. He suggested including comparative data

from other Organisations. Paul explained that different data parameters provided a challenge in obtaining a consistent level of reporting.

Ashok Pathak noted the reduction in Consultant vacancies at NLaG and queried whether the streamline package around international graduates from abroad had stopped. He recognised the financial constraints to recruit Consultants. Ashok noted 17.6% of leavers due to conflict with colleagues and queried whether culture was still having an impact.

Paul Bunyan explained that he and Dr Kate Wood had undertaken work to ensure the programme around internationally educated consultants was more organised, there was more grip and control in terms of management and Care Groups were managing the progress. Paul confirmed that there were no financial constraints in terms of recruiting Consultants. Dr Kate Wood advised that the Group had a better understanding of implementing change going forward.
Simon Nearney provided assurance that the Group would deliver £12 million savings on agency spend for 2025.

David Sharif queried when insight to the workforce metrics across the Care Groups would be shared with the WEC CiC. Paul Bunyan advised that it was currently being worked through by the IT team. The Group expect to have insight by the end of April 2025.

Action: Paul Bunyan to include the Care Group workforce metrics to be part of the IPR.

The CiC Chair noted that job planning was the outlier and recognised that work was underway.

4.3 **National Staff Survey Results and Action Plans (Annual)**

Simon Nearney shared a presentation containing a summary and proposed actions following the National Staff Survey results. The response rates saw a decrease on both sites, HUTH received a completion rate of 46%, in comparison to 50% last year. NLaG received a completion rate of 42%, in comparison to 48% last year. The national average response rate was 48%.

The Staff Survey included over 100 questions with 3 key questions which revealed:

- 50% of HUTH staff and 47% of NLaG staff would recommend this Organisation as a place to work.
- 52% of HUTH staff and 49% of NLaG staff were happy with standard of care provided.
- 63% of HUTH staff and 61% of NLaG staff felt that care of patients/service users was the top priority.

The Staff Survey data showed that the Group was in the lower quartile, below the national average. NLaG scores were slightly lower than HUTH scores and work was underway to improve this.

The declined scores around HUTH taking positive action on health and wellbeing was attributed to the loss of the resilience hub and Health and Well Being Officer. Simon Nearney emphasised the importance of providing a psychologically safe environment for staff to raise concerns. The current scores indicated that staff did

not feel secure in raising concerns which could impact patient safety. Work would take place to improve communication and teamworking.

Simon Nearney discussed staff engagement and the immense work the Group had undertaken over the last 12 months and whilst the Group was in a more settled place, there were still many issues we needed to harmonise such as clinical and non-clinical systems, policies, procedures and processes that still need to happen. Simon continued that we have a good opportunity to improve staff engagement, and the Group would need to encourage putting people first. The national average score for staff engagement was 6.8%, HUTH scored 6.5% and NLaG scored 6.4%. Myles Howell explained that the 3 key factors of the staff engagement score consisted of motivation, involvement and advocacy.

Conversations were taking place at performance meetings with Care Group senior managers around engagement data and action plans to address. Further meetings were in progress within those Care Groups to ensure specific wards and teams were engaged in the issues and improvement plans. At least 10 people within a team would need to complete the survey to receive results. Any departments or directorates with engagement scores below 6.5% would require essential intervention. This posed the question of whether senior leaders were supported in an environment that promoted meaningful conversations for improvement.

A discussion took place around common themes of feedback particularly in relation to outdated and uncomfortable office accommodation. Suggestions were made to shrink our footprint, including making use of accommodation and welcoming more staff working from home.

Simon Nearney highlighted the opportunities for 2025/26 efficiency, innovation and transformation. The Group would continue to focus on quality and safety and needed to be more creative and transformational to deliver the £130 million savings target. He recognised the huge performance targets around long waits, cancer treatment, diagnostics and ED, and suggested building on the ambulance handover times that had improved. Simon provided emphasis on the importance of encouraging discharges. The launch of the Super Surgical Centre at Castle Hill would benefit our patients. Simon highlighted the effectiveness of driving digital transformation and developments were taking place around DrDoctor and self service Kiosks. These developments would provide a more efficient and convenient way for patients to interact with the Group.

The Group aimed to improve staff engagement over the next 5 years culminating in the Group being in the top 20% of NHS trusts. Myles Howell recommended consistent and persistent communication to managers and staff regarding engagement, also our desire to improve our Group culture by putting people first all-year round.

Myles continued that conversations had taken place with a number of organisations who had successfully improved their staff survey results. Their key driver for success was focusing on a particular theme from their survey. Myles stated that there would be corporate actions, Care Group actions and team/ward actions, and then sharing their engagement scores to work on specific areas with them. Communicating successes and improvements across the Group.

Myles Howell shared the areas of focus every quarter over the next year:

- Communication and engagement

- Aid - Health and wellbeing
- Reward and recognition
- Essential foundations

A series of executive-led management sessions with Band 7 and above colleagues would be implemented from April to June 2025 and would focus on ensuring managers understand the challenge around our staff survey results and operating plan.

Local scorecards would be developed to look at the staff survey results from a Care Group and team level. Actions would be implemented following this and successes would be shared. Ward and team scorecards would also be developed. This would be measured on a quarterly basis and the quarterly results would be brought to the WEC CiC for review.

Ashok Pathak noted the abolishment of NHS England and queried whether that loss of managers and workforce was factored into the plans. He further queried how the programme would be monitored. Simon Nearney explained that cultural change would take 5 years. There is no short term fix and this was factored into the 5-year improvement trajectory. Simon also stated that NHSE would not be totally abolished and it may affect the Group. The Group anticipated a clearance house system for jobs when NHS England downsizing begins and that vacancies within the Group would be offered to NHS England staff before going out externally to advertisement.

David Sharif noted the free text categories slide within the presentation in comparison to categories on the risk register and highlighted that all of those were within the top six categories of risk across the Group which underlined the importance of this work.

Julie Beilby mentioned digital change and queried where the discussions were happening within the Group. She further queried how the Group ensured core values were managed under revised appraisals. Lucy Vere explained that a basic reset of appraisal merged the HUTH and NLaG templates and the goal was to create a template to talk about how actions will be achieved. She further explained 3 focuses: how to raise leaders, working with clinical colleagues and setting goals effectively. These predicate on whether the Group have one learning management system. The Group expect the new appraisal process to be in place by September/October 2025. There would be an audit to look at if the template was used. Lucy advised that harmonisation of the learning management system was required first.

Myles Howell shared that Andy Haywood was working alongside the Workforce team to understand where to invest for people to access information. Simon Nearney mentioned that the People Directorate were having conversations to look at how to maximise the benefits of artificial intelligence. Dr Kate Wood shared that a Digital Governance Group was being worked through.

Amanda Stanford explained that the Group needed to define the definition of psychological safety. She noted the challenges to set clear expectations across the organisation, safety culture and how the Group learn and reframe failures.

David Sulch advised that if the Group could support with everyday concerns from staff it would provide assurance around more significant issues.

Sue Liburd mentioned that the Group needed to review inclusion of all people when discussing ‘People First’.

The Committees-in-Common agreed reasonable assurance for this item.

4.4 **Health & Well Being Progress Report**

Paul Bunyan took the report as read and provided an update. The health and wellbeing framework focused on the physical and mental health of staff and colleagues, with a focus on getting the basic provision right in terms of feedback directly from staff. The Group aimed to strengthen responsive measures and alignment work was ongoing to enable staff to educate themselves on their health and wellbeing. Paul described that one of the most positive impacts was having leaders that invest in staff.

Ashok Pathak noted the psychological impact on staff. He queried if an increase in PTSD was seen and wondered if Occupational Health had the mechanisms to treat it. Paul explained that an increase of PTSD was seen following Covid, combined with the operational pressures faced. He shared that the Clinical Psychology team at HUTH had specialist skills to respond to PTSD. NLaG would refer to mainstream provision and the Group were focusing on how to get quicker access for staff into specialised psychological services.

Julie Beilby noted that a Flexible Working Steering Group had been established across the Group and queried where it would report into. Paul Bunyan shared that it currently reported into the Workforce Transformation Group.

4.5 **Apprenticeship Levy Annual Report 2025**

Lucy Vere took the report as read and shared an update. She mentioned the collective budget for the apprenticeship levy was £3.9 million, £1.7 million for NLaG and £2.2 million for HUTH. The Group were on target to spend £3.6 million on apprenticeships learned activity which painted a positive picture following a reduced spend due to Covid.

This funding supported 285 learner starts in the past year, with 134 colleagues at NLaG and 151 at HUTH.

Lucy Vere shared that the Group had started to consume the unspent Levy which was particularly greater at HUTH and the Group were working to get this underway at NLaG. The Group strived to strengthen arrangements around apprenticeships and engage managers to do this and this would increase retention. New starters on the North Bank had provided income which gave the Group an opportunity to reinvest into lower-level training courses. Lucy mentioned that new starters were a challenge on the South Bank and the Group aimed to attain more new starters on an apprenticeship.

Lucy highlighted the upcoming changes with a view to move the levy fund to a ‘Growth and Skills fund’ which would provide increased flexibility. She explained

that there would be a significant challenge if increased spending was removed which would put the levy spend at risk. Conversations were taking place around transfer of the levy and collaboration with local providers was planned.

Sue Liburd commended the positive report. She noted the 'Growth and Skills levy' and queried if there was a sense of when that would take effect. Lucy Vere advised that there was no sense of that but would bring an update to the WEC CiC once aware.

Laura Treadgold noted the report and queried if there was a particular objective to recruiting a younger workforce. Lucy Vere explained that the aim was to ensure hospitals represented the community which connected to participation work with schools. She shared that the Group were targeting schools to make career opportunities clear. A further discussion took place around how the Group can appeal to an older workforce.

The Committees-in-Common agreed significant assurance for this item.

5. ITEMS FOR INFORMATION

5.1 Band 2/3 HCA Support Workers Update

Amanda Stanford provided a verbal update. The Band 2/3 job descriptions were resolved. Some tasks were removed from the job descriptions as they were deemed unnecessary to the roles. The roles were under evaluation to ensure they met the Band 3 requirements. Conversations were ongoing around the Groups approach to bank workers, leavers and back pay, and the Group were working with Union colleagues to ensure consensus.

Simon Nearney informed the Group that they were aiming to have the Band 2/3 job descriptions implemented for June 2025. The Group were still awaiting a formal response regarding backpay from the Union. He mentioned the date offered was from 01 April 2021.

Tony Curry queried whether budget was factored in. Simon Nearney confirmed that it was.

5.2 Workplan

No issues were raised.

5.3 Workforce Transformation Group Minutes

Ashok Pathak queried the benefit for Medical Graduates and Healthcare practitioners once completing their course.

Action: Lucy Vere to investigate the benefit for Medical Graduates and Healthcare practitioners once completing their course.

Sue Liburd noted that it was hard for an outsider to get a sense of the quality of the dialog within the meetings from the minutes and proposed for more outcome-focused minutes.

5.4 **EDI Steering Group Minutes**

Sue Liburd identified that it was hard for an outsider to get a sense of the quality of the dialog within the meetings from the minutes and proposed for more outcome-focused minutes.

Sue Liburd mentioned the attendance list within the meeting and suggested a review of the terms of reference. Amanda Stanford advised that this concern was raised at the previous EDI Steering Group. She highlighted that it was crucial to ensure the right people were within the meetings and work was ongoing to review this.

Julie Beilby noted moving to a centralised process for reasonable adjustments and queried the timeframe and rationale behind that. Paul Bunyan explained that it was already implemented at NLaG and the rationale behind it was following a conversations around a manager not purchasing a chair due to being overspent, therefore it was moved to Occupational Health. The Group were working to implement this at HUTH, reviewing finances and creating a centralised budget to enable activity.

6. ANY OTHER URGENT BUSINESS

6.1 **Any Other Urgent Business**

Sue Liburd mentioned an issue that had arose regarding the postal team and wanted to make sure that the Workforce Team were sighted. Simon Nearney advised that he was aware and would provide Sue with further information.

Action: Simon Nearney to obtain more detail and update Sue Liburd on the DPoW post room restructuring.

Julie Beilby recognised that the NEDs needed to be vigilant around boundaries of operational work and processes. Julie further proposed taking on a more personal approach by signing cards when presenting Shining Light awards.

The Chair noted that Ashok Pathak's term office would come to an end in a few days and thanked Ashok on behalf of the CiC for his valuable contribution over the years.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 **Matters to be Referred to other Board Committees**

None to note.

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:

- International Educated Midwives issue and the Group would not tolerate racism. Amanda Stanford and Sue Liburd would carry out further investigations.
- Band 2/3 job descriptions awaiting a formal response from Unions regarding backpay.
- Awaiting a formal response from NLaG LNC and next steps regarding Consultant Extra-contractual pay rates.
- Staff survey results in the lower quartile, lots of work taking place to improve this.
- Pharmacy Staffing across the Group.
- Data Quality issues.
- Apprenticeship Levy annual policy.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 30th April 2025 at 9am till 12:30pm, via Microsoft Teams.

The Committee Chair closed the meeting at 12:31 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	June	Jul	Au	Sep	Oct	Nov	Dec
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG)	Y	Y	Y									
Tony Curry	Non-Executive Director (HUTH)	Y	N	Y									
Simon Nearney	Group Chief People Officer	Y	Y	Y									
Amanda Stanford	Group Chief Nurse	Y	Y	Y									
Kate Wood	Group Chief Medical Officer	D	D	Y									
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y									
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y									
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y									

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 30th April 2025 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Julie Beilby	Non-Executive Director (NLaG) (Chair)
Jo Ledger	Deputy Chief Nurse (Attending for Group Chief Nurse)
Simon Nearney	Group Chief People Officer
Kate Wood	Group Chief Medical Officer
Laura Treadgold	Non-Executive Director (HUTH)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement
Murray MacDonald	Non-Executive Director and Vice Chair
Lucy Vere	Group Director of Learning and Organisational Development
Myles Howell	Director of Communications & Engagement
Elizabeth Houchin	Freedom to Speak Up Guardian (NLaG) (until item 4.3)
Fran Moverely	Freedom to Speak Up Guardian (HUTH) (until item 4.3)
Peter O'Sullivan	Head of Occupational Health (item 4.4)
Lindsey Harding	Director of Workforce (item 4.5)
Helen Knowles	Director of People Services (item 4.6)
Joanne Goode	Chief Pharmacist (item 4.10)

Observers:

Robert Pickersgill	Public Governor

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees in Common Chair welcomed those present to the meeting. Apologies were noted for Tony Curry, Non-Executive Director (HUTH), Sue Liburd, Non-Executive Director (NLaG), David Sulch, Non-Executive Director (HUTH).

1.2 **Staff Charter and Values**

Julie Beilby noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting. She highlighted the importance of team work and tackling poor behaviours in a polite and constructive way.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meeting held on 26th March 2025**

The minutes of the meeting held on the 26th March 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

No matters were arising.

1.6 **Committees-in-Common Action Tracker**

Updates to the Action Tracker were provided within the agenda items.

1.7 **Urgent and Emerging Issues**

Simon Nearney provided an update on the ongoing discussions with the NLaG LNC due to the consultant rate changes. The Group had written to the LNC to state their position and clarify events that had unfolded since August 2024. They received a response from the BMA that the LNC would seek legal advice, but have agreed to meet with ACAS and Group representatives. All emergency calls had been covered and a number of patients had been cancelled as a result of the action.

Dr Kate Wood clarified that although no immediate patient safety issues had occurred as a result of the emergency on call work being covered, the Group would expect increased long waiters as 'planned' extra-contractual activity had been stood down. This would continue to be monitored and discussions through Executive Team took place around mitigations. North Bank colleagues continued to support on-calls on the South Bank, and Operational teams were reviewing the appropriateness of moving patients to different sites for procedures.

Simon Nearney updated the CiC on the Health Care Support Workers band 2/3. Conversations continued with trade unions who had written to their members to obtain an agreement backdated to April 2021. Further subgroup meetings are taking place with Unison to discuss the inclusion of bank staff and people who had left the Group. The first meeting would take place tomorrow. The Group were looking to implement the band 2/3 to circa 1500 staff across the Group would see an immediate pay rise as a result. Issues were ongoing with trade unions on the

South Bank with regards to job evaluation consistency checking. however, The posts had been checked on the North Bank and the outcome was as expected. The check was still to be completed on the South due to trade union absence. The Group expected the earliest go live date of 01 June 2025.

Leah Coneyworth joined the meeting at 09:16 hours.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 CQC Actions Group Progress Report

Leah Coneyworth took the report as read and provided an update. No actions relating to the Workforce and Transformation Committee had closed since the previous update and they remained open around mandatory training in relation to medical staffing. Mandatory training within NLaG remained an issue in Children and Young People, overall mandatory training identifying patients approaching end of life care, medical staffing within medical care, surgery and ED. Although performance had improved within a range of 60-70%, the Group had not achieved the 85% target.

HUTH saw 2 actions move from red to green. The overall Care Groups within surgery were compliant above 85%. Medical staffing had improved compliance at 77% but had not achieved target. Resuscitation training in surgery demonstrated an improving position except Theatres which decreased from 84% to 76%, all other areas showed an improved position and were 77-78% compliant.

The Trust wide Risk Reduction Training action remained open and would be taken through Executive Team for further discussion and investment around de-escalation lead.

Julie Beilby queried whether any underlying factors had taken place to improve mandatory training. Lucy Vere shared that given challenges with capacity, the Group had seen an improving position and should not be overly concerned as long as the Group continued to make improvements.

Elizabeth Houchin joined the meeting at 09:17 hours.

The Committees-in-Common agreed reasonable assurance for this item.

Fran Moverley joined the meeting at 09:19 hours.

Leah Coneyworth left the meeting at 09:20 hours.

3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate

None to note.

3.3 **Review of Relevant External Reports, Recommendations & Assurances as appropriate**

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Freedom To Speak Up Quarter 4 and Annual Report HUTH & NLaG

4.1.1 Freedom To Speak Up Quarter 4 and Annual Report HUTH

Fran Moverely provided an update on the Q4 position. She shared that Q4 saw 76 concerns which had reduced in comparison to Quarter 3.

Annually, HUTH saw an increase of 271 cases which was a record and increase of 35%. Top reasons for speaking up included varied concerns around roles, unprofessional behaviours, and worker safety including physical safety and psychological safety of speaking up. 24% of Nurses and Midwives were the front runners for raising concerns.

2% of cases were reported anonymously in 2024/25 and 21% of staff wished to remain anonymous. The Group were below the national average in comparison to previous years.

A feedback survey had commenced half-way through 2024 and received 35 responders. One national mandatory question in the survey revealed that 94% of respondents would speak up against the Guardian and 77% of staff would speak up again to the wider Trust. Themes coming through when speaking up to the wider Trust revealed not receiving timely feedback, favouritism, lack of compassion in terms of disability, and the emotional impact of speaking up.

Julie Beilby queried whether the suggested actions following the survey would be implemented. Fran Moverley shared that they would be implemented and an online reporting form was in progress.

Julie Beilby noted the level of concerns raised around patient and worker safety in Q4 which related to psychological safety and queried whether there were hot spots. Fran Moverley confirmed that the concerns raised were evenly distributed across the Group.

The Committees-in-Common agreed reasonable assurance for this item

4.1.2 Freedom To Speak Up Quarter 4 and Annual Report NLaG

Elizabeth Houchin shared that 128 concerns were raised in Q4, this included a group of 25 staff members and 10 separate concerns were raised individually around the same issue. There was reduction in the number of concerns closed on the same day following advice or signposting given. The main themes for Q4 were around worker safety, patient safety and inappropriate behaviours, particularly colleague against colleague. and bullying and harassment.

Annually, 401 concerns were raised which was the 7th consecutive increase and had increased by 20% in comparison to 2023/24. Main themes were worker safety, inappropriate behaviours and patient safety which mirrored the national picture. Nurses and Midwives reported the most concerns. 4% of concerns were raised anonymously which was below the national average.

Julie Beilby mentioned staff members subject to detriment following raising concerns and queried whether that had resolved. Elizabeth Houchin shared that upon investigation, other factors were discovered and it was determined that the staff had not suffered detriment as a result of speaking up.

The Committees-in-Common agreed reasonable assurance for this item

4.2 **Freedom to Speak Up Group Strategy 2025/28**

Elizabeth Houchin explained that the draft strategy was shared with Union Colleagues for feedback and taken through the People Senior Leadership Team (SLT), Staff Network Chairs at HUTH and both Equality and Diversity inclusion teams for feedback.

Simon Nearney commended the strategy. He highlighted that the staff survey evidenced that staff felt the Group did not provide a psychologically safe environment for people to raise issues. Work was ongoing via the cultural transformation programme. Early feedback received from managers was that they could feel change and a connection with senior leaders as a result of the sessions and conversations taking place.

Dr Kate Wood shared that NHS England requested that the Freedom To Speak Up (FTSU) Guardians attend the Quality Improvement Group to share the annual FTSU reports and Board understanding of FTSU with an aim to reinforce and acknowledge importance of psychological safety and the impact it has on patients.

The Committees-in-Common approved the strategy for Board Approval.

Fran Moverley and Elizabeth Houchin left the meeting at 09:43 hours.

David Sharif queried how the Group ensured individuals who raised concerns were supported. Simon Nearney shared that communication and conversations took place with the Freedom to Speak Up Guardians on a regular basis to discuss issues and any requirements for intervention.

4.3 **National Staff Survey 2024: Summary and Proposed Actions**

The agenda returned back to the correct order.

Myles Howell took the report as read. He shared that a putting people first approach was launched to improve the staff survey and Group culture. Work was taking place with Care Groups, HR business partners and triumvirates to develop their plans.

The first quarter focused on communication and engagement which was a key theme from the staff survey. The Group were asking people to focus on engaging

with their teams and provide teams the opportunity to meet with their managers to discuss concerns. A significant amount of progress was already made one month into the process. Structures were put into place and regular meetings were ongoing to monitor progress and understand work in areas.

Myles Howell explained the People Management approach. The Group were meeting with staff across all 5 sites who managed more than 5 people, alongside Tris and Quads. 5 sessions had taken place so far and the Group met with over 200 people. Feedback appeared positive and revealed that people found the sessions useful and were welcoming the approach.

Work was ongoing with HR colleagues to create guidance for managers to manage change effectively. The Group were working with Digital teams to look at improving access to digital communications.

Myles Howell shared that the first section of the communications and engagement aid, reward, recognition and essentials would be available at the end of June and would include a comprehensive package of support for managers, the engagement sessions and the speaking up approach.

Score cards were developed for Care Groups to look at their individual staff survey scores which would enable them to look at impact within their teams and identify 3 key themes per quarter to guide the staff surveys in the right direction. This would be reviewed in performance meetings with the Care Groups going forward.

The Group were working with managers in wards and departments to look at three things that could be done differently. Managers would then be asked to complete a feedback form and send the Group their three actions. This would continue to be measured in pulse surveys.

Simon Nearney mentioned that the sessions were led by the Executive Team and put simply could be game changers. Managers were engaging. He advised that the sessions were about recognition that the Group could improve and the Group would need to work together to ensure cultural transformation was successful. He highlighted that delivering the cultural programme and sessions within current resources was a challenge. Simon shared enthusiasm that if the Group kept up momentum then improvements would be seen within 18 months.

Lindsey Harding joined the meeting at 10:38 hours.

Julie Beilby noted that the risks around capacity and transformation would need to be monitored carefully.

The Committees-in-Common agreed reasonable assurance for this item

4.4 **Occupational Health Annual Report**

The agenda was out of order at this point. Discussed at 10:00 hours.

Peter O'Sullivan explained that the Occupational Health Service had formed a Group model with a central leadership which would enable an aligned leadership and shared services across the Group.

Presentation of KPIs between the North and South Bank differed due to historical differences of how the data was captured. The Group aimed to work towards a shared method of capturing KPIs to ensure comparable delivery. The South Bank had consistently met the target for the past three months. Referral into the service on the South Bank had significantly improved over the last two years.

The Occupational Health team were looking at a pathway for direct access which would enable managers, HR and Occupational Health to refer staff. Work was ongoing in conjunction with the Psychology service and health and well-being to enable a link-in support system which would alleviate pressure from staff and managers.

The Occupational Health team would prioritise focusing on aligning services over the next 12 months including digital records and processing to ensure standards aligned across the Group. The second key focus was on single point of access from an Occupational Health and well-being point of view and this was expected to be implemented in six months.

Paul Bunyan praised the Occupational Health Team. He shared that the transformational work has addressed significant issues that had existed for 5-6 years in terms of referral and recruitment time scales and the Group had started to see a benefit in health and well-being.

Julie Beilby noted the improvement in the recruitment process with a high focus on Occupational Health and advocated that single point of access was critical to provide individuals with support. She queried whether the Psychology service ability to refer from one service to another was available for staff on the South Bank. Peter O'Sullivan clarified that the South Bank did not currently offer a self-referral service to Psychology. Occupational Health aimed to align offering this service across the Group.

The Committees-in-Common agreed reasonable assurance for this item.

Peter O'Sullivan left the meeting at 10:15 hours.

4.5 **Employee Relations Cases across the Group - April 2024 to March 2025**

Lindsey Harding highlighted that 547 cases opened in 2024/25 across the Group. HUTH were averaging 200 cases year-on-year, and historical data for NLaG was not available. 50% of the workload was related to disciplinary cases, and 25% was related to sickness.

A disproportionate amount of cases were seen within Acute and Emergency. Improvement was seen in the average length of time to complete cases with a

medium figure of 40 days for completion. 70 cases took over 100 days to complete which was significantly high.

A Group policy for disciplinary cases was implemented on 01 April 2025 and the Group expected to see consistency in the outcomes for 2025/26.

A Group policy for supporting and managing attendance was created and expected to be implemented in a few days, however full effects would not take place until 2026 and challenges would arise in getting that to full effect due to the requirement of training staff on using the policy.

There were currently 8 current live cases for employment tribunals.

Upon reviewing demographic analysis, there was slight variance for staff declaring themselves homosexual or disabled however as the data was so small it was difficult to form conclusions. Male staff members in HUTH were more likely to be involved in an employee relations case due to the Faceless Facilitator Development (PFD).

Black, Asian and minority ethnic (BAME) colleagues were no more or less likely to be involved in an employee relations case. However 17.75% of disciplinary cases at HUTH involved BAME colleagues, and 28.3% of BAME colleagues at NLaG. 25 of the 60 disciplinary cases involved BAME colleagues in Acute and Emergency Medicine. Conversations were ongoing to identify how to address this further and the Care Group would complete an analysis of individual cases to review whether further training was required for those colleagues.

Kate Wood advised that there was a potential for the report to be enhanced to enable the Board to have oversight of the length of time that cases took for completion. She queried whether the Group were looking at ‘new to the UK’ colleagues and whether adequate support was in place, noting that significant vacancy gaps were filled by overseas recruitment, and an organisational issue may be identified rather than a Care Group issue. Lindsey Harding explained that an analysis identified where the problem occurred however further analysis could be carried out.

Lucy Vere provided assurance that the Group and triumvirate were aware of the issues within Acute and Emergency Medicine and work was ongoing with Organisational Development around culture. She proposed a Deep Dive and explained that onboarding was a challenge across the Group and practical understanding was needed.

Helen Knowles joined the meeting at 10:50 hours.

Lindsey Harding left the meeting at 11:10 hours.

4.6 **Annual Report for Job Planning**

Helen Knowles took the report as read and shared that this was the first year a joint report was created in the new Group model. Peter Sedman was leading on

the Group Job Planning policy and meetings were ongoing to establish a Group policy which was expected to be implemented in May 2025.

A job planning consistency group would be implemented across all Care Groups and the first series would take place from June to September 2025.

The Group would review job plans greater than 12 PAs with a direction of travel that no job should be greater than 12 PAs.

An event in October 2025 would review job planning capacity and demand for Chiefs of Service and Operations Directors.

The Committees-in-Common agreed reasonable assurance for this item.

Helen Knowles left the meeting at 11:23 hours.

4.7 **Medical Workforce Strategy 2025/28**

Agenda taken out of order. Item discussed at 09:46 hours.

Dr Kate Wood provided an overview of the Medical Workforce Strategy and praised Andy Gratrix and David Sprawka for their work undertaken to devise the Workforce Strategy. She reminded the CiC that the strategy did not sit in isolation and was part of the other strategies within the Group and emphasised the importance of inclusion of more than doctors when discussing medical workforce.

The Consultant vacancy rate was 13.6% and overall medical and dental vacancy rate was 5.4%. Previously the medical vacancy rate at NLaG was 30% which evidenced substantial improvement through the amount of work undertaken by the recruitment team.

Dr Kate Wood explained that there were seven different objectives within the developed strategy: right sizing, engagement, staffing, education learning and research, partnership working, leadership, and quality and productivity. The 2025/28 delivery plan detailed what the Group would implement in Year 1-3.

Laura Treadgold shared concerns that the strategy did not show how the research agenda would develop and queried if there would be an opportunity to include this within the report. Dr Kate Wood explained that a separate research strategy was in the development stage and the aim was to avoid duplication within both strategies. She assured the CiC that the reference points within the medical workforce strategy would be covered in the research strategy.

Action: Kate Wood to have a discussion with the Workforce Team to signpost research development within the strategy.

The Committees-in-Common endorsed approval for the Medical Workforce Strategy.

Peter O'Sullivan joined the meeting at 09:59 hours.

4.8 **Equality Delivery System 2022**

Lucy Vere took the report as read and explained that the Equality Delivery System 2022 (EDS) was a nationally mandated NHS standard contract and helped Organisations to look at both patient services and staff environment to ensure they met the requirements of the Equality Act 2010. The EDS covered three sections; Workforce Health and Well-being, Inclusive Leadership, and Commissioned or Provided Services which contributed to the score ratings.

NLaG and HUTH remained as developing although the scores had increased.

Lucy Vere shared that the Group had good health and well-being services particularly from a reactive perspective. She mentioned that there was depth around mental well-being and provision for reactive services. The Group did not have services to support staff around obesity, diabetes, asthma and COPD due to the legacy of health and well-being services.

Inclusive leadership was rated as developing due formation of the Group and the CiC working well.

It was expected that the work in progress around culture engagement would contribute to improved scores across the Group for 2025/26.

Joanne Goode joined the meeting at 11:33 hours.

The Committees-in-Common agreed reasonable assurance for this item.

4.9 **Harmonisation of National and Local Mandatory Learning across NHS Humber Health Partnership**

Lucy Vere provided assurance to the Committee that the Group had reached harmonisation across the nationally core mandated topics which would use e-Learning for Health. A Memorandum of Understanding (MOU) beginning from 01 May 2025 meant that the Group would accept a call list of prior statutory and mandatory training.

Unfortunately NHS England determined that the Digital Passport project would not commence which would not affect the Group from a learning perspective but could affect the recruitment and workforce team.

Compliance was above target. There were issues around nationally mandated and locally mandated training for medical and dental staff.

Work was ongoing with Acute and Emergency Medicine to reduce DNA rates for adult basic life support and filling late withdrawal spaces. The Group were working directly with clinical areas to look at direct enrolment onto outstanding e-learning provision and offering bespoke classroom sessions. Lucy Vere noted the challenge of sessions getting cancelled due to operational pressures. Compliance had improved slightly in ED at Diana, Princess of Wales Hospital (DPoW).

Compliance within Acute Care at NLaG had increased significantly and DPoW saw a 20% increase. Work was ongoing with HR business partners in each Care Group to review hot spots with an aim to improve compliance.

Lucy Vere shared that the Oliver McGowan approach had worked well in providing a clear trajectory to prioritise services and further work was ongoing.

A new course developed for nurses and non-registered nurses called ATHENS (Assessment, Treatment, Human Factors, Escalation, News Monitoring and Simulation) would provide the Group with more effective locally mandated and role specific training.

Nationally, the Group were asked to create a Mandatory Learning Oversight Group (MLOG) and produce an annual plan which would be taken through this CiC. A national policy was published and received a few weeks ago. The Group were establishing a Group policy to ensure that there were not two separate learning and development policies.

Dr Kate Wood shared that detailed discussions were taking place through the Department of Health National Working Group around the value and delivery of training and she noted the fantastic work undertaken for ATHENS.

David Sharif noted the initiatives to support attendance and queried what could be done to improve compliance in ED. Dr Kate Wood highlighted that there was no single approach and shared that the drive to reduce the amount of training required across the Group and ensure accessible and understandable training would support with compliance. Lucy Vere mentioned that the Group were looking at implementing a Clinical Safety Day to enable colleagues to complete training all at once.

The Committees-in-Common agreed reasonable assurance for this item.

4.10 **Deep Dive: Pharmacy Workforce**

Jo Goode presented the Pharmacy Workforce Deep Dive and explained that NHS benchmarking data was currently under collection and therefore the report contained last year's data.

The Group's pharmacy services included 404 team members across one pharmacy leadership team. The operational management team had started to create lead posts across the Group. There was significant capacity to increase the clinical trials work at NLaG.

Inpatient and outpatient dispensaries had moved from Lloyds to Rowlands in 2024/25 which caused challenge with contract negotiations. The Group held two aseptic units due to medicines legislation which meant that the Group could not share medicines across sites. Work would be undertaken to review whether further efficiencies could be made as a Group.

NHS Benchmarking results showed that NLaG spent less on medicine per 100 beds in comparison to HUTH. The Group were in the lower percentage quartile for

pharmacy establishment. The Group had less pharmacists than the national average percentage and more pharmacy support workers and assistants were utilised due to this.

Work was ongoing to align the Homecare teams as HUTH was well resourced whilst NLaG was in the lower percentage quartile.

Medicine shortages were an issue nationally and more time was spent managing this at HUTH due to more complex medication needs.

Vacancy rates across the Group were under 10% and sickness absence rates were 3% across the Group. A risk around staff recruitment at NLaG was removed from the risk register.

Jo Goode expressed concerns around the number of staff struggling with well-being as 17.4% of the team were affected.

There were challenges across the Group with the Antimicrobial Stewardship (AMS) team and a business case was in place for a pharmacist and pharmacy technician at NLaG.

The pharmacy team were looking to implement the already established QPulse HUTH system across the Group to enable policies and procedures to be managed more effectively.

David Sharif queried the reason for two procurement teams. Jo Goode explained this was due to the Group currently using two procurement systems.

Jo Goode left the meeting at 12:20 hours.

5. ITEMS FOR INFORMATION

5.1 Workplan

Julie Beilby mentioned the quarterly monitoring of key metrics in relation to the culture work which linked into pulse surveys and asked Simon Nearney and Myles Howell to ensure this was factored into agendas.

5.2 Workforce Transformation Group Minutes

Julie Beilby noted the flexible working wording within the minutes. She shared that a decision would need to be made without staff consent on the Group Paid Protection policy.

5.3 EDI Steering Group Minutes

Julie Beilby noted that the EDI Steering Group felt like a work in progress. Lucy Vere shared that a Time-Out session would take place in June 2025 to redesign what the EDI Steering Group should be and a proposal would be brought back to this CiC following this.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

None to note.

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:

- NLAG Consultant Extra-contractual pay dispute: Current position had no immediate safety issues although patients waiting longer were being monitored
- CQC Action (Group) improvements were being made, however there was more work to do
- The CIC endorsed the Freedom To Speak Up Strategy and recommended approval by the Boards in Common
- Approval of the Medical Workforce Strategy
- National staff survey – Meetings were taking place with senior managers and teams were agreeing actions to take forward
- Mandatory training improvements were noted
- Pharmacy Deep Dive

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Workforce, Education and Culture CiC meeting:

Wednesday 28th May 2025 at 9am till 12:30pm, in The Boardroom, Diana, Princess of Wales Hospital

The Committee Chair closed the meeting at 12:28 hours.

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	June	Jul	Au	Sep	Oct	Nov	Dec
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG)	Y	Y	Y	Y								
Tony Curry	Non-Executive Director (HUTH)	Y	N	Y	N								
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y								
Amanda Stanford	Group Chief Nurse	Y	Y	Y	D								
Kate Wood	Group Chief Medical Officer	D	D	Y	Y								
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N								
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N								
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	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(25)106

Name of the Meeting	**Trust Boards-in-Common (meeting held in Public)**
Date of the Meeting	12 June 2025
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	**NLaG:** Dr Liz Evans, Guardian of Safe Working Hours, Helen Fitzpatrick, Revalidation & Appraisal Coordinator and Admin for Guardian of Safe Working **HUTH:** Dr Wajiha Arshad, Guardian of Safe Working Hours, Joey Robson, Group Medical Staffing Manager, Rose Bundy, Guardian of Safe Working Hours Analyst
Title of the Report	**Quarterly Reports on Safe Working Hours (Doctors and Dentists in Training) Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust - 01 January 2025 to 31 March 2025**
Executive Summary	**NLaG:** The quarterly report for the GoSW for NLaG details the number of exception reports, along with the reasons behind them and details the fines imposed for contract breeches. There is also information contained concerning locum spends and fill rates per department. The number of reports in this quarter has increased compared to the preceding quarter, this pattern is in keeping with what we expect at this time of year, although the number of reports received is slightly higher than usual. All reports have been actioned and closed as appropriate. There were seven immediate safety concerns raised which have been escalated to the relevant departments, and no fines were imposed. The guardian has had some issues accessing the fine money owed from the previous quarter, but this issue seems to have been resolved. **HUTH:** <u>Exception reports:</u> 162 exception reports submitted over the quarter, with the highest number of 87 submitted by F1 trainees. <u>Fines:</u> No Guardian of Safe Working Fines were issued in this quarter <u>e-Roster Rollout:</u> Since the last Quarterly Report, of the remaining rotas that were yet to be implemented onto e-Roster, ongoing work with the Care Groups continues with ENT and OMFS to develop a compliant

	rota pattern to be implemented on the system at Blue as soon as compliant patterns are in place. Trainee Doctor Fill Rate: Over the quarter, 92.9% of NHSE appointed doctor in training posts were filled, a decrease from 93.2% last quarter. Immunology and Stroke Medicine have fill rates of 0% due to their establishment consisting of 1 doctor which NHSE were unable to recruit to. Oral & Maxillofacial Surgery has a 50% fill rate due to 6 out of 10 NHSE posts being unfilled at Dental Core Trainee Level. The department has appointed Locally Employed Dentists/Doctors to fill these roles. Emergency Medicine is the department with the highest bank and agency usage over the quarter, with a fill rate of 87.5%.
Background Information and/or Supporting Document(s) (if applicable)	**NLaG:** https://www.nhsemployers.org/system/files/2023-02/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf **HUTH:** Doctors and Dentists in Training Terms and Conditions (England) 2016 – Available on NHS Employers website.
Prior Approval Process	Workforce, Education, and Culture Committee Committees-in-Common meeting held on 28 May 2025
Financial implication(s) (if applicable)	**NLaG:** N/A **HUTH:** The Guardian of Safe Working Hours Funds stands at £65,764.00 at the time of the report being written and plans to utilise these funds are detailed in this 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:

Northern Lincolnshire and Goole NHS Foundation Trust
Quarterly Report on Safe Working Hours (Doctors and Dentists in Training)
1st January 2025 to 31st March 2025
Quarter Four

1. Purpose of this Report

Under the terms of the Doctors and Dentists in Residence Terms and Conditions (England) 2016, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from 1st January 2025 to 31st March 2025.

- 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 resident (total):	217.09
(establishment)	241.44
Amount of time available in job plan for guardian to do the role:	2 PA (8 hours per week)
Admin support provided to the guardian (if any):	8 hours per week.
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between health groups)

Information on exception reporting is detailed within the resident doctor's contract (pages 37-39)

3. Immediate Safety Concerns

There have been 7 reports this quarter with an immediate safety concern highlighted. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and escalated appropriately.

This quarter the immediate safety concerns are within both Trauma and Orthopaedics and the medicine care groups. The concerns have been raised across all sites for within NLAG. The themes of these concerns include lack of service support and insufficient rota cover for resident doctors impacting the safe delivery of service. All issues have been escalated to the areas concerns and have been addressed appropriately.

4. Exception Reports

There was a total of 131 exception reports reported by doctors in residence and locally employed doctors in this quarter. This represents a slight increase from the 108 report

received in the preceding quarter. This pattern is the norm for this time of year, although the number of reports received is higher than normal. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

General Medicine and accident and Trauma & Orthopaedic Surgery (T&O) had the highest number of exception reports submitted over the quarter.

Table A: Exception reports (episodes) by department

Specialty (Where exception occurred)	No. exeptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstsanding
Accident and emergency	0	5	3	2
Acute Medicine	1	6	7	0
Anaesthetics	0	7	7	0
Gastroenterology	0	7	7	0
General medicine	9	66	65	12
General surgery	3	7	9	1
Geriatric medicine	0	5	5	0
Obstetrics and gynaecology	1	1	2	0
Paediatrics	0	6	4	2
Respiratory Medicine	0	9	9	1
Trauma & Orthopaedic Surgery	0	12	10	2
Total	**14**	**131**	**128**	**20**

Table B: Exception reports (episodes) by grade

Grade	No. exeptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstsanding
F1	2	82	77	11
F2	5	23	24	4
F2 (TG)	0	2	2	0
CT1	6	20	23	2
CT3	1	1	2	0
ST4	0	2	0	2
ST5	0	1	0	1
Total	14	131	128	20

Table C: Exception reports (episodes) by rota

Rota	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstsanding
AAU SGH Sept 2024	1	1	0
Acute SpD Rota DPoW	4	4	0
Acute SpD Rota SGH Jan 24	1	1	0
DPoW A&E FY1 Dec 24	3	3	0
DPOW Anaesthetics F1-F2 Dec 24	6	6	0
DPOW Anaesthetics Junior Feb 25	1	1	0
DPOW Gen Surg Junior Dec 24	3	3	0
DPOW Medicine FY1 FY2 December 24	33	32	5
DPOW Medicine IMT in 14 Dec 24	5	5	0
DPOW Paediatrics FY1 Dec 24	6	6	0
DPOW T&O ENT Junior Dec 24	7	7	0
DPOW T&O FY1 Dec 24	8	8	0
SAS Rota A&E March 25	2	2	0
SGH Gen Med FY1 F2 Dec 24	48	34	14
SGH Gen Med FY1 F2 Dec 23	3	3	0
SGH Gen Surg FY1 Dec 24	3	3	0
SGH Gen Surg Junior Dec 24	1	1	0
SGH Med Rota IMT Aug 24	3	3	0
SGH Med Rota IMT Dec 24	4	4	0
SGH O&G FY1 Dec 24	1	1	0
SGH Paediatrics St4+ SAS LTFT 80%	1	0	1
Total	**144**	**128**	**20**

(Note: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself. The figures shown above include the figures of safety concerns).

The 2016 TCS require that the trainer meets with the doctor in resident 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 resident doctors and supervisors on the importance of exception reporting and meeting in a timely manner, however the overwhelming majority of the reports were closed by the Guardian of Safe Working.

Table D: Exception reports (episodes) - response time

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	Outstanding
F1	33	62	26	7
F2	5	13	11	2
F2 (TG)	0	0	3	0
CT1	9	12	9	0
CT3	1	0	0	0
ST4	0	2	0	0
ST5	0	0	0	1
Total	**48**	**89**	**49**	**10**

5. Work Schedule Reviews

No work schedule reviews have been requested or carried out during this quarter.

6. Locum bookings 1st January 2025 to 31st March 2025

This section details the use of Bank and Agency doctors to backfill vacant shifts. This is broken down into Bank (not including additional hours) and Agency bookings. This is also presented via department, grade and reason for booking.

Bank 1st January 2025 to 31st March 2025

The Trust has several 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 'Care 1 bank and agile 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 Rota coordinators for all care groups.

Table E: Locum Bookings (Bank) by Grade

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Core Trainee/ST1&2 (formerly SHO)	169	169	1519.78	1519.78
CT	93	93	696	696
FY 1	3	3	16.5	16.5
FY 2	9	9	63	63
Specialist Registrar	369	369	2998.25	2998.25
ST4-8	5	5	17.75	17.75
StR (ST3-8)	112	112	785.25	785.25
StR Lower Paediatrics (ST1-3)	37	37	176.5	176.5
StR Paediatrics (ST4-8)	14	14	98	98
Trust Grade (Junior)	6	6	759.25	759.25
Total	**817**	**817**	**7130.28**	**7130.28**

Table F: Locum bookings by speciality

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	8	8	818.75	818.75
Cardiology (Medical)	9	9	67.5	67.5
Care of the Elderly	20	20	169.28	169.28
Discharges	3	3	30.5	30.5
Emergency Medicine	360	360	2140.75	2140.75
Endocrinology and Diabetes	5	5	38.25	38.25
ENT	60	60	443.25	443.25
Frailty	1	1	8.5	8.5
General Medicine	28	28	1071	1071
General Surgery	3	3	25	25
Obstetrics and Gynaecology	180	180	1082.5	1082.5
Orthopaedic and Trauma Surgery	5	5	317.5	317.5
Paediatrics and Neonates	91	91	593	593
Respiratory Medicine	2	2	15	15
Stroke Medicine	42	42	309.5	309.5
Total	**817**	**817**	**7130.28**	**7130.28**

Table G: Locum Bookings (Bank) by Reason

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	13	13	200	200
Compassionate/Special leave	19	19	127	127
Deanary gap - Vacancy	32	32	616.5	616.5
Establishment Vacancy	3	3	19.5	19.5
Exempt from on calls for health reasons	3	3	37.5	37.5
Extra Cover	21	21	167	167
Induction/Rotation	16	16	104.5	104.5
Less Than FT Trainee Gap	8	8	55	55
Maternity/Paternity leave	55	55	368.25	368.25
None given	1	1	12	12
Pregnancy/Maternity Leave	3	3	24.5	24.5
Restricted Duties	1	1	8.5	8.5
Seasonal Pressures	9	9	387	387
Sick	58	58	483.5	483.5
Sick Leave Cover Non-Covid	2	2	4.5	4.5
Study Leave	8	8	51.25	51.25
Vacancy	565	565	4463.78	4463.78
Total	**817**	**817**	**7130.28**	**7130.28**

Agency Quarter 4: 1st January 2025 to 31st March 2025

The Trust also uses limited amount of agency staff. All agency bookings are managed by the Care group Rota coordinators, however, are only used when internal and bank routes are exhausted.

Table H: Locum Bookings (Agency) by Grade

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Core Trainee/ST1&2 (formerly SHO)	36	36	288	288
CT	12	12	96	96
FY 2	76	76	608	608
Specialist Registrar	80	80	640	640
StR (ST3-8)	48	48	384	384
Total	252	252	2016	2016

Table I: Locum Bookings (Agency) by Department

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	16	16	128	128
Care of the Elderly	12	12	96	96
Emergency Medicine	79	79	632	632
General Surgery	76	76	608	608
Obstetrics and Gynaecology	69	69	552	552
Total	**252**	**252**	**2016**	**2016**

Table J: Locum Bookings (Agency) by Reason:

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	70	70	560	560
Maternity Leave	6	6	48	48
paternity leave	6	6	48	48
Sickness	58	58	464	464
vacancy	112	112	896	896
Total	**14**	**14**	**182**	**182**

Table K: Locum work carried out by doctors in resident quarter 4 - 1st January 2025 to 31st March 2025

This data is collected to help assess whether individual doctors in resident are in breach of the WTR and the 2016 TCS, or at significant risk of breaching.

The table represents the top 4 doctors in resident that have worked the most extra hours and whether they have opted out of the WTD.

Base Specialty	Grade	Number of hours worked	Number of hours rostered per week
GP Trainee	GPST3	188.5	26
Paediatrics	ST1	84	13
Obs and Gynae	ST1	96	13
Paediatrics	ST4	87	14

7. Vacancies:

The below table details the Doctors and Dentists in resident establishment and current doctors in resident in post as appointed by NHS England (formerly Health Education England).

Row Labels	Sum of Sum of WTE Bud	Sum of Sum of WTE Cont	Sum of Vacancies WTE
Acute Medicine	**12**	**3.9**	**8.1**
Acute And Emergency Medicine	**12**	**3.9**	**8.1**
OTHER-TRAINING GRADE	12	3.9	8.1
Acute Surgery	**25**	**20**	**5**
Digestive Diseases	**25**	**20**	**5**
OTHER-TRAINING GRADE	25	20	5
Anaesthetics	**14**	**19.76**	**-5.76**
Theatres, Anaesthetics And Critical Care	**14**	**19.76**	**-5.76**
OTHER-TRAINING GRADE	14	19.76	-5.76
Breast Surgery	**0.5**	**0.5**	**0**
Specialist Surgery	**0.5**	**0.5**	**0**
OTHER-TRAINING GRADE	0.5	0.5	0
Cardiology	**8**	**7.8**	**0.2**
Cardiovascular	**8**	**7.8**	**0.2**
OTHER-TRAINING GRADE	8	7.8	0.2

Community Dentistry	**0.94**	**0**	**0.94**
Head & Neck	**0.94**	**0**	**0.94**
OTHER-TRAINING GRADE	0.94	0	0.94
Dermatology	**0.55**	**0**	**0.55**
Specialist Surgery	**0.55**	**0**	**0.55**
OTHER-TRAINING GRADE	0.55	0	0.55
Diabetes & Endocrine	**13**	**11**	**2**
Specialist Medicine	**13**	**11**	**2**
OTHER-TRAINING GRADE	13	11	2
Emergency Medicine	**31**	**21.49**	**9.51**
Acute And Emergency Medicine	**31**	**21.49**	**9.51**
OTHER-TRAINING GRADE	31	21.49	9.51
Ent	**3**	**3**	**0**
Head & Neck	**3**	**3**	**0**
OTHER-TRAINING GRADE	3	3	0
Frailty	**16**	**12.58**	**3.42**
Community, Frailty & Therapy	**16**	**12.58**	**3.42**
OTHER-TRAINING GRADE	16	12.58	3.42
Gastroenterology	**11**	**8**	**3**

Digestive Diseases	**11**	**8**	**3**
OTHER-TRAINING GRADE	11	8	3
Gynaecology	**13**	**13.81**	**-0.81**
Family Services	**13**	**13.81**	**-0.81**
OTHER-TRAINING GRADE	13	13.81	-0.81
Maternity Services	**13**	**13.82**	**-0.82**
Family Services	**13**	**13.82**	**-0.82**
OTHER-TRAINING GRADE	13	13.82	-0.82
Medical Education	**5**	**5**	**0**
Medical Education	**5**	**5**	**0**
OTHER-TRAINING GRADE	5	5	0
Neonatal Services	**3**	**3**	**0**
Family Services	**3**	**3**	**0**
OTHER-TRAINING GRADE	3	3	0
Ophthalmology	**4**	**4**	**0**
Head & Neck	**4**	**4**	**0**
OTHER-TRAINING GRADE	4	4	0
Orthopaedics	**11**	**9**	**2**
Specialist Surgery	**11**	**9**	**2**

OTHER-TRAINING GRADE	11	9	2
Paediatrics	**27**	**31.64**	**-4.64**
Family Services	**27**	**31.64**	**-4.64**
OTHER-TRAINING GRADE	27	31.64	-4.64
Rehab Medicine	**1**	**1.96**	**-0.96**
Major Trauma Network	**1**	**1.96**	**-0.96**
OTHER-TRAINING GRADE	1	1.96	-0.96
Respiratory	**17**	**14.91**	**2.09**
Specialist Medicine	**17**	**14.91**	**2.09**
OTHER-TRAINING GRADE	17	14.91	2.09
Rheumatology	**3.45**	**2**	**1.45**
Specialist Medicine	**3.45**	**2**	**1.45**
OTHER-TRAINING GRADE	3.45	2	1.45
Specialist Palliative Care	**1**	**0**	**1**
Community, Frailty & Therapy	**1**	**0**	**1**
OTHER-TRAINING GRADE	1	0	1
Stroke	**5**	**4.92**	**0.08**
Neuroscience	**5**	**4.92**	**0.08**
OTHER-TRAINING GRADE	5	4.92	0.08

Urology	**3**	**5**	**-2**
Specialist Surgery	**3**	**5**	**-2**
OTHER-TRAINING GRADE	3	5	-2
Grand Total	**241.44**	**217.09**	**24.35**

8. 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.

No fines have been issued this quarter, however, the GoSW continues to have a total of £521.01 owed from December 2024. The GoSW admin team continues to work with finance to gain access to these funds- this has been difficult as since the changes to the group structure it has become less clear where the funds come from. This issue has been resolved at the time of writing, so moving forward these problems should not recur.

9. GOSW Funds Expenditure

No purchases have been made during this quarter, resident doctors have been asked their thoughts on how they would like to spend these funds, however, this has yet to be agreed.
All expenditure from the GOSW Funds is agreed at the Resident Doctors' Forum.

10. Resident Doctors Forum

The Guardian of Safe Working runs a monthly Resident Doctors Forum in line with the Terms and Conditions of service. This is attended by the resident doctors and representatives from PGME, Medical Rostering, and higher management. This allows issues raised to be effectively dealt with and provides the resident doctors a supportive environment in which to air their concerns.
Some issues which have been raised continually during both this quarter and last concerning the working environment in general medicine has been escalated to the site Medical Director for further action, at present these issues remain unresolved, however, work is being carried out to ensure resolution.

Officer to Contact
Dr Liz Evans, Guardian of Safe Working Hours NLaG
Helen Fitzpatrick - E-Medical workforce Administrator and Admin for Guardian of Safe Working

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st January to 31st March 2025

1. Purpose of this Report

Under the Doctors and Dentists in Training Terms and Conditions (England) 2016 the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from 1st January to 31st March 2025.

- Exception reports and monitoring
- Locum usage
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	663.30
(establishment)	714
Amount of time available in job plan for Guardian of Safe Working Hours to do the role:	1 PA (4 hours per week)
Admin support provided to the guardian (if any):	1 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between care groups)

Information on exception reporting is detailed within the Doctors and Dentists in Training Terms and Conditions (England) 2016 (pages 37-39) which can be found on the NHS Employers website.

3. Immediate Safety Concerns

Resident doctors are able to escalate exception reports as immediate safety concern (ISC) where they feel appropriate. Over the quarter, there has been 7 exception reports escalated as an immediate safety concern. 4 of these related to increased workload due to colleague's short notice absence. 1 was in regards to the doctor's work schedule which was also escalated directly to the Guardian of Safe Working Hours. 1 was due to missed breaks and impact on educational time. The last was in relation to staff absence impacting a doctor who was rostered to work a Non-Resident On Call shift and was therefore required to be resident (on-site) for much of the shift. Investigations are currently taking place to ascertain whether a Guardian of Safe Working Hours fine should be levied to the department.

4. Exception Reports

There has been a total of 162 exception reports (162 episodes) reported by resident doctors this quarter highlighting a wide range of themes further detailed in this report.

4.1 Exception reports (episodes) by department 1st January to 31st March 2025

Endocrinology, Gastroenterology and General Practice have had the highest number of exception reports submitted over the quarter.

Within Endocrinology, out of the 35 exception reports submitted, all 35 were due to additional hours worked (overtime).

Out of the 31 exception reports submitted within Gastroenterology, 28 were for additional hours worked (overtime), 2 were related to the rota pattern, and 1 was due to educational reasons.

Out of the 22 exception reports submitted for General Practice, 15 were for additional hours worked (overtime) and 7 were related to educational reasons.

Table A: Exception Reports by Department 01/01/2025 – 31/03/2025

Specialty (Where exception occurred)	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
Endocrinology	35	35	0
Gastroenterology	31	25	6
General Practice	22	22	0
Oncology	12	9	3
Colorectal Surgery	8	6	2
NCTR/General Medicine	8	5	3
Acute Medicine	7	3	4
Paediatric Surgery	6	6	0
Vascular Surgery	6	1	5
Respiratory Medicine	5	5	0
Cardiothoracic Surgery	4	3	1
Urology	4	0	4
Elderly Medicine	3	3	0
Paediatric Emergency Medicine	3	0	3
ENT	2	1	1
Neurology	2	2	0
Obstetrics and Gynaecology	2	0	2
Cardiology	1	1	0
Psychiatry	1	0	1
Total	**162**	**127**	**35**

4.2 Exception reports (episodes) by grade 1st January – 31st March 2025

The highest number of exception reports were submitted by FY1 trainees. 87 exception reports were submitted by FY1 trainees in the quarter, and of those, 80 were submitted in relation to additional hours (overtime) worked, 3 were for educational reasons, 2 were for lack of service support and 2 were related to the rota pattern.

Table B: Exception Reports by Grade 01/01/2025 – 31/03/2025

Grade of Doctor submitting ER	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
FY1	87	72	15
FY2	36	31	5
ST1/CT1	26	19	7
ST3+	13	5	8
Total	**162**	**127**	**35**

4.3 Exception reports (episodes) by rota 1st January – 31st March 2025

Rota 18B (Medicine F1), General Practice (F2) and Rota 4 (Medicine F1) were the rotas with the highest number of exception reports over the quarter.

Rota 18B (Medicine F1) had 36 exception reports submitted in total, with 35 relating to additional hours (overtime) worked and 1 for missed educational opportunities.

General Practice (F2) had 22 exception reports submitted, 15 relating to additional hours (overtime) worked and 7 for missed educational opportunities.

Rota 4 (Medicine F1) had 15 exception reports submitted, all 15 were in relation to additional hours (overtime) worked.

Table C: Exception Reports by Rota 01/01/2025 – 31/03/2025

Rota Number & Department	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
Rota 18B - Medicine F1	36	35	1
General Practice	22	22	0
Rota 4 - Medicine F1	15	10	5
Rota 4B - Medicine F1	14	14	0
Rota 8 - Oncology and Haematology F2/CT	10	8	2
Rota 130/131 - NCTR / General Medicine	8	5	3
Rota 25 - Acute/Elective Surgery F1	8	6	2
Rota 15 - Gastro/Endo/Rheum F2/CT	6	5	1
Rota 66 - Paediatric Surgery 27.10.20	6	6	0
Rota 19 - AAU F2/CT	5	3	2
Rota 29 - Vascular Surgery ST3+	5	0	5
Rota 121 - CT Surgery & Cardiology F2/CT	4	3	1
Rota 124b - Urology/ENT	4	0	4
Rota 18 - Medicine F1	3	3	0
Rota 2C - Paediatric Emergency Medicine ST1-3	3	0	3
Rota 9 - Chest/Renal F2/CT	3	3	0
Rota 34 - ENT ST3+	2	1	1
Rota 6a - RMO 5 ST3+	2	0	2
Rota 12 - Medical Oncology ST3+	1	0	1
Rota 14 - Elderly Medicine F2/CT	1	1	0
Rota 20 - Cardiology ST3+	1	1	0
Rota 23 - Surgery F1	1	1	0
Rota 51 - O&G ST1-2	1	0	1
Rota 52 - Obstetrics & Gynaecology ST4+	1	0	1
Total	**162**	**127**	**35**

4.4 Exception reports (episodes) - response time 1st January – 31st March 2025

The Doctors and Dentists in Training Terms and Conditions (England) 2016 require that the supervisor meets with the resident doctor to discuss an exception report within seven days.

It has continually been identified that meeting within seven days is often difficult for resident doctors and supervisors. The Guardian of Safe Working Hours continues to educate both resident doctors and supervisors on the importance of exception reporting and meeting in a timely manner.

Table D: Exception Reports Response Time by Grade 01/01/2025 – 31/03/2025

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	No. outstanding
FY1	25	10	37	15
FY2	3	11	17	5
ST1/CT1	4	0	15	7
ST3/CT3+	3	0	2	8
Total	**35**	**21**	**71**	**35**

5. Work Schedule Reviews

There are a high number of rotas currently being reviewed across the Trust. The 2 major reviews taking place are detailed below:

F2/CT Level Tower Block Rotas at Hull Royal Infirmary covering Medical Specialities

Feedback was received via the HUTH Resident Doctors' Forum in relation to the following rotas that cover Medical Wards in the Tower Block at Hull Royal Infirmary:

- Rota 14 – Elderly Medicine
- Rota 15 – Gastroenterology, Endocrinology, Rheumatology
- Rota 5 – Neurology and Elderly Medicine
- Rota 9 – Chest and Renal Medicine
- Rota 130 & 129 – General Medicine and NCTR

Resident Doctors advised that:

- Handover time between long days and nights did not include sufficient time (currently rostered as 15 minutes)
- Handover to the out of hours team at 17:00 is not rostered into the working pattern resulting in some doctors being required to stay at work after 17:00
- Taking leave over multiple weeks was not possible in the current patterns without needing to swap shifts

Dr Caroline Hibbert (Medical Director, North Bank) is leading a working group in conjunction with the Guardian of Safe Working, Medical Staffing and Human Resources to design alternate rota patterns whilst still providing the level of cover for the Medical Wards as is currently in place. The need to standardise working hours across the rotas (and at different grades) has also been identified as part of this work.

Work is ongoing with a view to implement new rota patterns as soon as practically possible in within the Trust's Organisational Change policy (including working with Resident Doctors currently working on these rotas).

F2/CT Level Surgical Rotas working across multiple specialities and sites

There are a number of rotas across Hull Royal Infirmary and Castle Hill Hospital that provide cover at F2 and CT level with an intricate level of cross cover between surgical specialities. The rotas in question are:

- Rota 124a – General and Elective Surgery
- Rota 124b – Urology & ENT
- Rota 134 – Orthopaedics

- Rota 135 – Orthopaedics & Plastic Surgery
- Rota 133 – Neurosurgery

Feedback has been received that the current cross cover arrangements in place may no longer be fit for purpose with some specialities no longer able to support in the long term due to increased workloads.

Alternate Rota patterns have been developed and presented to the impacted departments and Care Groups but work is ongoing in regards to implementation as this may require investment in new roles to support the new rotas. Any change will be managed via the Trust's Organisational Change policy (including working with Resident Doctors currently working on these rotas).

6. Locum bookings 1st January to 31st March 2025

This section details the use of bank and agency doctors to backfill vacant shifts, this is broken down into bank (not including additional hours) and agency bookings. This is also presented by department, grade and reason for booking.

6.1 Bank 1st January to 31st March 2025

Bank usage shown below does not include additional hours worked by substantive resident doctors. HUTH utilises the Remarkable Bank to cover bank shifts and this is detailed below.

Table E: Locum Bookings Bank by Grade 01/01/2025 – 31/03/2025

Locum Bookings Bank by Grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	103	6	867.750	45.33
F2	763	67	7107.50	708.75
CT/GPSTR/ST1-2	3455	1387	33506.65	13396.41
ST3+	612	77	4752.00	652.50
Total	**4933**	**1537**	**46233.90**	**14802.99**

Table F: Locum Bookings Bank by Reason 01/01/2025 – 31/03/2025

Locum Bookings Bank by Reason				
	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	62	22	504.50	208.00
Extra Cover	1211	429	10145.95	3759.58
Other Leave	116	16	1213.75	147.5
Sickness	482	96	4350.30	982.00
Study Leave	4	0	18.00	0.00
Vacancy	3058	955	30001.40	9498.33
Total	**4933**	**1537**	**46233.90**	**14802.99**

Table G: Locum Bookings Bank by Department 01/01/2025 – 31/03/2025

Locum Bookings Bank by Department				
	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	532	213	4983.15	1971.91
Anaesthetics	92	0	716.00	0.00
Cardiology	121	27	1167.50	311.50
Chest Medicine	25	5	197.65	53.25
Clinical Oncology	106	31	1053.75	0.00
Colorectal	194	93	1915.50	872.92
CT Surgery	11	0	61.50	0.00
Dermatology	2	0	12.25	0.00
Elderly Medicine	306	98	2891.50	962.00
Emergency Medicine	1886	488	18554.50	4897.98
Endocrinology	41	9	331.25	68.50
ENT	71	35	815.50	414.93
Gastroenterology	38	22	324.25	199.25
Haematology	8	0	72.00	0.00
Infectious Diseases	65	26	667.50	284.00
Neonatal Medicine	21	8	244.75	99.75
Neurology	80	8	683.35	78.00
Neuro-Rehab	2	2	9.00	9.00
Neurosurgery	206	50	2017.50	584.09
Obstetrics	149	21	1329.50	211.50
OMFS	187	111	1724.0	1065.75
Ophthalmology	1	1	16.00	16.00
Paediatric Surgery	76	55	395.50	307.50
Paediatrics	33	20	289.00	192.00
Plastic Surgery	6	0	64.00	0.00
Radiology	7	0	71.50	0.00
Renal	16	3	165.75	28.25
Rheumatology	52	19	437.00	166.83
Stroke Medicine	50	22	404.00	176.00
Trauma & Orthopaedics	230	44	2103.50	479.00
Upper GI	131	71	1102.25	564.83
Urology	96	20	726.50	196.25
Vascular Surgery	92	35	687.00	217.50
Total	**4933**	**1537**	**46233.90**	**14802.99**

6.2 Agency 1st January to 31st March 2025

Use of Agency staff to backfill vacancies is a last resort once all other avenues (ie. Additional Hours, Bank, Alternate Staff roles) have been exhausted. Clear Agency approval processes are

in place across all Care Groups and all agency bookings are managed by the central Medical Staffing Team.

Table H: Locum Bookings Agency by Grade 01/01/2025 – 31/03/2025

Locum Bookings Agency by Grade				
	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	103	0	867.75	0.00
F2	763	5	7107.5	57.50
CT/GPSTR/ST1-2	3455	604	33506.65	6361.12
ST3+	612	0	4752.00	0.00
Total	**4933**	**609**	**46233.90**	**6418.62**

Table I: Locum Bookings Agency by Reason 01/01/2025 – 31/03/2025

Locum Bookings Agency by Reason				
	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	62	11	504.50	102.00
Extra Cover	1211	90	10145.95	816.18
Other Leave	116	53	1213.75	639.11
Sickness	482	28	4350.30	322.82
Study Leave	4	0	18.00	0.00
Vacancy	3058	427	30001.40	4538.51
Total	**4933**	**609**	**46233.90**	**6418.62**

Table J: Locum Bookings Agency by Department 01/01/2025 – 31/03/2025

Locum Bookings Agency by Department				
	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	532	94	4983.15	954.90
Anaesthetics	92	0	716.00	0.00
Cardiology	121	5	1167.50	57.50
Chest Medicine	25	1	197.65	11.25
Clinical Oncology	106	13	1053.75	147.00
Colorectal	194	53	1915.50	646.00
CT Surgery	11	0	61.50	0.00
Dermatology	2	0	12.25	0.00
Elderly Medicine	306	54	2891.50	609.50
Emergency Medicine	1886	242	18554.50	2350.19
Endocrinology	41	0	331.25	0.00
ENT	71	1	815.50	12.00
Gastroenterology	38	0	324.25	0.00
Haematology	8	0	72.00	0.00
Infectious Diseases	65	0	667.50	0.00
Neonatal Medicine	21	9	244.75	116.00
Neurology	80	6	683.35	67.50
Neuro-Rehab	2	0	9.00	0.00
Neurosurgery	206	50	2017.50	613.28
Obstetrics	149	0	1329.50	0.00
OMFS	187	5	1724.00	61.50
Ophthalmology	1	0	16.00	0.00
Paediatric Surgery	76	0	395.50	0.00
Paediatrics	33	0	289.00	0.00
Plastic Surgery	6	0	64.00	0.00
Radiology	7	0	71.50	0.00
Renal	16	0	165.75	0.00
Rheumatology	52	0	437.00	0.00
Stroke Medicine	50	0	404.00	0.00
Trauma & Orthopaedics	230	52	2103.50	508.00
Upper GI	131	20	1102.25	191.00
Urology	96	4	726.50	73.00
Vascular Surgery	92	0	687.00	0.00
Total	**4933**	**609**	**46233.90**	**6418.62**

6.3 Locum work carried out by doctors in training 1st January to 31st March 2025

This data is collected to help assess where individual doctors in training are working the most additional hours so that any breaches of the Working Time Directive (WTD) and the 2016 Terms and Conditions can be explored.

The table represents the top 10 doctors in training that have worked the most extra hours.

Table K: Additional Hours worked by Doctors in Training 01/01/2025 – 31/03/2025

Base Speciality	Grade	Number of Locum Hours Worked	Number of hours rostered per week
General Practice	ST2	210.75	40:00
General Practice	ST3	203.75	40:00
Vascular Surgery	ST1	140.75	40:00
General Practice	F2	134.00	20:00
Emergency Medicine	F2	120.50	40:45
General Practice	ST2	119.50	40:00
General Practice	ST2	114.00	40:00
General Practice	ST1	111.00	40:00
Cardiology	F2	107.50	47:30
General Practice	ST2	104.50	40:00

7. **Vacancies:** The below table details the Doctors and Dentists in training establishment and current doctors in training in post as appointed by NHS England (formerly Health Education England).

Hull University Teaching Hospitals NHS Trust - Resident Doctor Trainee Establishment January to March 2025

	Trainee Establishment						Trainee In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Filled March 2025	% Filled December 2024
Academic, GP, Psych & Community	9	33	0	106	0	148	8	33.5	0	93.9	0	135.4	**91.5%**	90.5%
Acute Medicine	4	7	8	0	7	26	4	7	4	0	4.8	19.8	**76.2%**	90.4%
Anaesthetics	5	4	23	0	31	63	5	4	20.5	0	33.3	62.8	**99.7%**	100.3%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	**80.0%**	80.0%
Cardiology	3	2	3	1	8	17	3	2	3	0.8	11.4	20.2	**118.8%**	109.4%
Cardiothroacic Surgery	0	3	0	0	4	7	0	2.8	0	0	3	5.8	**82.9%**	82.9%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	100.0%
Colorectal Surgery	9	0	2	0	4	15	9	0	1	0	3.6	13.6	**90.7%**	90.7%
Dermatology	1	0	0	1	0	2	1	0	0	0.8	0	1.8	**90.0%**	50.0%
Elderly Medicine	7	3	5	7	6	28	6	4	5	7	5.2	27.2	**97.1%**	95.7%
Emergency Medicine	0	14	13	6	18	51	0	14	12.3	4	14.3	44.6	**87.5%**	90.9%
Endocrinology	3	0	2	0	4	9	3	0	1.8	0	4	8.8	**97.8%**	97.8%
ENT	2	2	2	3	5	14	2	2	2	2.2	5	13.2	**94.3%**	100.0%
Gastroenterology	3	1	2	0	7	13	3	0	3	0	6.8	12.8	**98.5%**	98.5%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	**100.0%**	100.0%
Haematology	2	2	2	0	5	11	2	2	2	0	3.8	9.8	**89.1%**	105.5%
Histopathology	0	0	0	0	7	7	0	0	0	0	4.6	4.6	**65.7%**	82.9%
Immunology	0	0	0	0	1	1	0	0	0	0	0	0	**0.0%**	0.0%
Infectious Diseases	2	1	1	2	6	12	2	0	1	2	6.6	11.6	**96.7%**	88.3%
Neuro-Rehab	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**	40.0%
Neurology	4	3	3	0	5	15	4	3	3	0	3	13	**86.7%**	86.7%
Neurosurgery	1	1	2	0	4	8	1	1	1.5	0	4	7.5	**93.8%**	100.0%
Obstetrics & Gynaecology	0	4	6	4	13	27	0	4	5	3.8	12.6	25.4	**94.1%**	98.5%
Oncology	3	1	2	4	12	22	3	1	2	4	10.6	20.6	**93.6%**	89.1%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	6.8	8.8	**110.0%**	110.0%
Oral & Maxillofacial Surgery	0	0	10	0	2	12	0	0	4	0	2	6	**50.0%**	50.0%
Paediatric Neonatal Medicine	0	0	9	0	5	14	0	0	6.6	0	4.8	11.4	**81.4%**	102.9%
Paediatric Surgery	0	1	2	0	0	3	0	1	1.8	0	0	2.8	**93.3%**	66.7%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**	100.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	6	9	**100.0%**	100.0%
Paediatrics	4	4	5	2	10	25	3	5	6	1.8	13.1	28.9	**115.6%**	103.0%
Radiology	0	1	0	0	39	40	0	1	0	0	38.6	39.6	**99.0%**	98.5%
Renal Medicine	2	1	2	0	6	11	2	1	2	0	5.6	10.6	**96.4%**	96.4%
Respiratory Medicine	6	2	2	2	8	20	5	2	2	1.8	7	17.8	**89.0%**	93.0%
Rheumatology	3	1	1	2	3	10	1.8	1	1	1.8	3.6	9.2	**92.0%**	94.0%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	**0.0%**	0.0%
Trauma & Orthopaedics	0	5	3	1	9	18	0	5	3	1	8	17	**94.4%**	94.4%
Upper GI	9	0	2	0	4	15	9	0	1	0	2.6	12.6	**84.0%**	84.0%
Urology	1	3	2	0	3	9	1	3	2.3	0	3	9.3	**103.3%**	88.9%
Vascular Surgery	6	0	1	0	5	12	6	0	0.8	0	5	11.8	**98.3%**	100.0%
TOTAL	**92**	**101**	**119**	**145**	**257**	**714**	**86.8**	**101.3**	**101.6**	**128.9**	**244.7**	**663.3**	**92.9%**	93.2%

8. Fines

The Doctors and Dentists in Training Terms and Conditions (England) 2016 states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.
- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved
- Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working Hours will levy a fine.

Standard rates are outlined in the Doctors and Dentists in Training Terms and Conditions.

8.1 Summary of fines issued 1st January to 31st March 2025

There were no fines issued in this quarter.

GOSW Funds Expenditure

The Guardian of Safe Working Hours Funds stands at £63,898.00 at the time of the report being written.

The Guardian of Safe Working Hours has plans to run a series of Vascular Access Courses using the funds to purchase necessary equipment.

All expenditure from the GOSW Funds is agreed at the Resident Doctors' Forum but no funds were agreed and spent within this quarter.

Officer to contact:
Dr Wajiha Arshad, Guardian of Safe Working Hours
Joey Robson, Group Medical Staffing Manager
Rose Bundy, Medical Staffing Analyst
May 2025

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(25)107

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	**12 June 2025**
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships
Contact Officer / Author	Adam Creeggan, Group Director of Performance Jackie Railton, Deputy Director, Planning & Performance Louise Topliss, Head of Performance Maria Wingham, Head of Performance
Title of Report	**Integrated Performance Report – NlaG and HUTH**
Executive Summary	This report provides details of performance achieved against key national performance, quality and governance indicators defined in the NHSE Single Oversight Framework (SOF).
Background Information and/or Supporting Document(s) (if applicable)	Presented to the Committees-in-Common – April 2025
Prior Approval Process	N/A
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 1: April 2025 Performance

March 2025 for Cancer data
Produced May 2025

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	**April 2025** **0** **1** **62** **2,799**	**April 2025** **0** **1** **37** **964**	• HUTH reported 1 x 78w breach due to capacity; NLAG reported 1 x 78w breach due to a late IPT from Sheffield • Increase in 65w breaches at NLAG +14 but HUTH decreased -40 • Increase in 52w breaches at NLAG +96 and increase at HUTH of +256 • The latter increases target delivery in 25/26 and relates to linear growth in PTL due to supply/demand imbalance.
Diagnostic 6w Performance	**April 2025** **18.1%**	**April 2025** **35.2%**	• HUTH performance decreased by 2.2% • NLaG performance decreased by 6.1% • HUTH – Deteriorating performance in Neurophysiology and Echocardiography. • NLAG - Deteriorating performance in Barium Enema, Audiology, Echocardiography, Endoscopy modalities, DEXA, Neurophysiology and NOUS.
Cancer 62-day Performance (all sources)	**March 2025** **57.3%**	**March 2025** **60.2%**	• Both Trusts in Tier 1 for Cancer delivery; working with NE&Y Regional Office on recovery assurance • 62-day performance at NLaG improved by 0.4%. • 62-day performance at HUTH improved by 6.7% • +63-day backlog test and challenge meetings in place. Concerns remain in HUTH 104 + backlog is above trajectory, Complex pathways transferred to Tertiary late in pathway (IPT), urology surgical capacity & LGI screening diagnostic delays impact on 62 Day). • NLAG continues to see improvement in the reduction of the 63+Backlog.
ED: 4-hour standard (Type 1 & 3)	**April 2025** **56.3%** **Trust compliance**	**April 2025** **68.8%** **Trust compliance**	• HUTH A&E 4 Hour standard (all types) was 56.3% in April 2025 (plan 64.4%). Type 1 performance of 42.3% was below the 25/26 operating plan target of 49.7%. Type 3 performance (HRI UTC) was 84.0% against the 95% target. Attendances at UTC were above planned levels in April. • NLaG combined type 1 and 3 performance was 68.8% in April against a target of 73.5%. Type 1 performance = 45.6% (Target 56.4%) and Type 3 performance = 98.8% (Target 99%). Type 3 attendance volumes are significantly higher than planned, generating a partial offset of Type 1 compliance shortfall.

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Key Performance Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
RTT 52 Week Breach	Mar 25	0	2,543			11
RTT 65 Week Breach	Mar 25	-	102			11
RTT 78 Week Breach	Mar 25	0	2			39
RTT 95th Percentile Admitted Waiting Time	Mar 25	18.0	61.4			40
RTT 95th Percentile Non-Admitted Waiting Time	Mar 25	18.0	56.3			28
RTT Admitted Treatment Within 18 Weeks	Mar 25	90.0%	55.7%			51
RTT Average (Median) Admitted Waiting Time	Mar 25	9.0	14.7			49
RTT Average (Median) Non-Admitted Waiting Time	Mar 25	5.0	8.7			50
RTT Average Wait for Incomplete	Mar 25	7.00	14.66			36
RTT Incomplete 18 Week Standard	Mar 25	92.00%	57.28%			33
RTT Incomplete 92nd Percentile	Mar 25	-	44.6			20
RTT Incomplete Pathways With a DTA	Mar 25	25.0%	17.3%			36
RTT Non-Admitted Treatment Within 18 Weeks	Mar 25	95.0%	65.0%			42
RTT Total Clock Starts	Mar 25	-	19,785			88
RTT Total Clock Stops	Mar 25	-	20,052			93
RTT Total Incompletes	Mar 25	-	78,509			16

NLAG

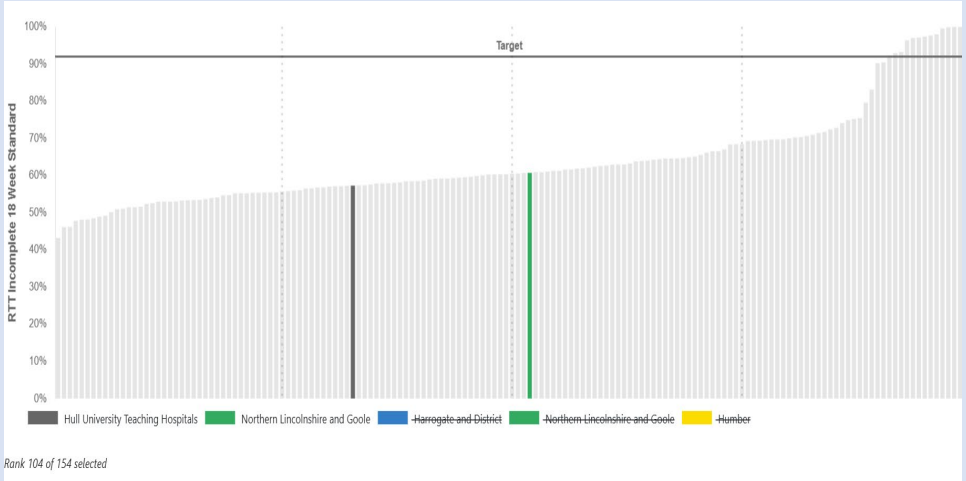
Key Performance Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
RTT 52 Week Breach	Mar 25	0	868			48
RTT 65 Week Breach	Mar 25	-	23			42
RTT 78 Week Breach	Mar 25	0	1			46
RTT 95th Percentile Admitted Waiting Time	Mar 25	18.0	56.4			72
RTT 95th Percentile Non-Admitted Waiting Time	Mar 25	18.0	49.3			56
RTT Admitted Treatment Within 18 Weeks	Mar 25	90.0%	60.1%			69
RTT Average (Median) Admitted Waiting Time	Mar 25	9.0	12.0			67
RTT Average (Median) Non-Admitted Waiting Time	Mar 25	5.0	9.6			42
RTT Average Wait for Incomplete	Mar 25	7.00	12.92			56
RTT Incomplete 18 Week Standard	Mar 25	92.00%	60.72%			52
RTT Incomplete 92nd Percentile	Mar 25	-	41.0			46
RTT Incomplete Pathways With a DTA	Mar 25	25.0%	15.2%			52
RTT Non-Admitted Treatment Within 18 Weeks	Mar 25	95.0%	64.8%			41
RTT Total Clock Starts	Mar 25	-	10,090			53
RTT Total Clock Stops	Mar 25	-	9,130			58
RTT Total Incompletes	Mar 25	-	42,286			44

2. Pathway Benchmarking & Trend – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

RTT – Incomplete Standard

Ranking Chart



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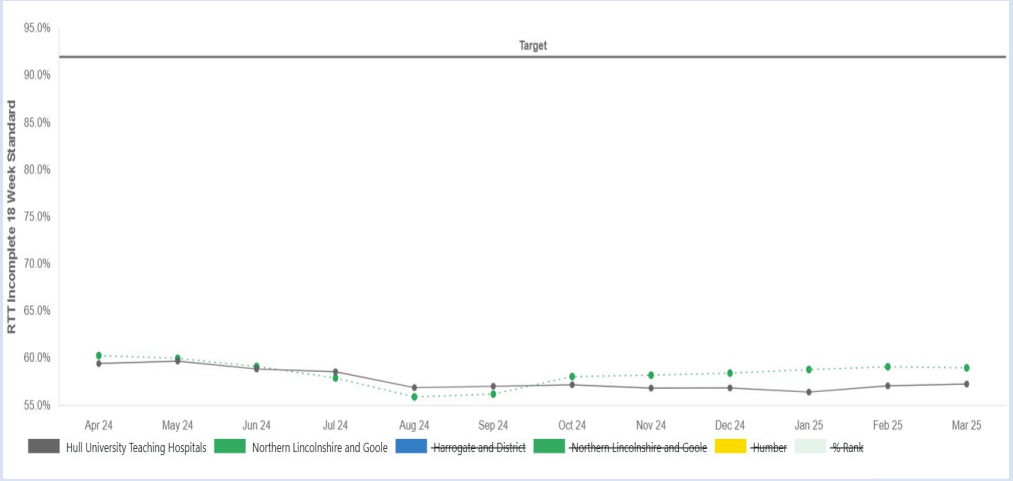
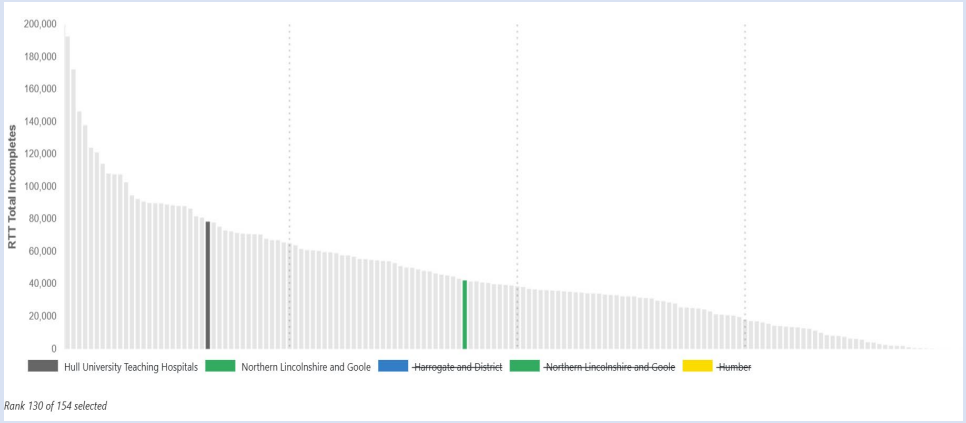
Trend Chart



RTT – Total Waiting List Volume

Ranking Chart



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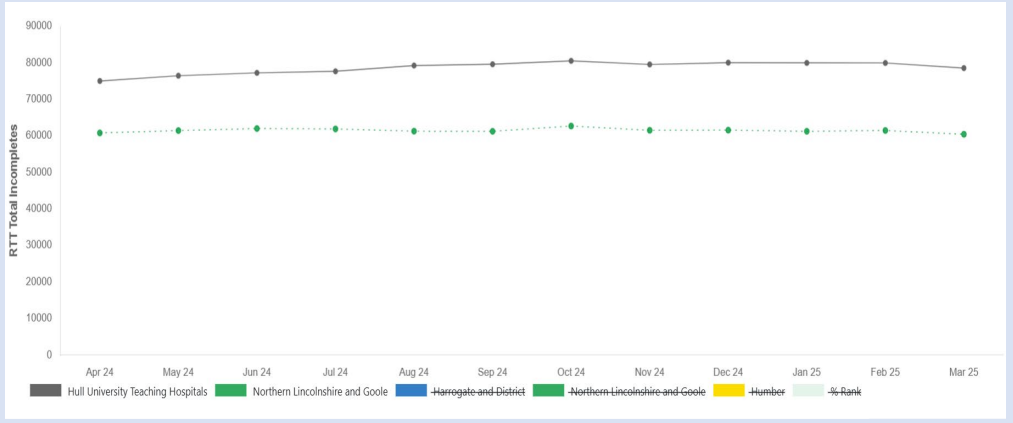
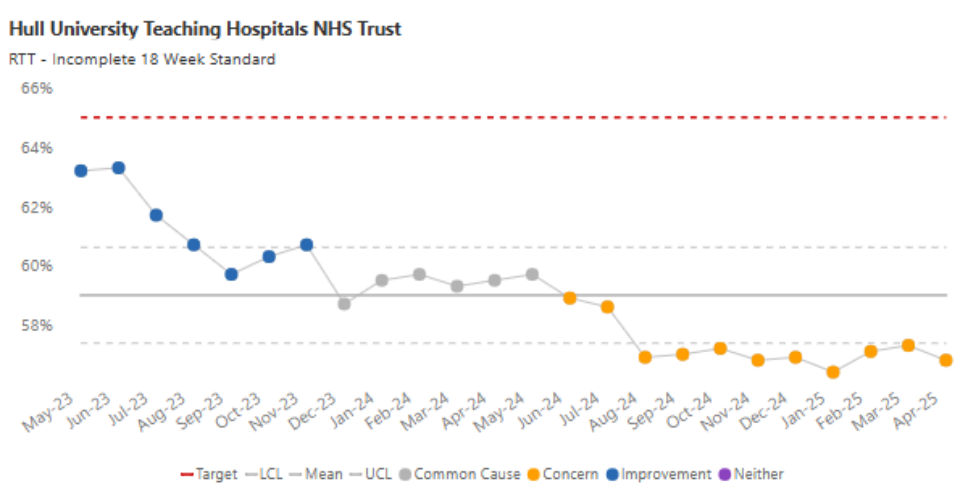
Trend Chart



3. Referral to Treatment - HUTH

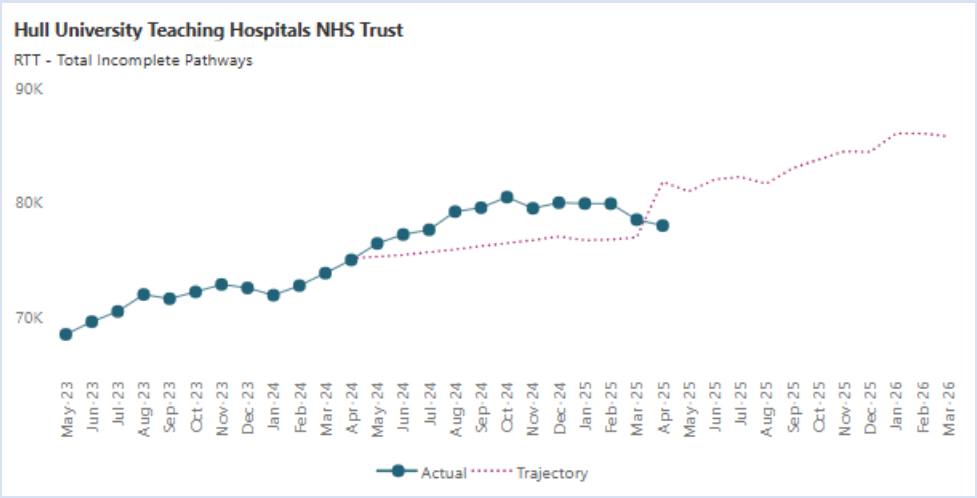
Compliance



Key Themes

- April 18 week RTT performance of 56.8% is a slight reduction on the previous month and this will be impacted by the validation sprint work which is removing patients that are less than 18 weeks.
- Waiting list volume is reducing and is now at 77,990, which is below plan. This predominately due to the validation sprint work.
- Referrals are 2% up on last year.
- Sustainable RTT waiting list volume to achieve the 92% by 2029 is 45,000.
- 54% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Ophthalmology, Dermatology, Oral Surgery and Respiratory Medicine
- Average wait for incomplete pathway is 14 weeks but remains broadly stable.

Critical Enabler



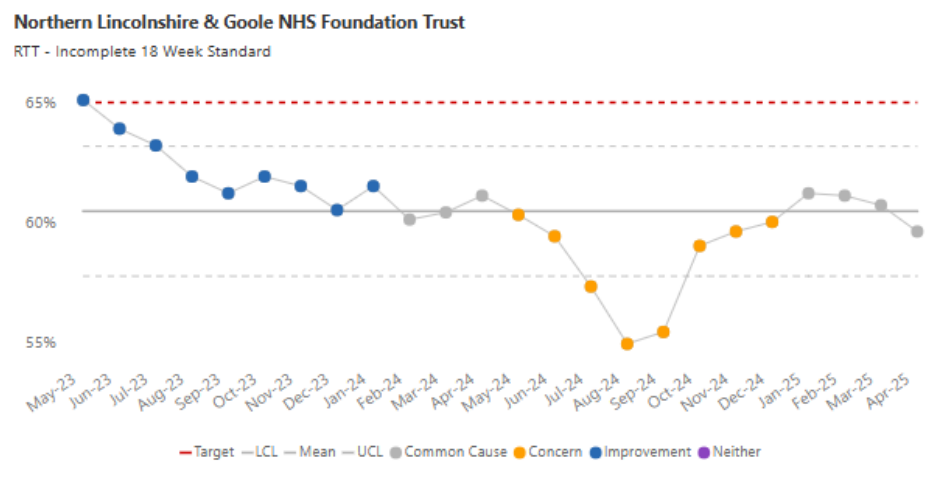
Actions

Critical actions being progressed through RTT Delivery Group:

- Commissioning of automated PTL validation product (LUNA ROVA) capable of scanning structured and unstructured data for 500,000 documents per day. A project group is being established to deploy to both HUTH and NLAG.
- Ongoing planning process to develop additional outpatient & day case/inpatient capacity in response to sustained demand increases.
- Commencement of validation Sprint from 7.4.25 with incentive payment of £33 per clock stop above baseline.

4. Referral to Treatment - NLAG

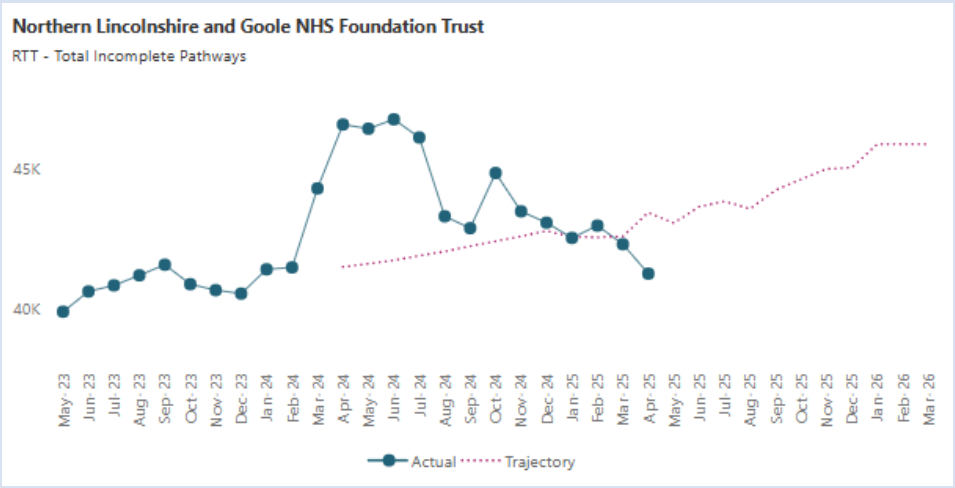
Compliance



Key Themes

- April performance of 59.6% with is a slight deterioration of 1% on last month and this will be impacted by the validation sprint work which is removing patients that are less than 18 weeks.
- Since the correction of ASI reporting the RTT waiting list volume has subsequently been reduced to 41,241 and is below the planned trajectory. This predominately due to the validation sprint work.
- Sustainable RTT waiting list volume to achieve the 92% by 2029 is 22,000.

Critical Enabler



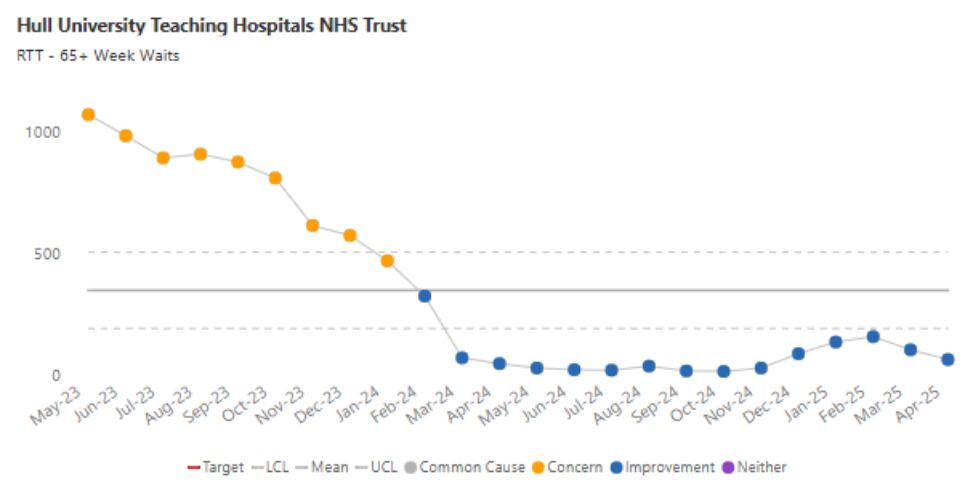
Actions

Critical actions being progressed through RTT Delivery Group

- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Proof of concept trial of automated PTL pathway review to increase validation resource of the PTL, particularly over 18 weeks to support the national drive to deliver a minimum 65% incomplete standard by March 2026.
- Commencement of validation Sprint from 7.4.25 with incentive payment of £33 per clock stop above baseline.

5. Referral to Treatment – 65w Waits - HUTH

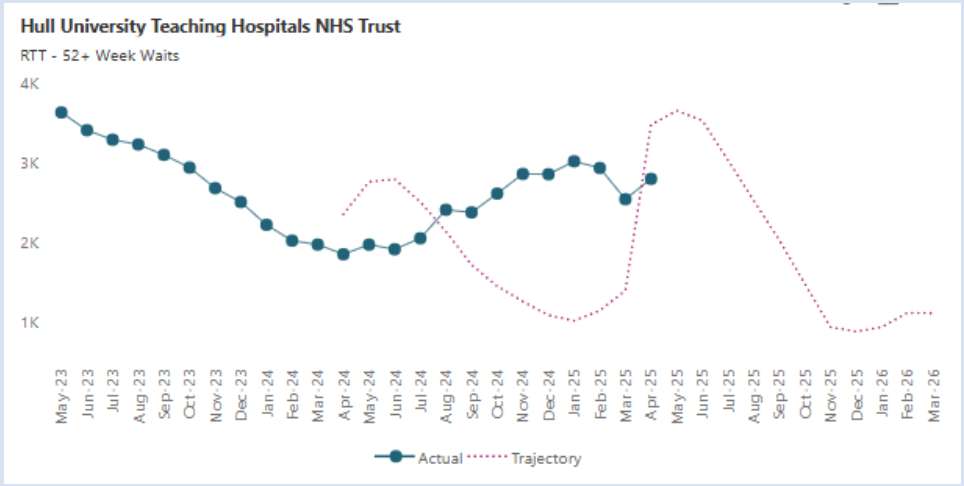
Compliance



Key Themes

- 62 patients exceeded 65 weeks at the end of April which is a reduction of 40 on the previous month
- Risks identified relating to March delivery: -
  - ENT – additional weekend audiology and outpatient capacity is being delivered through DMC.
  - Cardiology – additional weekend outpatient and echocardiogram capacity is being delivered through Modality.
  - Plastic Surgery – a plan is in place for provision additional weekend lists to support the complex delayed breast reconstruction (DIEP requires 3 session day)
  - Delays in offering admission dates leading to unreasonable offers and patient choice breaches.
- 3.6% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year 2024. The 25/26 planning requirement is to achieve no more than 1% waiting over 52 weeks.

Critical Enabler



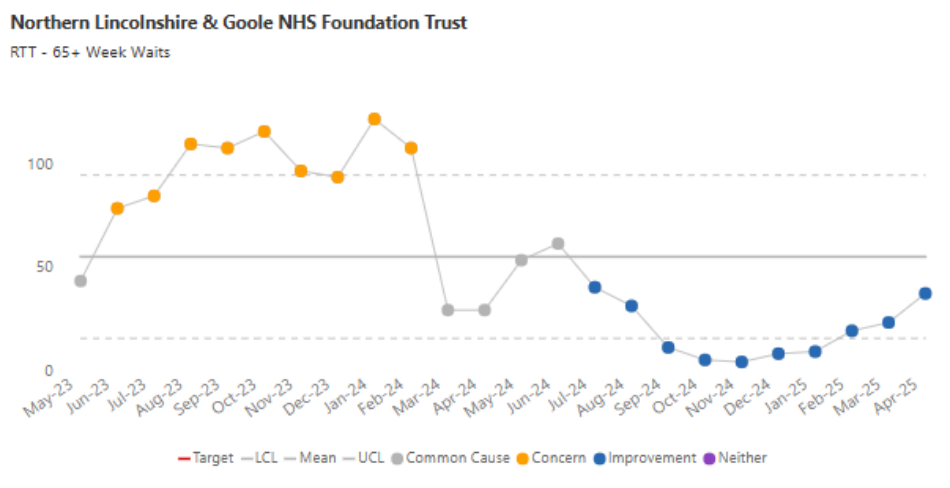
Actions

Critical actions being delivered through the RTT Delivery Group

- Delivery of 24/25 operating plan activity extension plans.
- Reduce first outpatient waits to <40 weeks, with the main challenge in ENT. Additional insourced activity in place and ongoing engagement with system partners on mutual aid support
- Additional weekend waiting list initiatives to create capacity in Plastic surgery, Breast Surgery and ENT.
- Executive oversight and scrutiny of patients dated and/or risks to eliminate the number of >65-week waits

6. Referral to Treatment – 65w Waits - NLAG

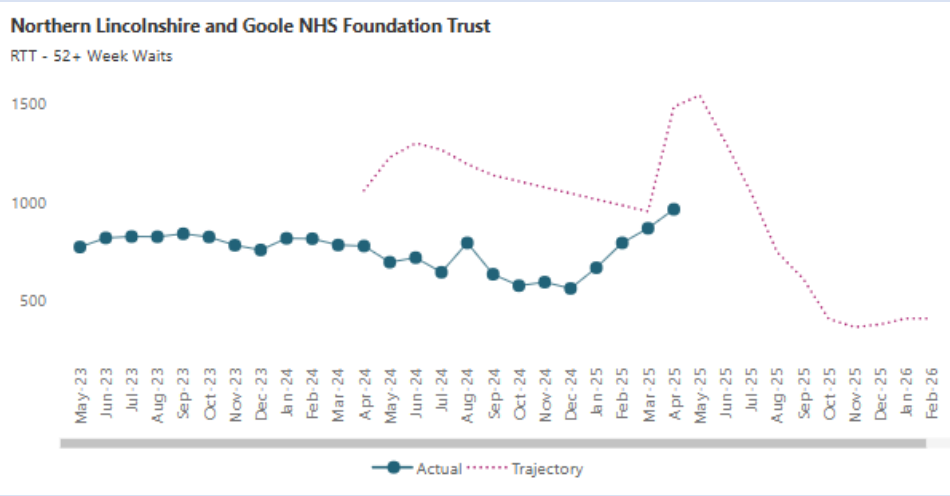
Compliance



Key Themes

- 37 breaches at the end of April, predominately due to capacity constraints in Paediatric ADHD
- Improvement in the median waiting time for incomplete pathways by 2 weeks.
- Increasing 52w profile, driven mainly by increases in ENT, Paediatrics and Urology. 2.3% of the PTL is over 52 weeks.

Critical Enabler



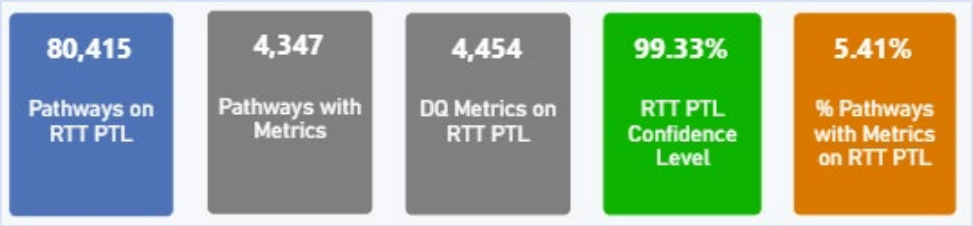
Actions

Critical actions being delivered through the RTT Delivery Group

- Delivery of 24/25 operating plan activity extension plans.
- Reduce first outpatient waits to <40 weeks, with the main challenge in Paediatrics (ADHD). Additional insourced activity has ceased and the major risk now is that the only consultant that delivers ADHD service leaves at the end of July 2025.
- Focus on booking practice via earlier planning of admission dates to reduce unreasonable offers and subsequent patient choice breaches, as per the revised Group Access Policy.

7. Referral to Treatment – Data Quality - HUTH

Compliance



Key Themes

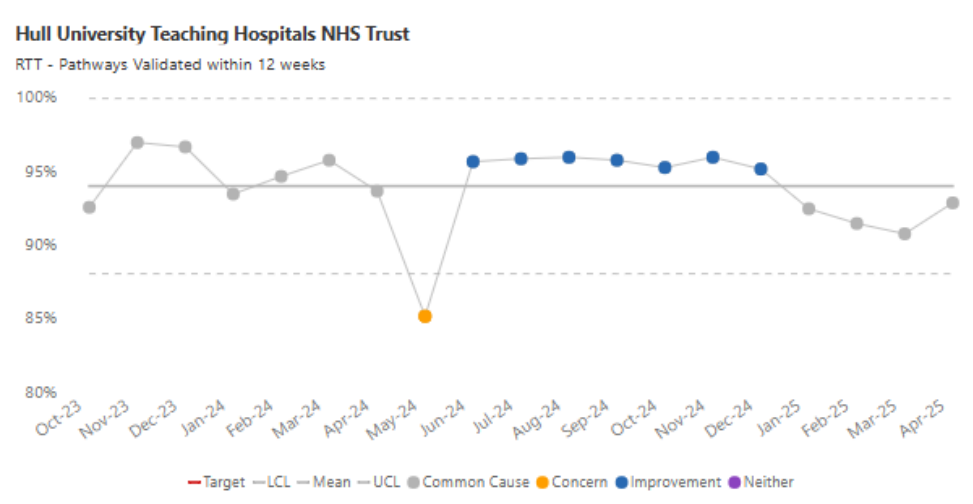
It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.33% confidence level for RTT PTL data quality.

92.8% pathways have been validated every 12 weeks.

The validation sprint results for w/e 4.5.25 shows +2% clock stops above baseline.

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
- Deployment of LUNA ROVA proof of concept trial during March/April to support the national drive to deliver a minimum 65% incomplete standard by March 2026.
- Validation Sprint to commence 6th April 2025 through to 22nd June 2025. Additional national income at £33 per clock of the baseline waiting list volume with the 5% cap now removed.

8. Referral to Treatment – Data Quality - NLAG

Compliance

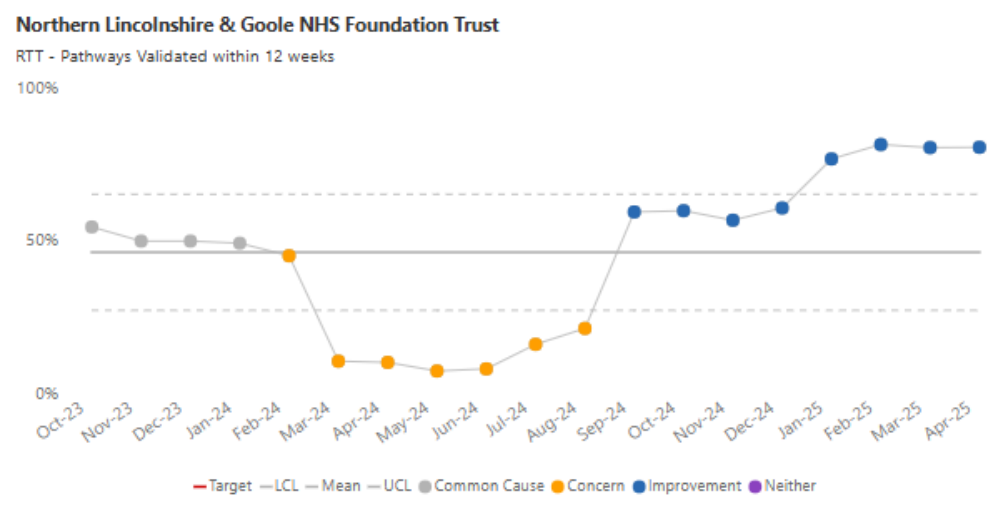
Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a confidence rate to 99.23% which is an improved position.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks the latest data shows sustained improvement against the 90% standard following admin delays in transacting pathway events post Lorenzo deployment. Current performance is at 80.2%

The validation sprint results for w/e 4.5.25 shows +29% clock stops above baseline.

Critical Enabler

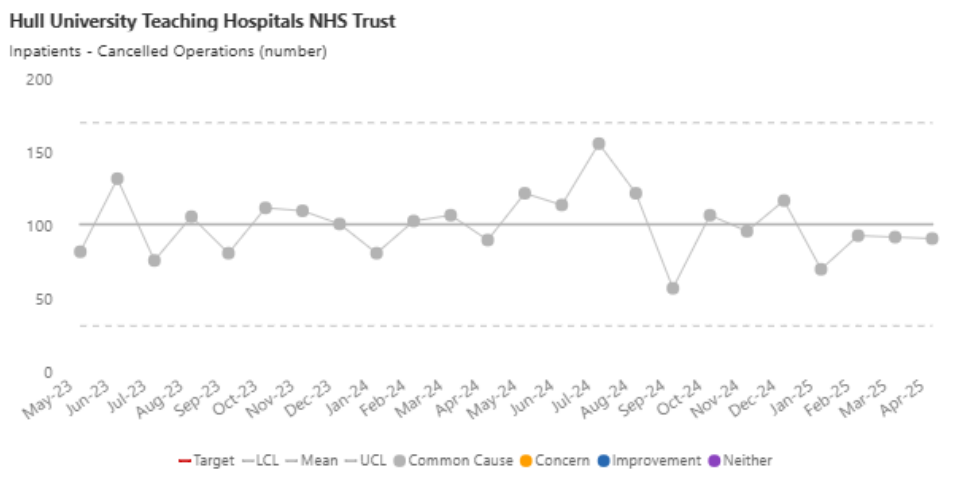


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments.
- Deployment of LUNA ROVA proof of concept trial during March/April to support the national drive to deliver a minimum 65% incomplete standard by March 2026.
- Validation Sprint to commence 6th April 2025 through to 22nd June 2025. Additional national income at £33 per clock of the baseline waiting list volume with the 5% cap now removed.

9. Cancelled Operations - HUTH

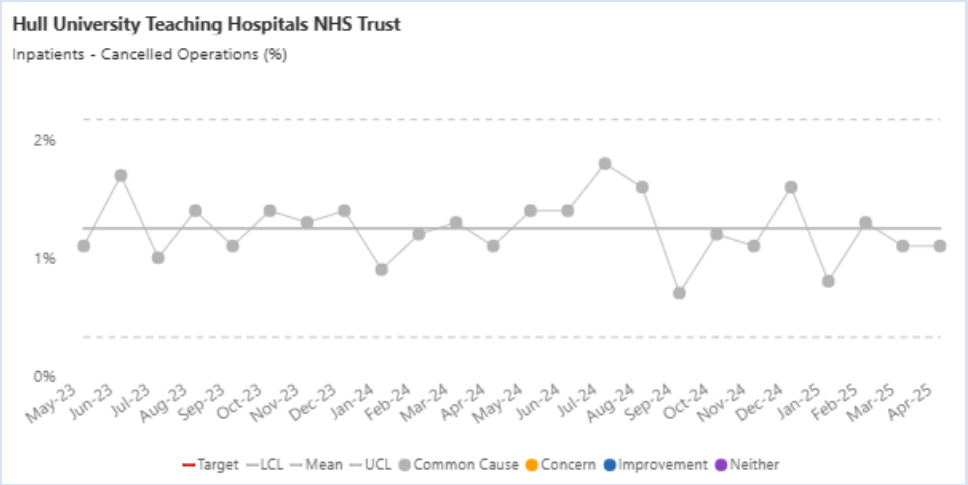
Compliance



Key Themes

- In April there were 91 cancelled operations on the day for non-clinical reasons and represents 1.1% of admissions.
- The largest reasons were –
  - Bed unavailable (ward and ICU) – 30
  - Theatre list overrun – 28
  - Equipment failure - 13
  - Surgeon unavailable – 10
- The main specialties for cancellations on the day were –
  - Vascular Surgery – 15 (No beds)
  - Neurosurgery – 10 (List overrun)
  - Cardiology – 9 (List overrun)
  - Interventional Radiology – 9 (No beds)
  - Ophthalmology – 9 (Surgeon unavailable)

Critical Enabler

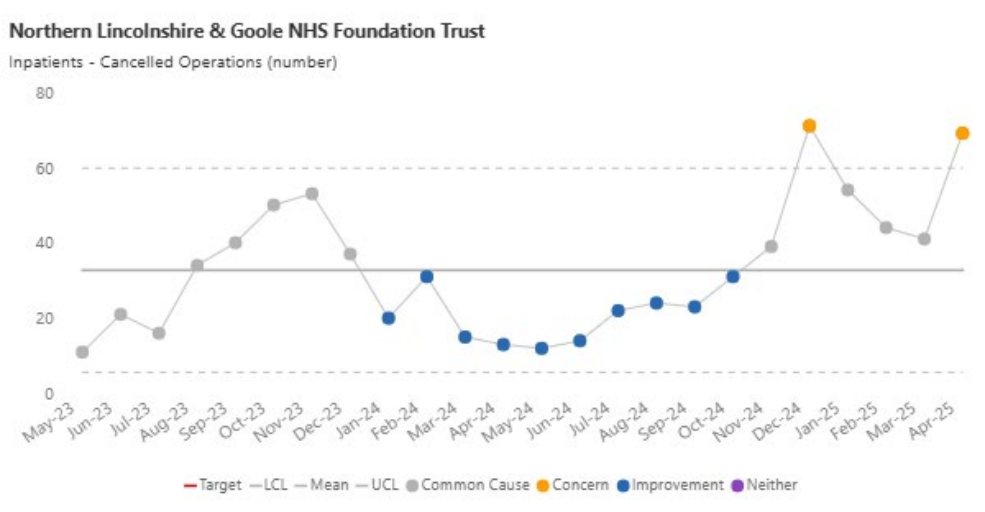


Actions

- Group level cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28 day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus in operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 day pre-op to commence in Orthopaedics and ENT.

10. Cancelled Operations - NLAG

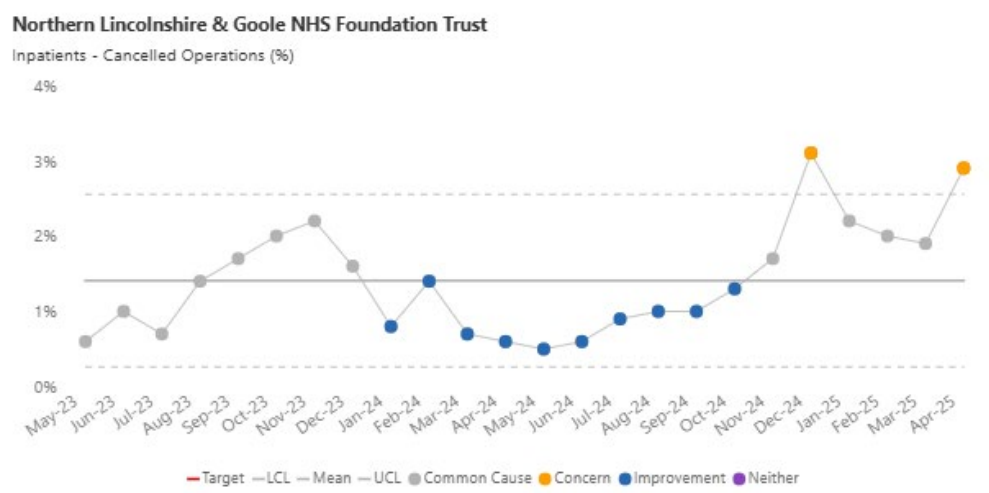
Compliance



Key Themes

- April cancellation volumes increased to 69 – representing 2.9% of admissions.
- The largest reasons were –
  - Equipment failure – 29
  - Treatment deferred – 15
  - List overrun - 10
- The main specialties incurring cancellations on the day were –
  - Urology – 23 (predominately equipment failure)
  - Ophthalmology – 19 (predominantly equipment failure)
  - Gynaecology – 11 (predominantly list overrun)
  - General Surgery – 9 (predominately equipment failure)

Critical Enabler

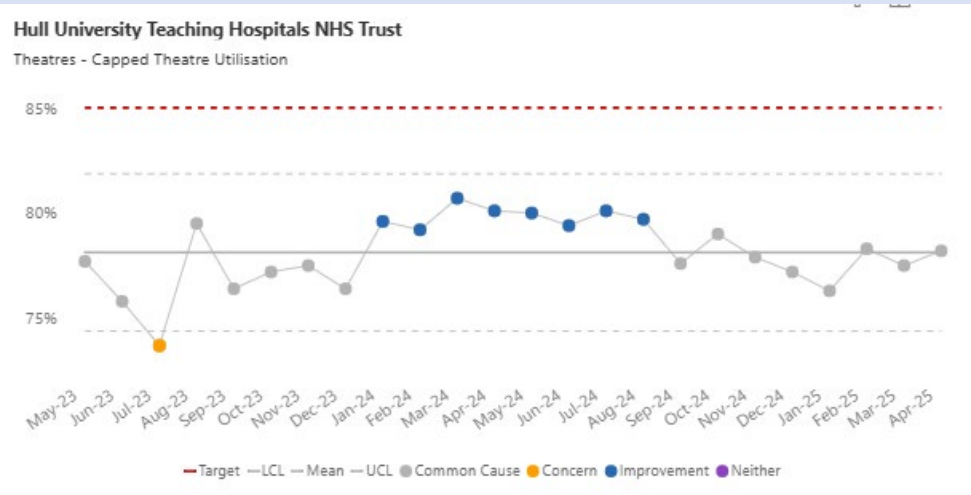


Actions

- 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
- 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.
- Standing down or lifting sessions SOP completed and deployed.
- Working with NHSE/GIRFT on improvement recommendations
- Enhanced BIU support to report national data set and eliminate DQ issues.

11. Capped Theatre Utilisation - HUTH

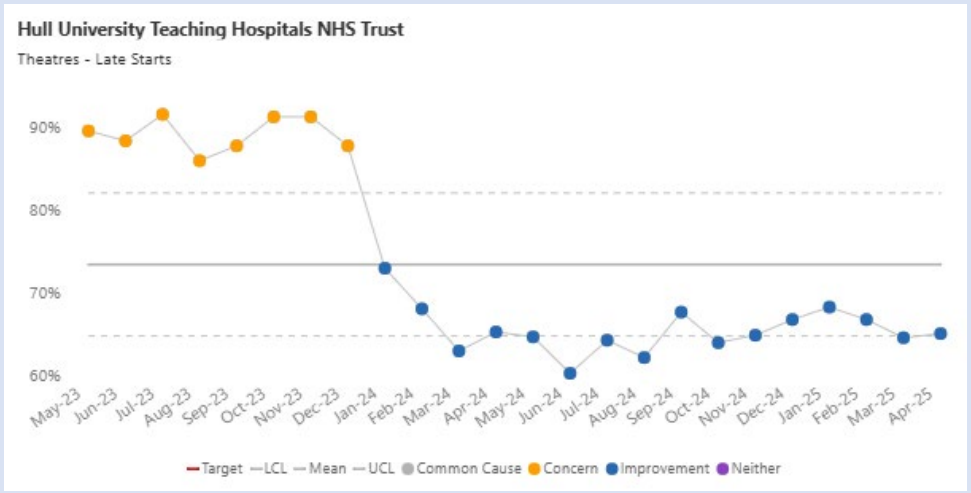
Compliance



Key Themes

- Improvement in capped theatre utilisation with latest Model Hospital data showing performance at 79.6% placing the Trust in Quartile 2 nationally.
- Internal reporting at 78.2% for capped theatre utilisation for April.
- Day Case capped theatre utilisation has improved marginally to 71.9% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- Utilisation deterioration linked to increase in late starts to 65.1% (methodology 0 minutes = late start)

Critical Enabler

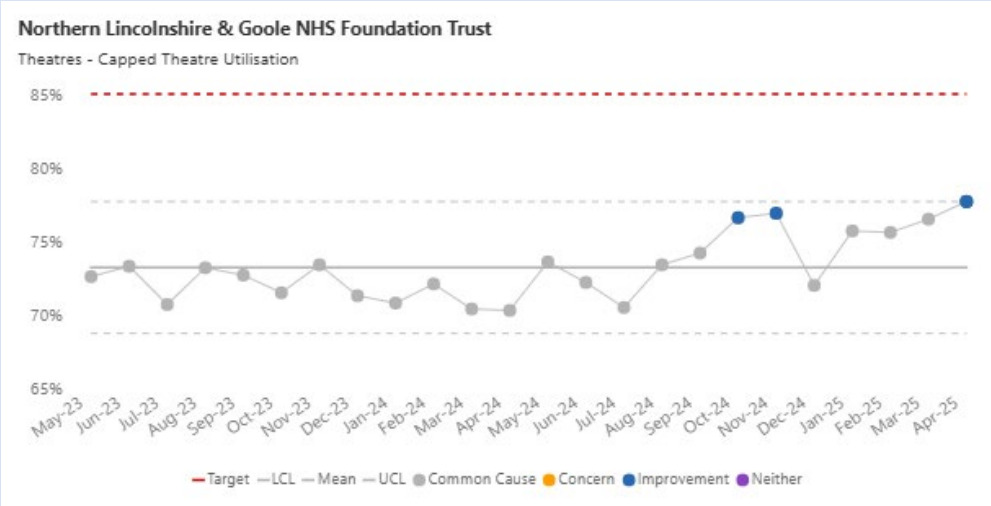


Actions

- Improve recording of day case touch points in ORMIS
- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Theatres Insights Model being implemented – training roll out completed at both Trusts.

12. Capped Theatre Utilisation - NLAG

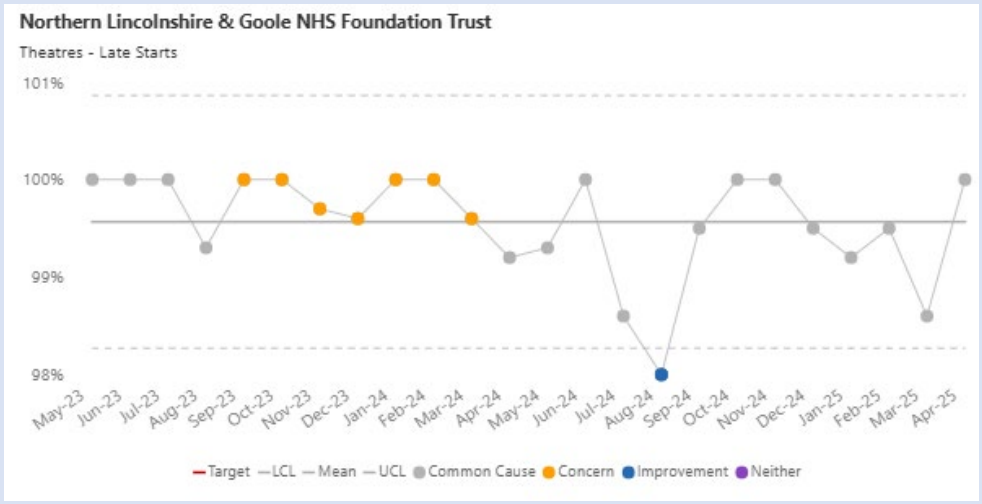
Compliance



Key Themes

- Improved performance in Model Hospital at 76.6% and in Quartile 1 (lowest) nationally.
- Internal reporting shows performance at 77.7%.
- Theatre late starts issue at NLAG with 100% of sessions starting late in April on the zero-minute measure.

Critical Enabler



Actions

- Implementation of 1 extra patient per day case list for any list at <85% capped utilisation
- 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.
- Theatres Insights Model being implemented – training roll out completed at both Trusts

13. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Mar 25	5.00%	3.30%			73
Colonoscopy	Mar 25	5.00%	56.69%			3
Computed Tomography	Mar 25	5.00%	13.03%			20
Cystoscopy	Mar 25	5.00%	41.64%			19
DEXA Scan	Mar 25	5.00%	3.84%			33
Diagnostic activity levels - Audiology Assessments	Mar 25	-	835			76
Diagnostic activity levels - Barium Enema	Mar 25	-	67			87
Diagnostic activity levels - Colonoscopy	Mar 25	-	232			36
Diagnostic activity levels - CT	Mar 25	-	6,681			72
Diagnostic activity levels - Cystoscopy	Mar 25	-	400			87
Diagnostic activity levels - Dexa Scan	Mar 25	-	550			87
Diagnostic activity levels - Echocardiography	Mar 25	-	831			47
Diagnostic activity levels - Endoscopy	Mar 25	-	1,228			63
Diagnostic activity levels - Flexi Sigmoidoscopy	Mar 25	-	134			72
Diagnostic activity levels - Gastroscopy	Mar 25	-	462			66
Diagnostic activity levels - Imaging	Mar 25	-	15,583			71
Diagnostic activity levels - Non Obstetric Ultrasound	Mar 25	-	5,078			65
Diagnostic activity levels - Total	Mar 25	-	18,917			66
Diagnostic activity levels - Urodynamics	Mar 25	-	46			69
Diagnostics - 6 Week Standard	Mar 25	5.00%	15.86%			39
Diagnostics - 6 Week Standard Reversed	Mar 25	95.00%	84.14%			39
DM01 Waiting <13 Weeks	Mar 25	100.00%	94.60%			28
Echocardiography	Mar 25	5.00%	26.98%			25
Gastroscopy	Mar 25	5.00%	8.19%			56
Magnetic Resonance Imaging	Mar 25	5.00%	1.88%			74
Neurophysiology	Mar 25	5.00%	15.97%			41
Non-obstetric Ultrasound	Mar 25	5.00%	2.87%			59
Urodynamics	Mar 25	5.00%	43.86%			33

NLAG

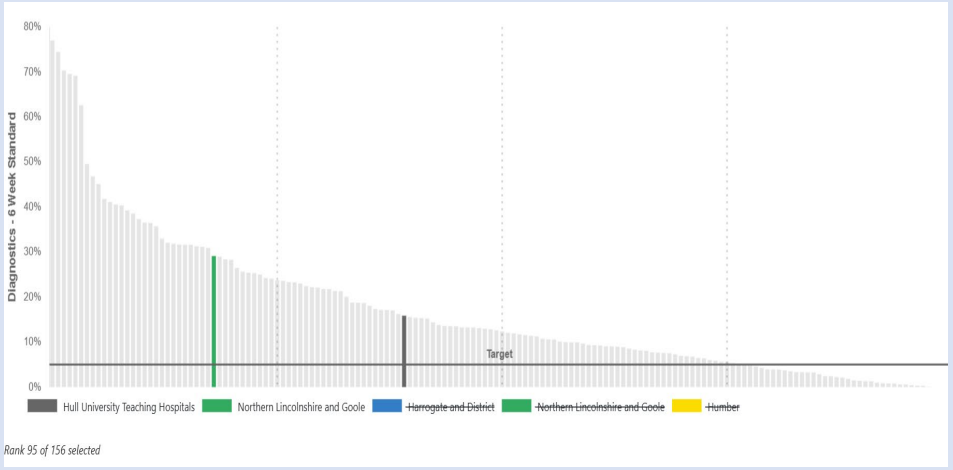
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Mar 25	5.00%	59.90%			15
Barium Enema	Mar 25	5.00%	10.43%			20
Colonoscopy	Mar 25	5.00%	13.84%			43
Computed Tomography	Mar 25	5.00%	1.77%			57
Cystoscopy	Mar 25	5.00%	20.63%			43
DEXA Scan	Mar 25	5.00%	36.90%			7
Diagnostic activity levels - Audiology Assessments	Mar 25	-	337			40
Diagnostic activity levels - Barium Enema	Mar 25	-	55			83
Diagnostic activity levels - Colonoscopy	Mar 25	-	220			35
Diagnostic activity levels - CT	Mar 25	-	10,825			94
Diagnostic activity levels - Cystoscopy	Mar 25	-	67			33
Diagnostic activity levels - Dexa Scan	Mar 25	-	270			47
Diagnostic activity levels - Echocardiography	Mar 25	-	1,226			68
Diagnostic activity levels - Endoscopy	Mar 25	-	729			37
Diagnostic activity levels - Flexi Sigmoidoscopy	Mar 25	-	121			65
Diagnostic activity levels - Gastroscopy	Mar 25	-	321			44
Diagnostic activity levels - Imaging	Mar 25	-	20,948			87
Diagnostic activity levels - Non Obstetric Ultrasound	Mar 25	-	4,606			57
Diagnostic activity levels - Total	Mar 25	-	23,666			85
Diagnostic activity levels - Urodynamics	Mar 25	-	159			94
Diagnostics - 6 Week Standard	Mar 25	5.00%	29.12%			18
Diagnostics - 6 Week Standard Reversed	Mar 25	95.00%	70.88%			18
DM01 Waiting <13 Weeks	Mar 25	100.00%	95.72%			34
Echocardiography	Mar 25	5.00%	21.83%			33
Gastroscopy	Mar 25	5.00%	14.29%			47
Magnetic Resonance Imaging	Mar 25	5.00%	24.62%			12
Neurophysiology	Mar 25	5.00%	38.41%			22
Non-obstetric Ultrasound	Mar 25	5.00%	35.25%			5
Urodynamics	Mar 25	5.00%	28.00%			54

14. Pathway Benchmarking & Trend – Diagnostics

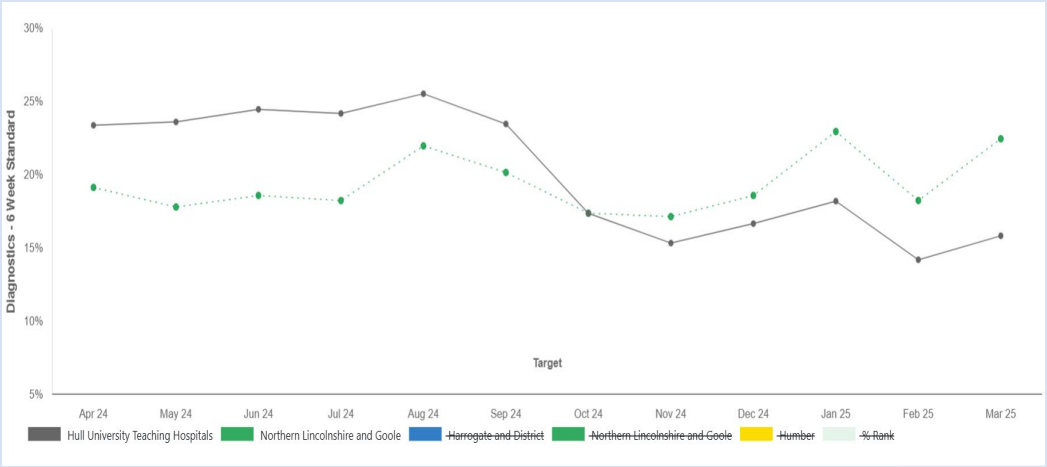
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

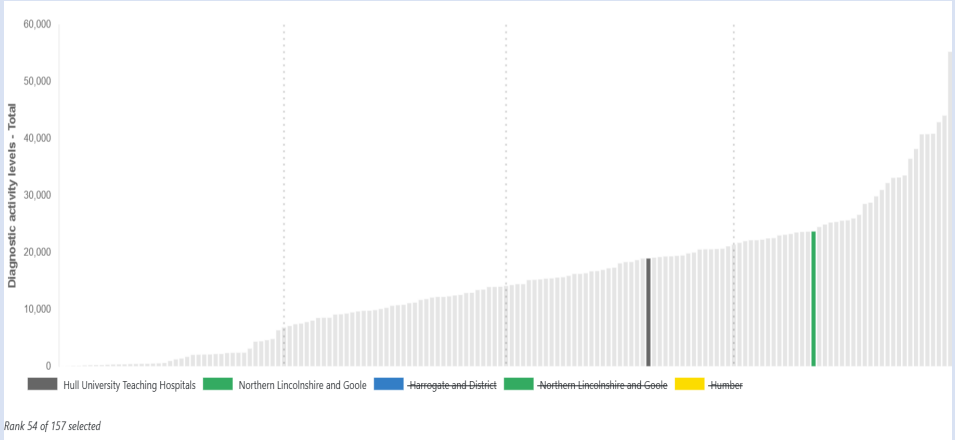


Trend Chart

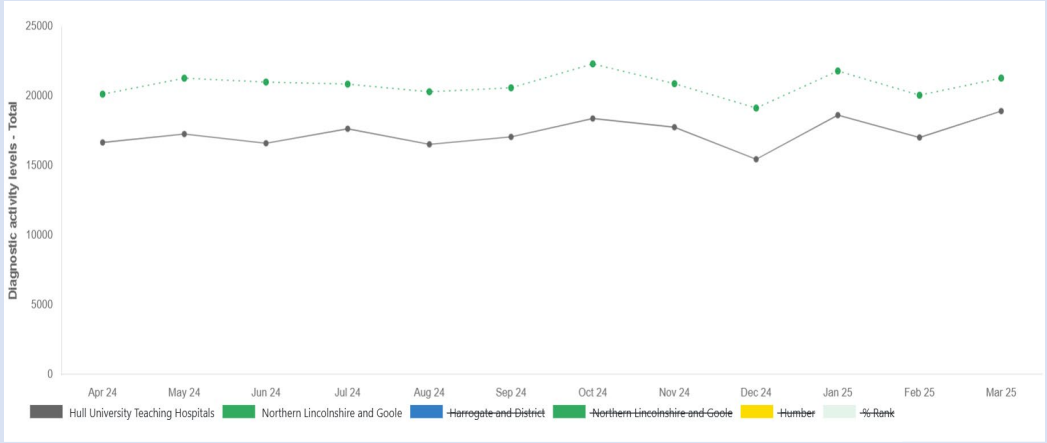


Diagnostics – Activity

Ranking Chart

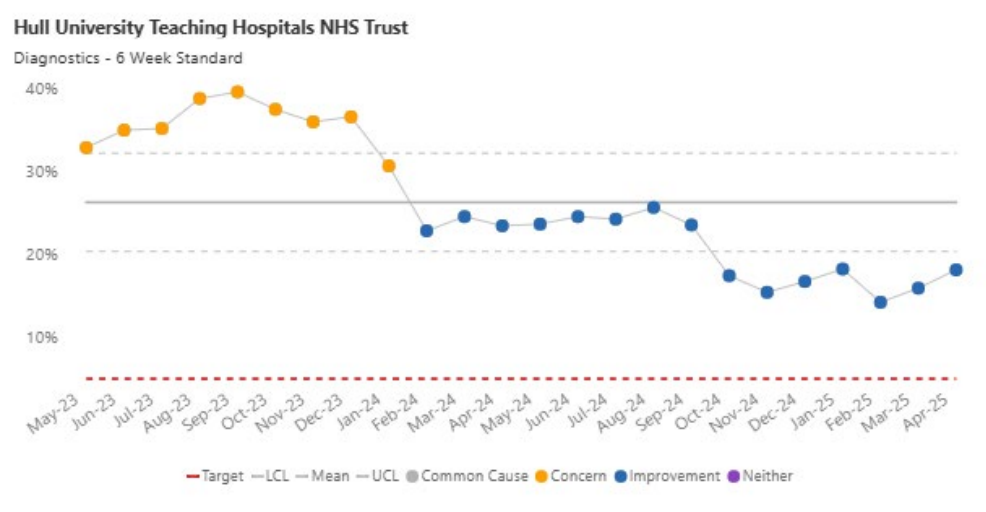


Trend Chart



15. Diagnostic 6 Week Standard - HUTH

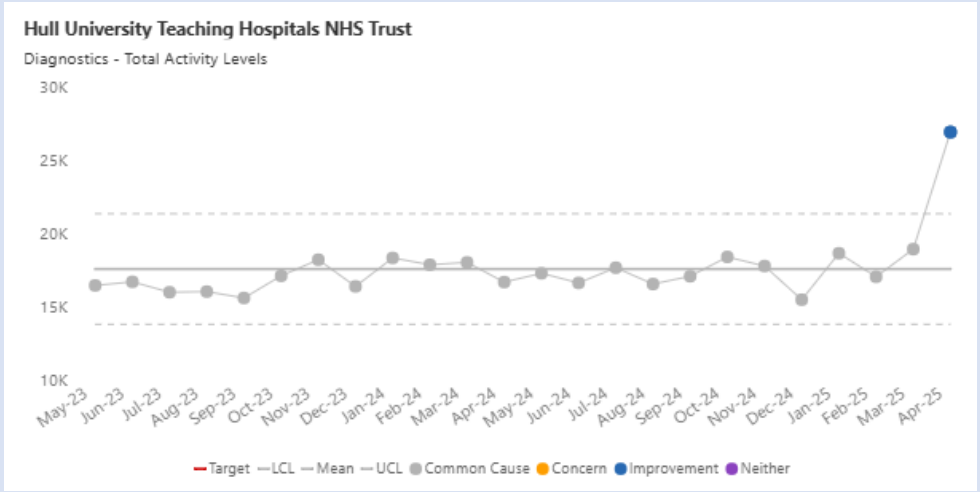
Compliance



Key Themes

- April showed a deterioration of 2.2%
- Deteriorating performance in Neurophysiology of 13.8% due to the impact of ceasing the insourced consultant capacity
- Deterioration in Echocardiology (10.3%).
- Improved performance was seen in Cystoscopy (10.5%), Urodynamics (4%) and Colonoscopy (4.2%).
- Most modalities at HUTH increased activity levels over 23/24 and into 24/25 with further improvement in April and ahead of delivery trajectory,

Critical Enabler

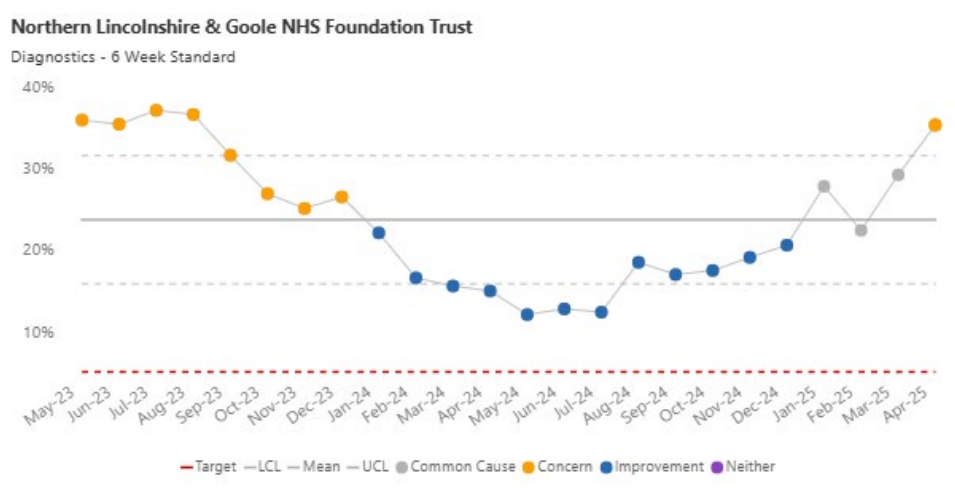


Actions

- Critical actions in place:
  - Tender exercise completed for NOUS to create additional capacity.
  - Services have developed improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
  - Validation of DMO1 activity recording underway to support performance and forecasting going forward.

16. Diagnostic 6 Week Standard - NLAG

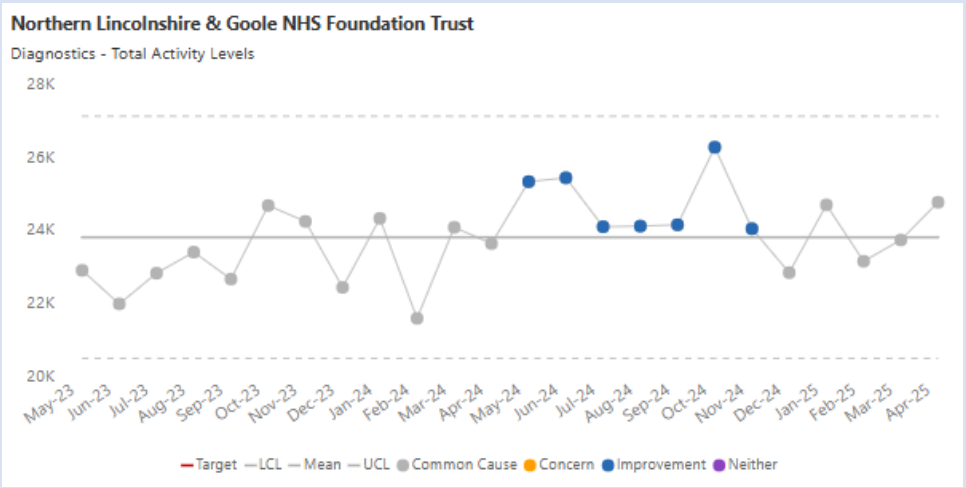
Compliance



Key Themes

- April performance showed deterioration of 6.1%
- Deteriorating performance in the endoscopy modalities impacted by the lack of WLIs due to the consultant pay dispute
- Continuing deterioration in Audiology (4.3%), Barium Enema (7.6%.) Neurophysiology (13.0%) and NOUS (5.7%)
- Decreasing performance in Echocardiography (19.4%) and Cystoscopy (20.9%). Decreasing performance in DEXA (13.3%) due to capacity shortfalls and equipment failure for a week in April.
- Improved performance was seen in Urodynamics (11.2%).
- Activity levels have increased but remain below trajectory.

Critical Enabler



Actions

- To mitigate capacity shortfalls relating to staffing in Neurophysiology on the South Bank enhanced workforce arrangements have been deployed to reduce backlog.
- Capacity & Demand work together with alternative ways of working to improve DEXA position.
- Review of referral process for Echocardiogram.
- Further activity stretch plans have been deployed to create additional diagnostic activity levels above the annual plan and utilise mutual aid opportunities across the Group. Where associated investment plans have been approved operational teams are commencing implementation either through use of WLIs, locums and substantive appointments.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Mar 25	93.00%	68.73%			13
Cancer 2 Week Wait Breast Symptomatic	Mar 25	93.0%	13.3%			9
Cancer 28 Day Faster Diagnosis	Mar 25	75.0%	78.3%			37
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	Jul 23	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Brain Tumours	Mar 25	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Breast Cancer	Mar 25	75.0%	94.4%			62
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Mar 25	75.0%	92.9%			42
Cancer 28 Day Faster Diagnosis - Children's Cancer	Mar 25	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Mar 25	75.0%	61.7%			24
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Mar 25	75.0%	75.0%			72
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Mar 25	75.0%	90.7%			90
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Mar 25	75.0%	54.1%			14
Cancer 28 Day Faster Diagnosis - Lung Cancer	Mar 25	75.0%	82.9%			52
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Dec 24	75.0%	50.0%			32
Cancer 28 Day Faster Diagnosis - Skin Cancer	Mar 25	75.0%	94.6%			67
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Dec 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Mar 25	75.0%	92.9%			95
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Mar 25	75.0%	43.5%			11
Cancer 31 Day All Stages	Mar 25	96.0%	74.8%			1
Cancer 31 Day First Treatment	Mar 25	96.00%	81.77%			1
Cancer 31 Day Subsequent Treatment	Mar 25	96.0%	68.5%			5
Cancer 31 Day Subsequent Treatment - Drugs	Mar 25	96.0%	97.6%			18
Cancer 31 Day Subsequent Treatment - Radiotherapy	Mar 25	96.0%	51.2%			0
Cancer 62 Day All Routes	Mar 25	85.00%	57.39%			9
Cancer 62 Day Consultant Upgrade	Mar 25	85.0%	50.6%			1
Cancer 62 Day Screening	Mar 25	90.0%	62.8%			35
Cancer 62 Day Urgent Suspected	Mar 25	85.00%	57.71%			22
Cancer of bronchus; lung	Jan 25	1.00	1.19			22

NLAG

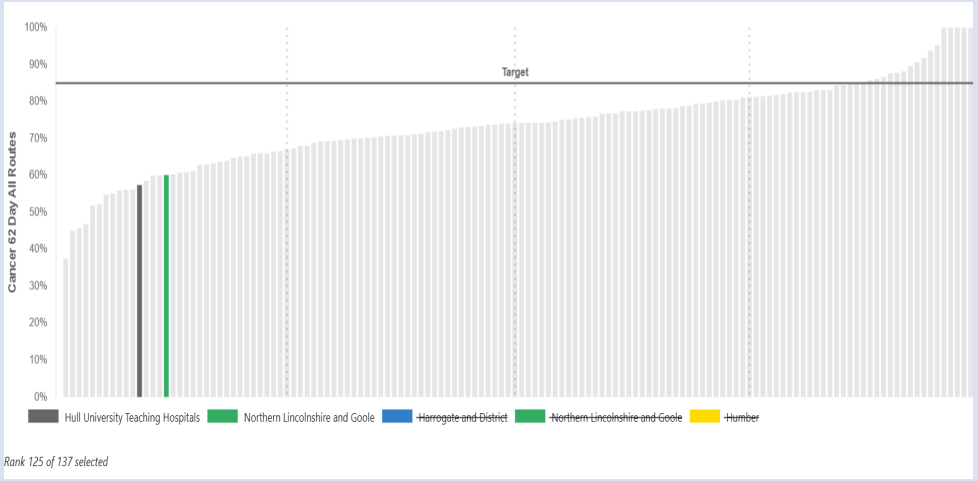
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Mar 25	93.00%	77.47%			28
Cancer 2 Week Wait Breast Symptomatic	Mar 25	93.0%	16.4%			13
Cancer 28 Day Faster Diagnosis	Mar 25	75.0%	60.0%			1
Cancer 28 Day Faster Diagnosis - Breast Cancer	Mar 25	75.0%	45.6%			1
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Mar 25	75.0%	42.6%			1
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Mar 25	75.0%	65.7%			32
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Mar 25	75.0%	60.8%			4
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Mar 25	75.0%	58.3%			20
Cancer 28 Day Faster Diagnosis - Lung Cancer	Mar 25	75.0%	56.8%			5
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Apr 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Other Cancer	Mar 25	75.0%	55.6%			31
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Mar 25	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Mar 25	75.0%	83.9%			63
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Mar 25	75.0%	66.5%			63
Cancer 31 Day All Stages	Mar 25	96.0%	96.4%			62
Cancer 31 Day First Treatment	Mar 25	96.00%	96.77%			64
Cancer 31 Day Subsequent Treatment	Mar 25	96.0%	95.7%			51
Cancer 31 Day Subsequent Treatment - Drugs	Mar 25	96.0%	94.5%			8
Cancer 31 Day Subsequent Treatment - Radiotherapy	Sep 24	96.0%	100.0%			100
Cancer 62 Day All Routes	Mar 25	85.00%	60.10%			12
Cancer 62 Day Consultant Upgrade	Mar 25	85.0%	93.1%			84
Cancer 62 Day Screening	Mar 25	90.0%	35.7%			9
Cancer 62 Day Urgent Suspected	Mar 25	85.00%	56.25%			17
Cancer of bronchus; lung	Jan 25	1.00	0.80			87

18. Pathway Benchmarking & Trending – Cancer Waiting Times

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

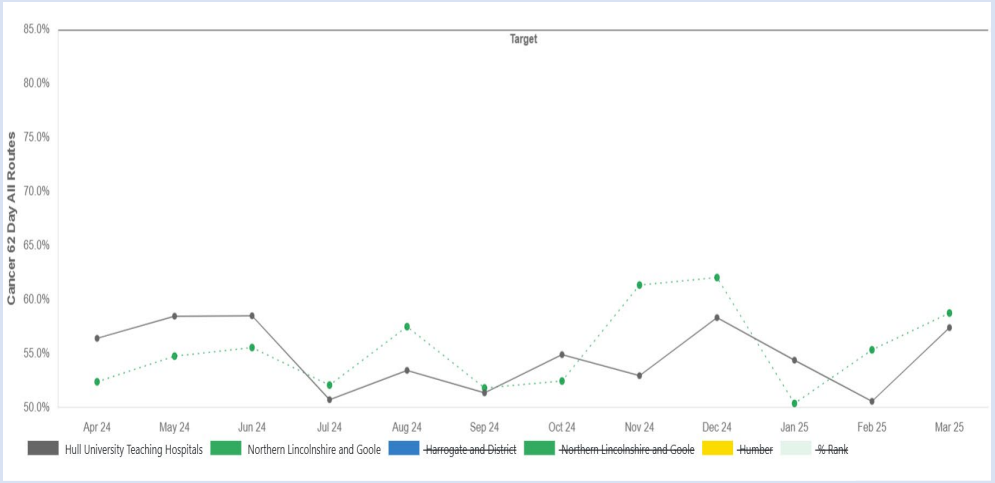
62 Day Performance

Ranking Chart



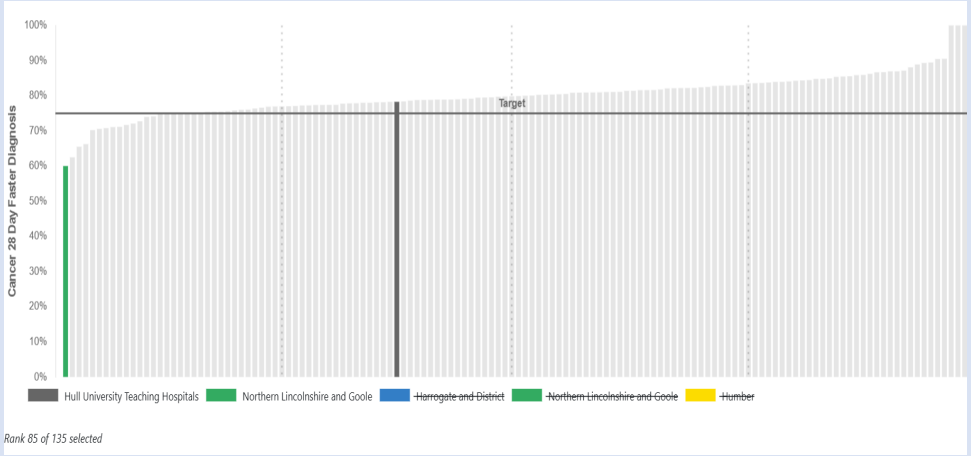
Rank 125 of 137 selected

Trending Chart



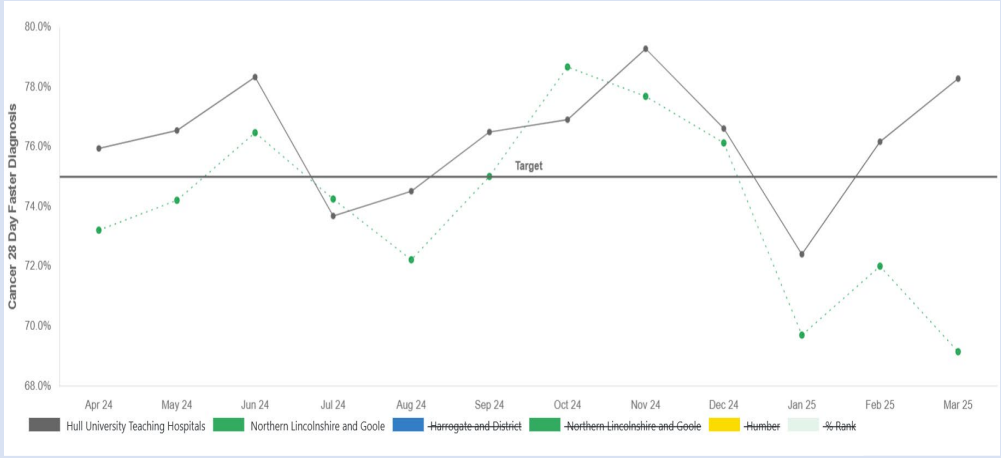
Faster Diagnosis Performance

Ranking Chart



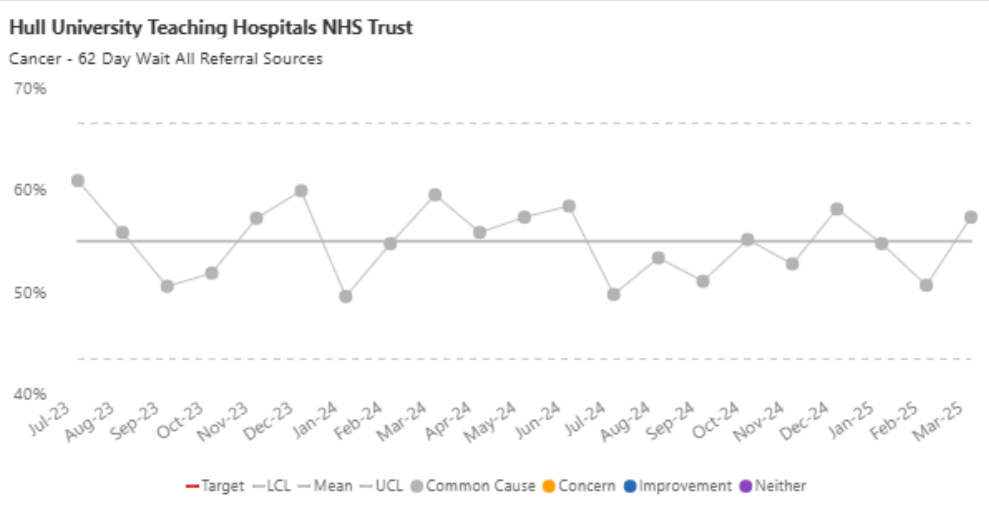
Rank 85 of 135 selected

Trending Chart



19. 62 Day Cancer Performance - HUTH

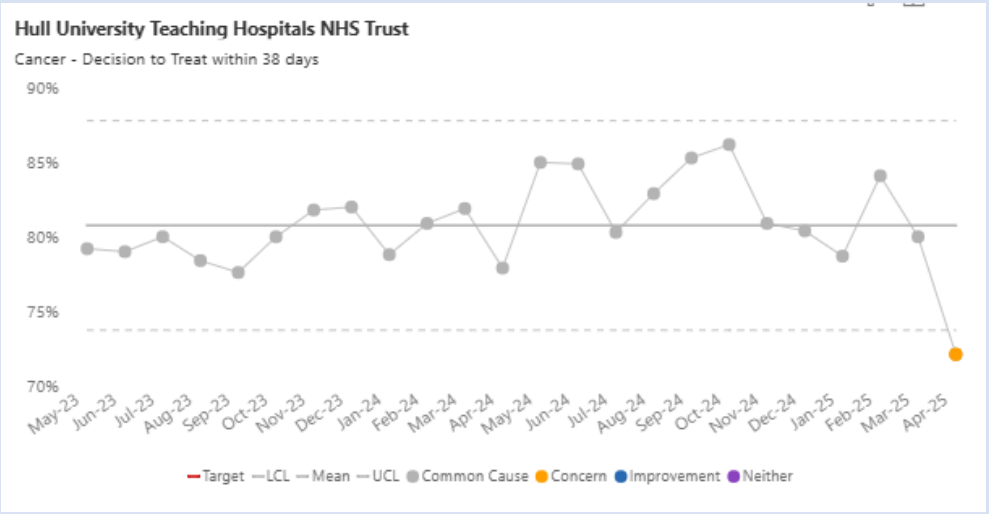
Compliance



Key Themes

- March performance of 57.3% shows a 6.7% improvement on previous month.
- Colorectal; delays in Radiotherapy, small number of complex patients with significant co-morbidities
- Gynaecology; late IPTs, small number of complex patients with significant co-morbidities
- Head and Neck; Thyroid capacity
- Lung; Capacity in Radiotherapy and SABR, Late IPTs, Thoracic OPA capacity
- Urology; Loss of HEYAS weekend capacity, outpatient capacity for treatment planning, late IPTs, small number of complex patients with significant co-morbidities
- Reduction in delivery of first appointment within 2 weeks is impacting on 62 day and 28-day FDS delivery.
- Significant decrease in DTT within 38 days to 72.1%.

Critical Enabler

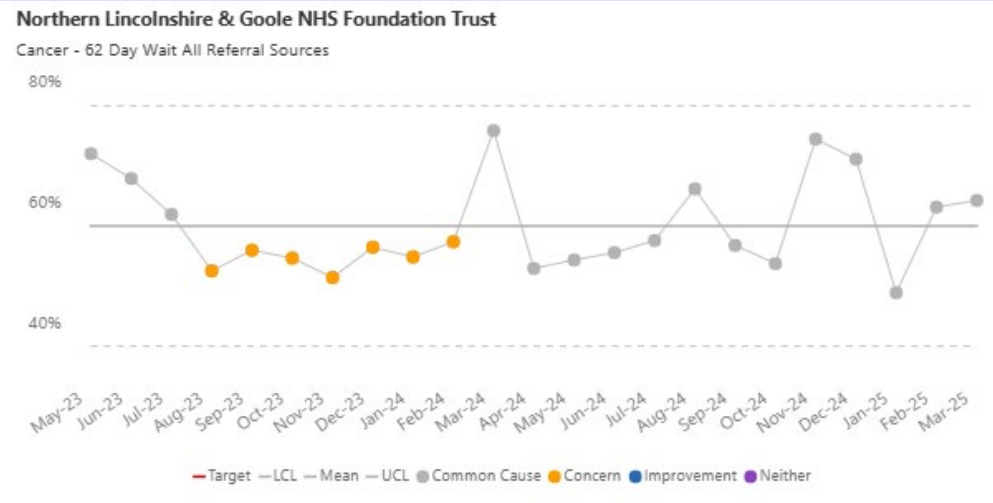


Actions

- Oncology; Radiotherapy recovery plan continues and mutual aid from Lincoln in place
- Lung; Right sizing paper being undertaken and potential to recruit a 5th Thoracic Surgeon, Business Case being developed

20. 62 Day Cancer Performance - NLAG

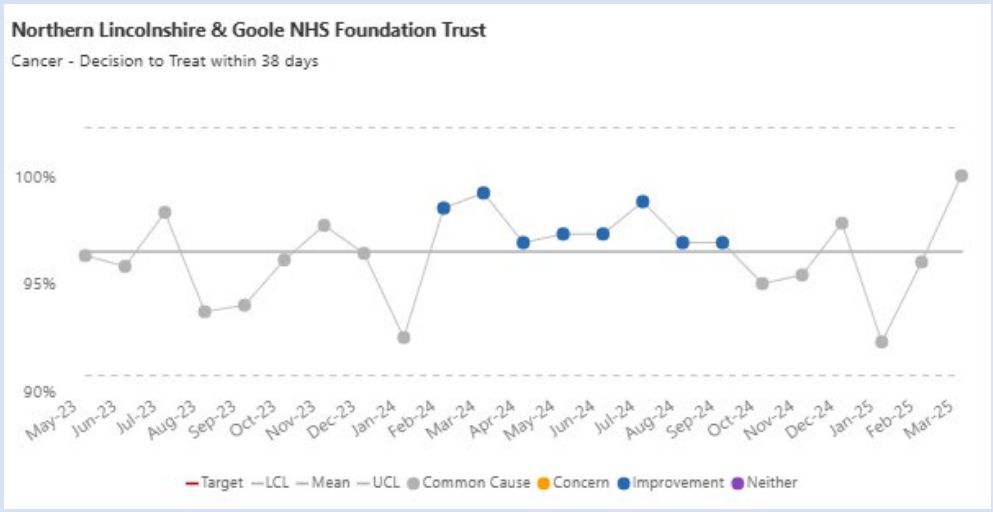
Compliance



Key Themes

- Improvement in performance in March to 60.2%
- Breast; clinical vacancies and Oncology outpatient capacity
- Colorectal; surgical capacity
- Gynaecology; surgical capacity
- Head & Neck; Thyrdoid and Max Fax capacity
- Lung; clinical vacancies, Oncology capacity
- Urology; Increase in prostate biopsy demand, Theatre capacity
- Reduction in delivery of first appointment within 2 weeks is impacting on 62 day and 28-day FDS delivery.

Critical Enabler

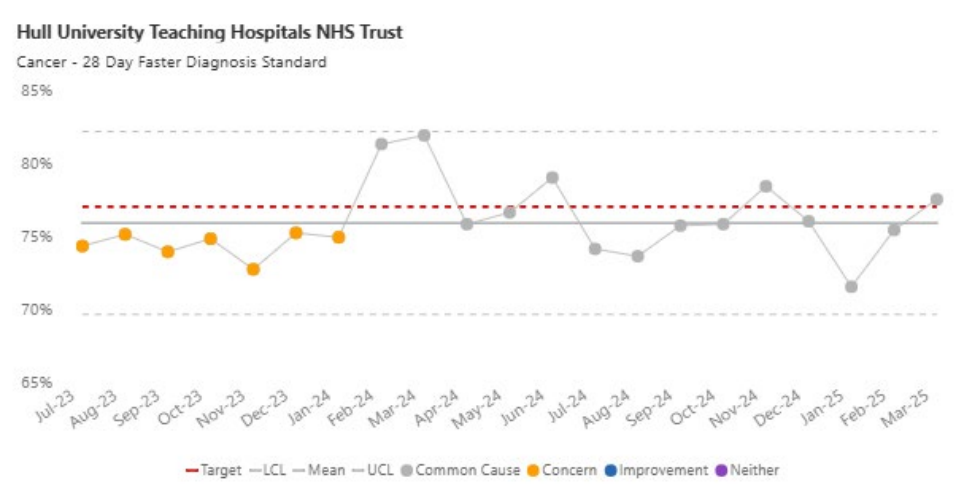


Actions

- Breast – Action plans being confirmed
- Colorectal – Action plans being confirmed
- Head & Neck - Action plans being confirmed
- Lung – continuous advertisement for recruitment into 5 x WTE Respiratory Physician posts, Pooling of outpatient and theatre lists, Right sizing paper being developed
- Urology - Action plans being confirmed

21. 28 Day Faster Diagnosis Standard - HUTH

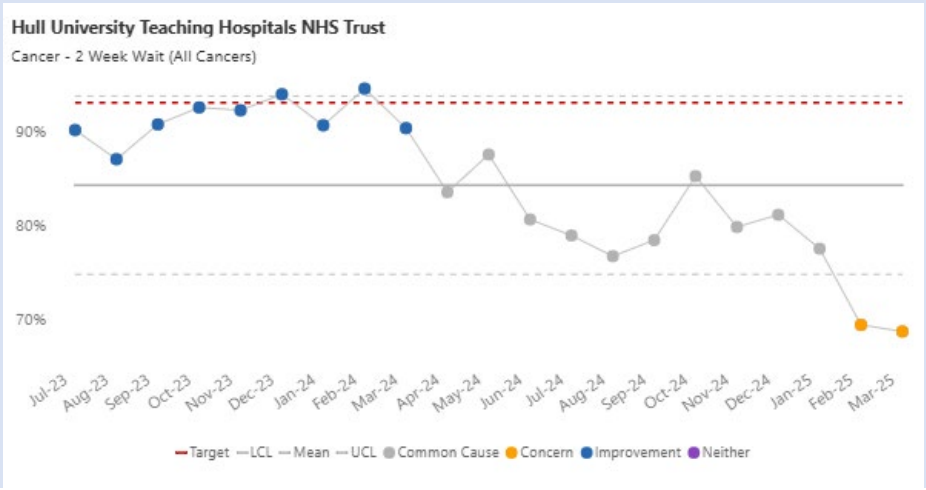
Compliance



Key Themes

- March performance 77.5%, which is an improvement on the previous month
- Wait to first appointment is a contributory factor with USC 2ww performance at 68.7% - impacted by reduced capacity in Breast, Upper GI and Skin.
- Breast; significant delays due to radiologist capacity
- Colorectal; loss of CNS through Alliance funding has reduced capacity for triage, bowel screening Endoscopy capacity shortfall for accredited scopists, CT Colon radiologist capacity with current waits up to 4 weeks
- Gynaecology; outpatient capacity and US capacity, diagnostic histology turnaround times up to 3 weeks
- Head & Neck; significant delays with first outpatient consultant capacity
- Skin; significant delays with first outpatient consultant capacity
- Urology; Haematuria capacity constraint with current waits up to 3 weeks

Critical Enabler

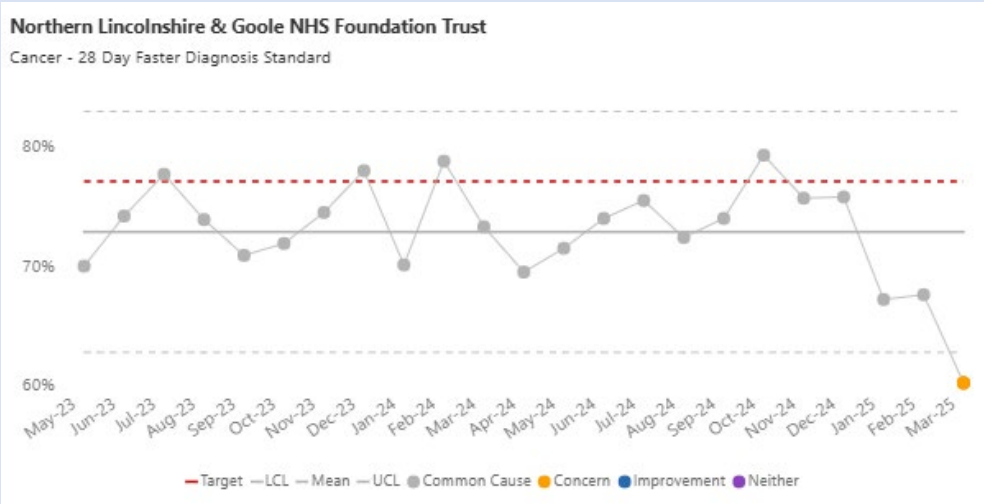


Actions

- Breast – the service are working with Radiology support services to increase capacity
- Colorectal – service improvement bid in place for additional nurse funding, training programme in place to increase bowel screening capacity, CT colon Radiology capacity action plan in place
- Gynaecology – Action plan has been shared with he improvement team and Family Services to look at capacity and demand planning
- Head & Neck – Additional outpatient capacity to be done via WLIs and service working on plans to clear backlog
- Urology – Haematuria pathway under review with a straight to test pathway, working in partnership with Primary Care.

22. 28 Day Faster Diagnosis Standard - NLAG

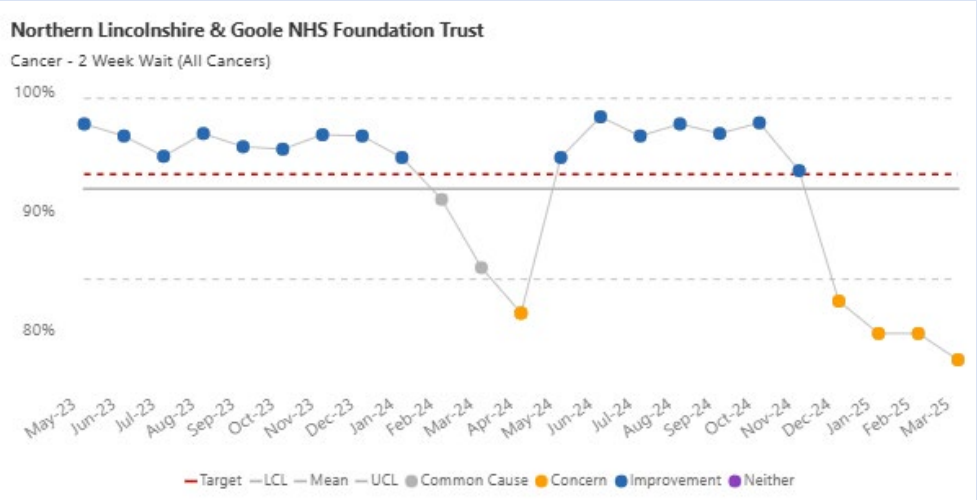
Compliance



Key Themes

- March performance has significantly deteriorated at 60.1%.
- Wait to first appointment is a contributory factor with USC 2ww performance at 77.5%, impacted by Breast and Gynaecology
- Breast; first outpatient capacity
- Colorectal; endoscopy capacity constraints, screening continued delays due to patient choice
- Gynaecology; Consultant capacity constraints, histology TAT up to 6 weeks
- Head & Neck; capacity issues due to job plan changes
- Upper GI; OGD waits up to 22 days, barium waits up to 20 days
- Lung; 5 x WTE consultant vacancies
- Urology; increase in referrals for prostate

Critical Enabler



Actions

- Breast; recruitment to consultant vacancies, additional capacity for biopsies
- Colorectal; extra contractual sessions not operating due to pay dispute
- Gynaecology; Business case progressing
- Head & Neck; Time out session with clinicians and managers to be arranged
- Upper GI; extra contractual sessions not operating due to pay dispute
- Lung; Recruitment plan in place
- Urology; Utilising additional capacity with registrars where possible.

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Apr 25	78.00%	56.34%			2
A&E - 4 Hour Standard (Type 1)	Apr 25	78.0%	42.3%			3
A&E - 4 Hour Standard (Type 2 or 3)	Apr 25	95.0%	84.0%			1
A&E - Conversion Rate	Apr 25	25.0%	26.4%			14
A&E - DTA to Admission >12 Hours	Apr 25	0.0%	13.9%			36
A&E - DTA to Admission >12 Hours#	Apr 25	0.0	506.0			23
A&E - DTA to Admission >4 Hours	Apr 25	10.00%	42.44%			29
A&E - Left Without Being Seen	Mar 25	5.00%	9.24%			6
A&E - Reattendance Rate	Mar 25	5.0%	9.3%			32
A&E - Time to Initial Assessment	Mar 25	15.0	18.0			12
A&E - Time to Treatment	Mar 25	60.0	99.0			17
A&E - Total Time in A&E	Mar 25	160.0	280.0			1
A&E - Total Time in A&E (Admitted)	Mar 25	180.0	336.0			40
A&E - Total Time in A&E (Non-Admitted)	Mar 25	140.0	263.0			1
A&E Attendances All	Apr 25	-	13,767			50
A&E Attendances Type 1	Apr 25	-	9,122			60
A&E Attendances Type 3	Apr 25	-	4,645			53
Emergency Admissions Type 1	Apr 25	-	3,636			33
Emergency Admissions via A&E	Apr 25	-	3,636			33
Friends & Family A&E Score	Jan 25	85%	71%			7
Other Emergency Admissions	Apr 25	-	2,226			10
Total Emergency Admissions	Apr 25	-	5,862			19

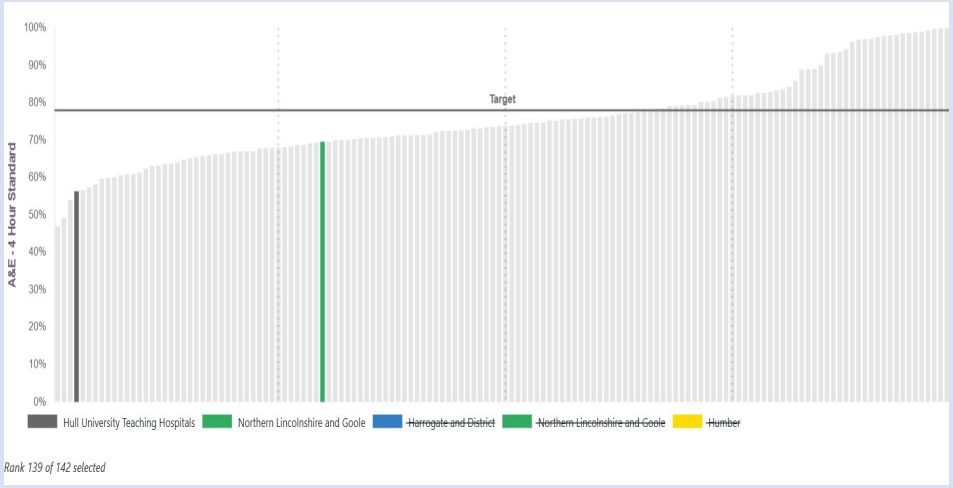
NLAG

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Apr 25	78.00%	69.60%			30
A&E - 4 Hour Standard (Type 1)	Apr 25	78.0%	45.6%			5
A&E - 4 Hour Standard (Type 2 or 3)	Apr 25	95.0%	98.9%			67
A&E - Conversion Rate	Apr 25	25.0%	29.1%			6
A&E - DTA to Admission >12 Hours	Apr 25	0.0%	16.6%			30
A&E - DTA to Admission >12 Hours#	Apr 25	0.0	800.0			9
A&E - DTA to Admission >4 Hours	Apr 25	10.00%	30.23%			55
A&E - Left Without Being Seen	Mar 25	5.00%	2.67%			82
A&E - Reattendance Rate	Mar 25	5.0%	9.4%			31
A&E - Time to Initial Assessment	Mar 25	15.0	22.0			5
A&E - Time to Treatment	Mar 25	60.0	58.0			72
A&E - Total Time in A&E	Mar 25	160.0	151.0			73
A&E - Total Time in A&E (Admitted)	Mar 25	180.0	370.0			30
A&E - Total Time in A&E (Non-Admitted)	Mar 25	140.0	118.0			87
A&E Attendances All	Apr 25	-	16,551			39
A&E Attendances Type 1	Apr 25	-	9,087			61
A&E Attendances Type 3	Apr 25	-	7,464			34
Emergency Admissions Type 1	Apr 25	-	4,810			13
Emergency Admissions via A&E	Apr 25	-	4,810			13
Friends & Family A&E Score	Jan 25	85%	75%			22
Other Emergency Admissions	Apr 25	-	380			69
Total Emergency Admissions	Apr 25	-	5,190			28

24. Pathway Benchmarking & Trending – Unscheduled Care

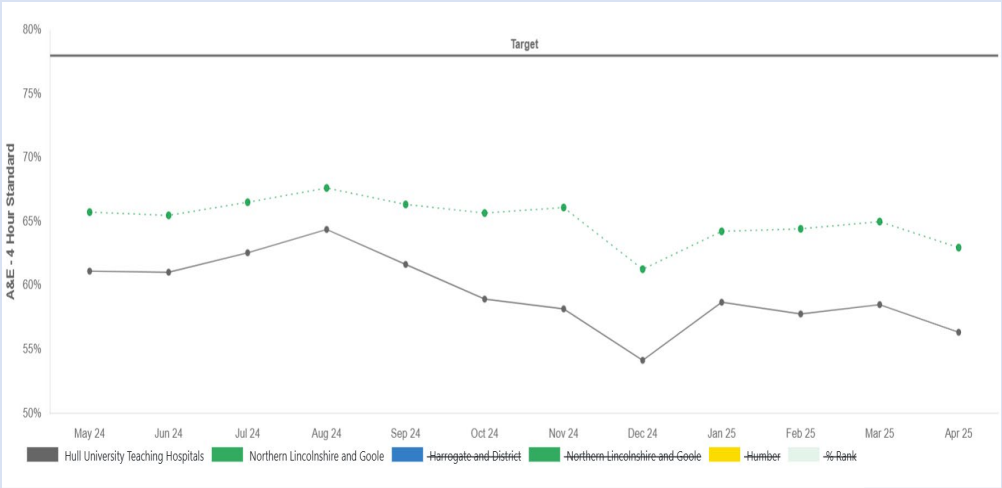
A&E - 4 Hour Performance

Ranking Chart



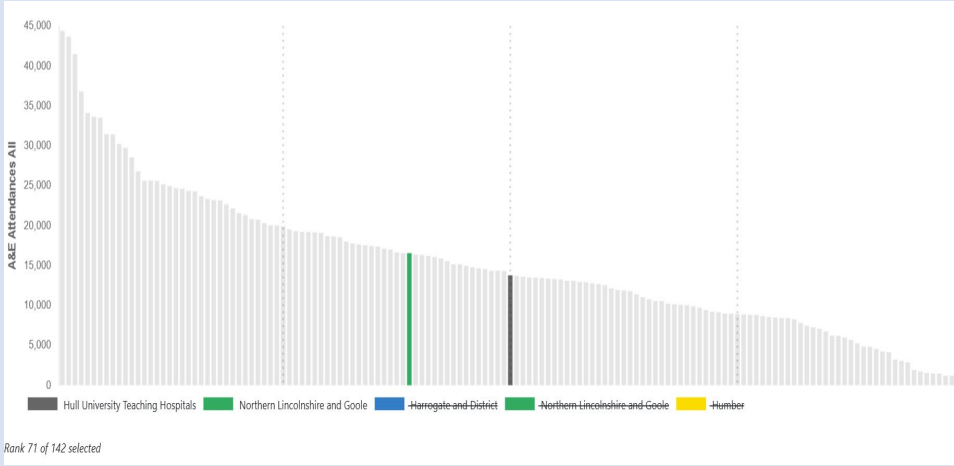
Rank 139 of 142 selected

Trending Chart



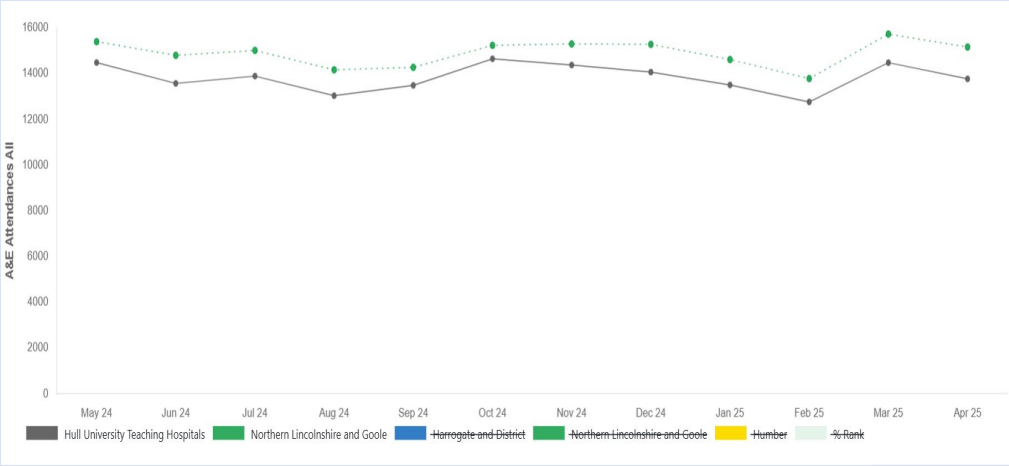
A&E – Attendances

Ranking Chart



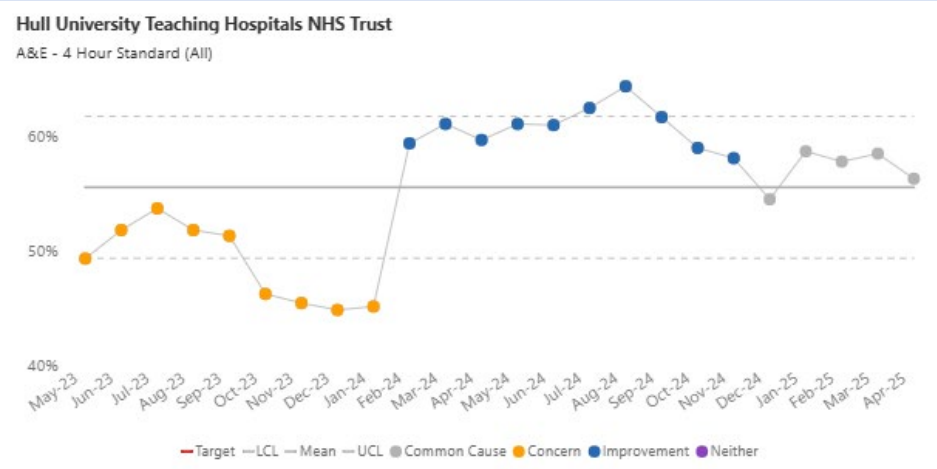
Rank 71 of 142 selected

Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

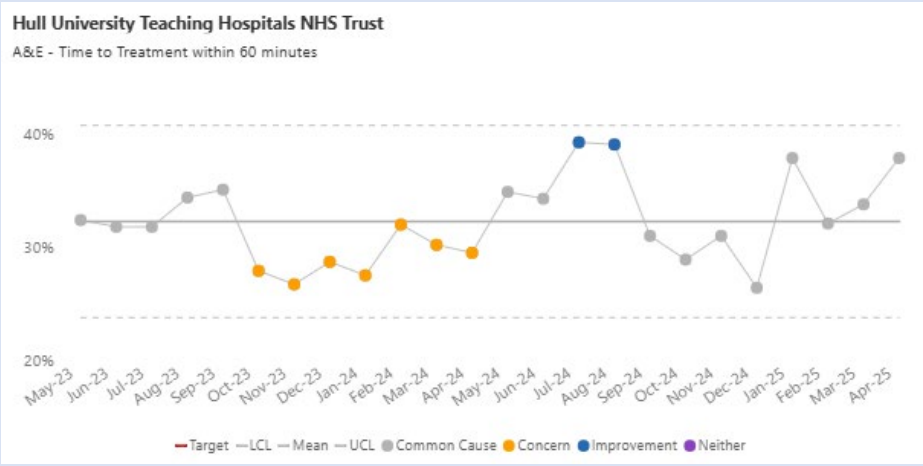
Compliance



Key Themes

- A&E 4 Hour standard (all types) was 56.3% in April 2025 (plan 64.4%).
- Type 1 performance of 42.3% was below the 25/26 operating plan target of 49.7%. Attendances were below plan.
- Type 3 performance (HRI UTC) was 84% against the 95% target. Attendances at UTC were above planned levels in April
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival - 37.9% in April (improvement on previous month).

Critical Enabler



Actions

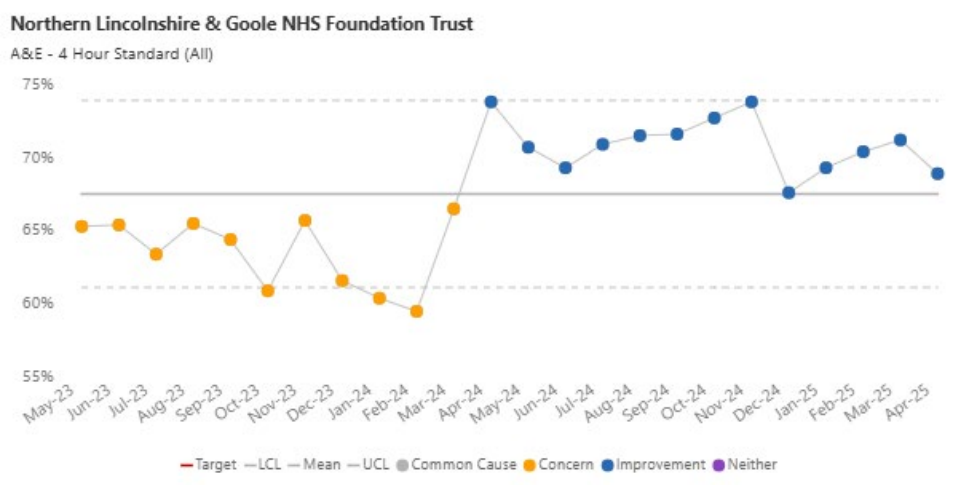
3 critical 'front door' objectives in place:

1. Reducing non-admitted breaches: - 3,012 in April 2025. Sustained increases from 2,497 in August 2024.
2. Time to first clinician: - Deterioration from mean of 121.9 in August to December (183), reducing to 132 in April 2025
3. Improved frailty assessment: - Deterioration from 457.2mins in August to 696 mins in December for total time in department for patients >65 years of age (target time of 160 minutes). April position – 565 minutes.

The Group has implemented a comprehensive action plan to improve performance against the 78% 4-hour target. Workstreams include recruitment to senior and middle grade medical posts, redesign of the ground floor of the Tower Block to facilitate additional AAU and SDEC capacity, review of ED systems and processes, flow programme to improve timely transfer to base wards, facilitate earlier discharge and reduce the number of NCTRs, revised site management arrangements and the use of digital enablers to increase efficiency and productivity

26. Emergency Care Standards – 4 hour Performance - NLAG

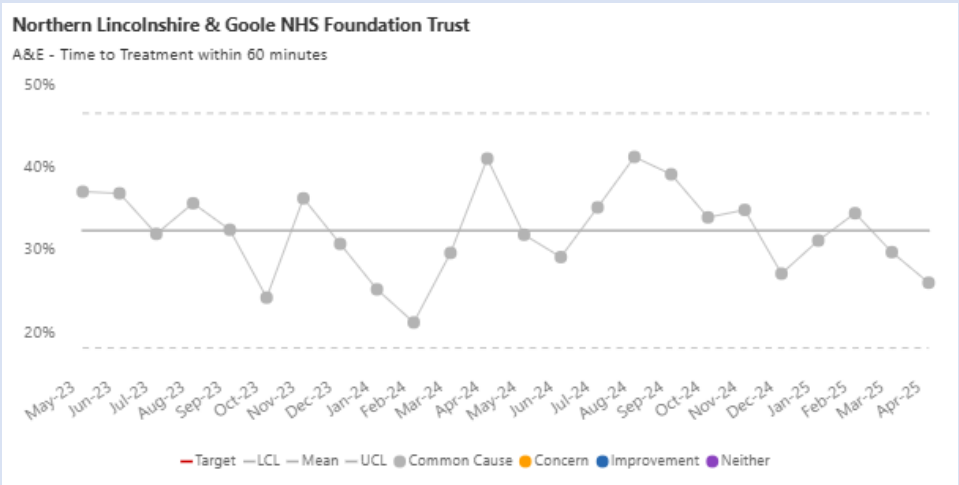
Compliance



Key Themes

- Combined type 1 and 3 performance was 68.8% in April against a target of 73.5%.
- Type 1 performance = 45.6% (Target 56.4%)
- Type 3 performance = 98.8% (Target 99%)
- Time to treatment within 60 minutes was 25.9% in April (a deterioration on the previous month)

Critical Enabler



Actions

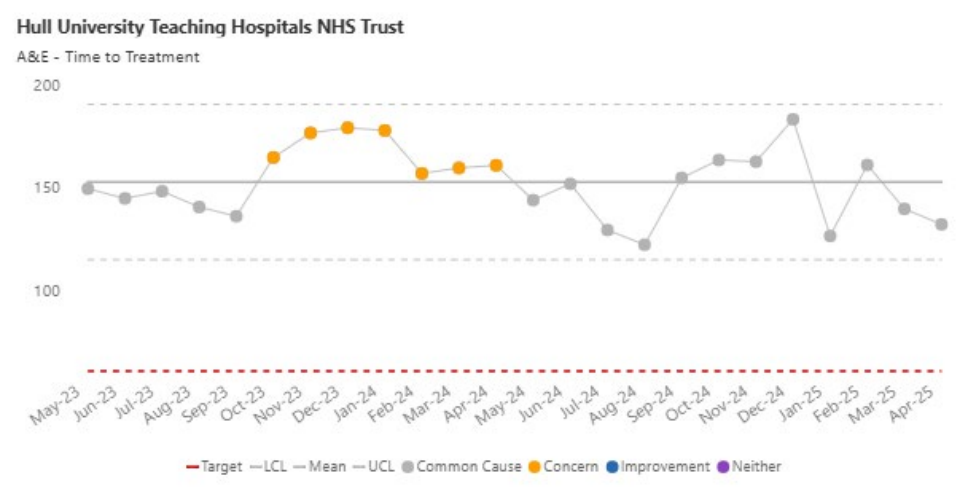
3 critical 'front door' objectives in place:

1. Reducing non-admitted breaches: - 3,456 in April 2025 (increase in number on previous month)
2. Time to first clinician: 131 minutes in April 2025 (deterioration)
3. Improved frailty assessment: - Increase in waiting time from 239 mins in August to 495 minutes in April for total time in department for patients >65 years of age (target time of 160 mins)

The UEC Improvement Programme for NLaG includes the development of a front door frailty model, working with EMAS to improve 15-minute ambulance handover performance, and review of the criteria for admission. Patient flow outside ED also being prioritised: - CDU now functional across both sites. Patient flow outside ED also being prioritised. Implementation of SAFER Bundle, designated cover of GIM wards and reduction of NCTR.

27. Core Objective 1 – Mean Time to Treatment

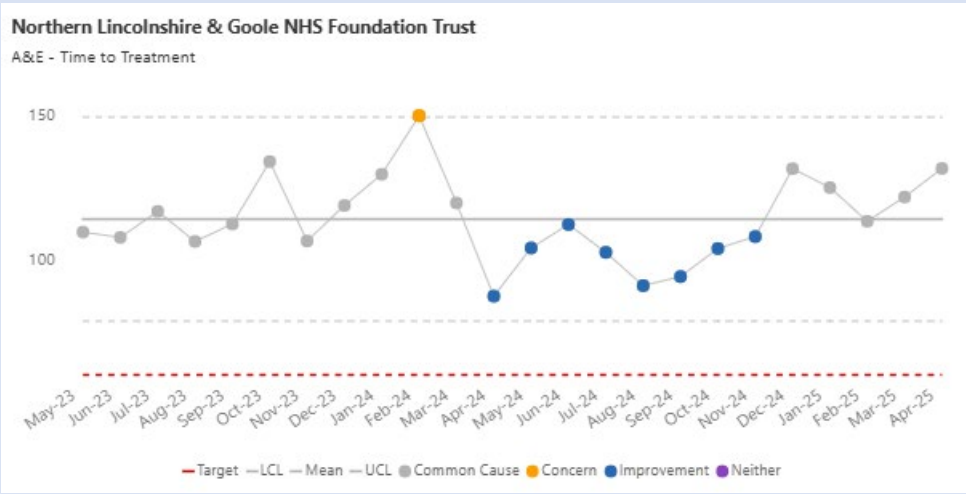
Compliance



Key Themes

- The Group established a target of 60 minutes for time to first clinician (time to treatment)
- HUTH saw a decrease in mean waiting time in April 2025 = 132 minutes

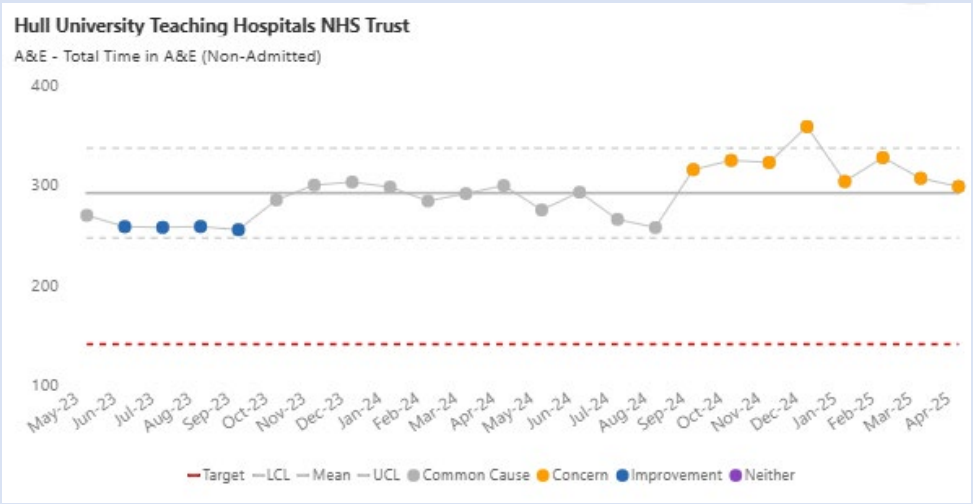
Compliance



- There was a further deterioration in performance in April 2025 with time to treatment increasing to 131 minutes.

28. Core Objective 2 – Non-Admitted Total Time in Department

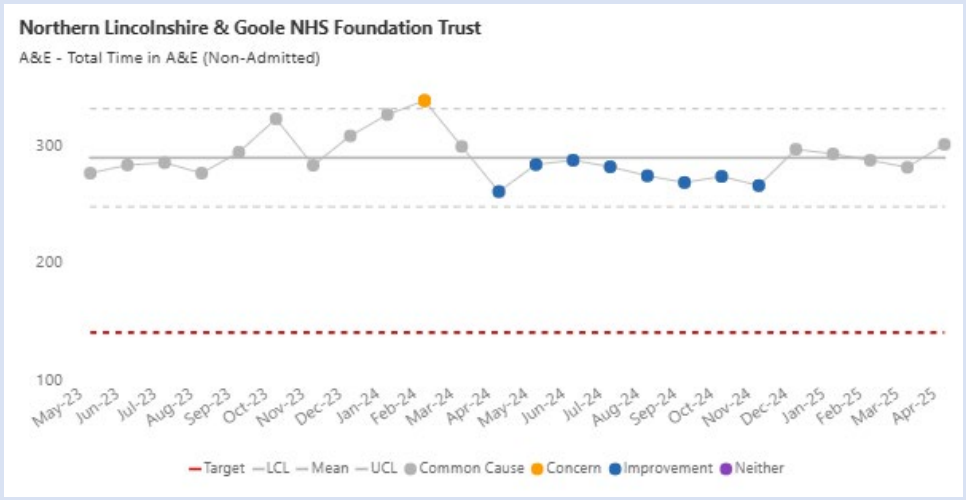
Compliance



Key Themes

- The Group established a target of 140 minutes for time spent by non-admitted Type 1 patients in the ED.
- HUTH's performance remains a concern, with April 2025 at 298 minutes average (slight improvement on March position).

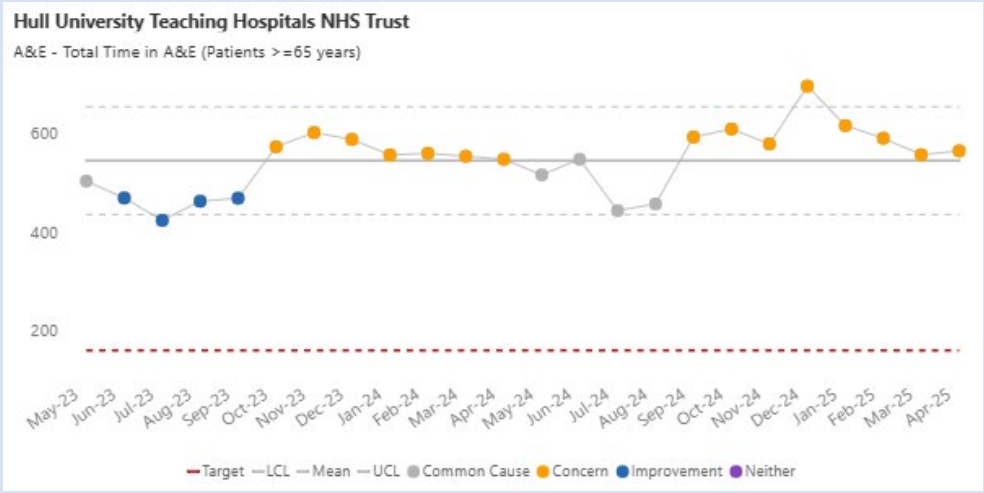
Compliance



- NLaG has performed consistently in 265-300 mins range since late Spring, with a slight deterioration in December. April 2025 performance 300 mins.

29. Core Objective 3 – Total Time in Department (Patients >= 65 years)

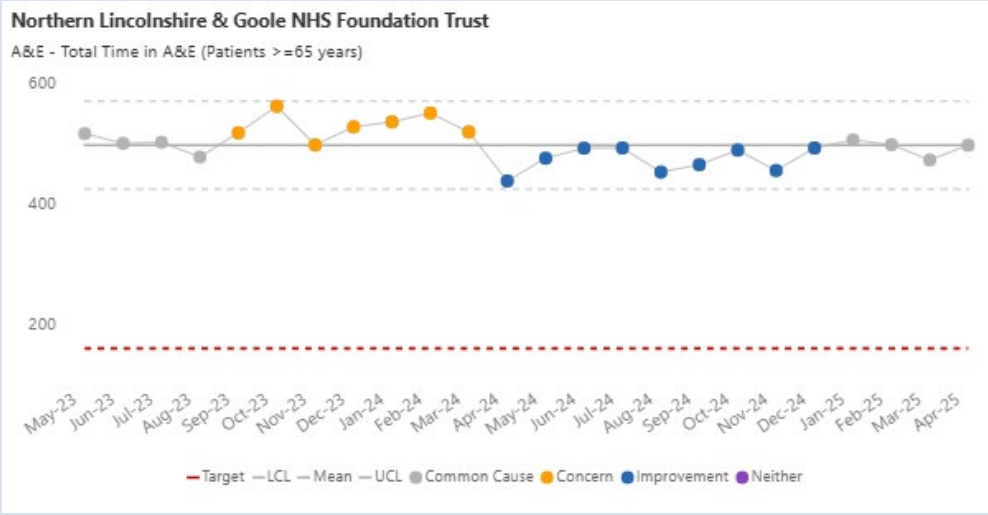
Compliance



Key Themes

- The Group established a target of 160 minutes for total time in the ED for patients aged 65 years and over
- The mean for HUTH was 565 minutes in April, reducing from December's peak of 696 minutes.

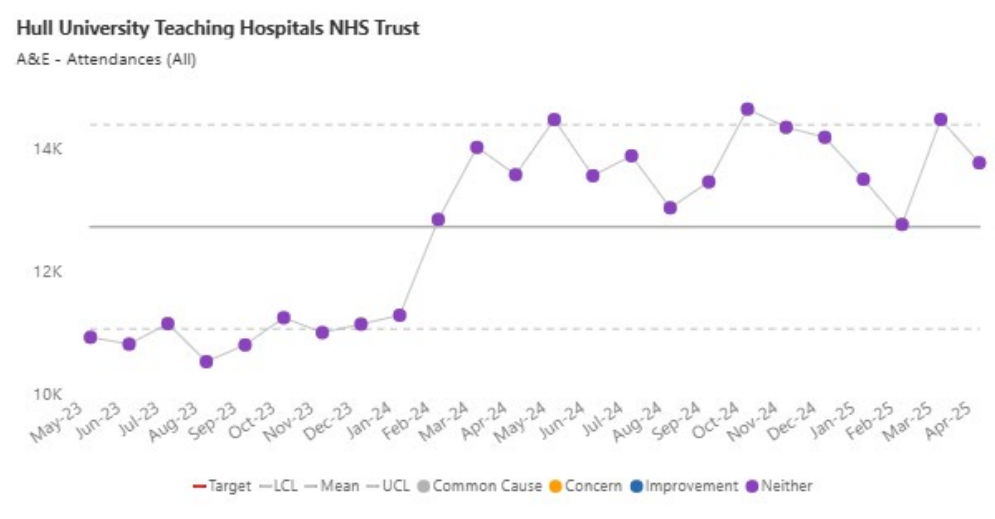
Compliance



- The mean for NLaG was 495 minutes in April 2025

30. A&E Attendances – All Types

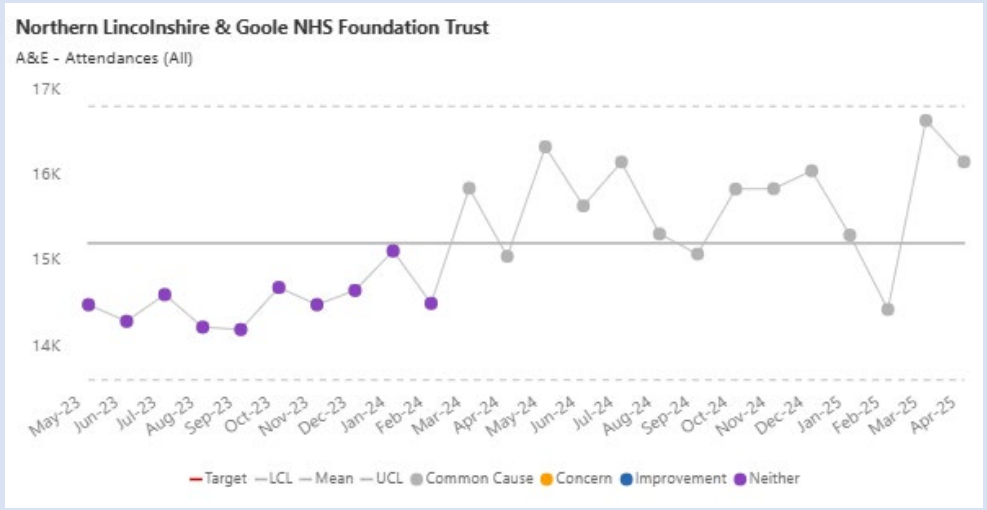
Compliance



Key Themes

- HUTH April 2025 – 13,767 total attendances comprising 9,122 Type 1 (below plan) and 4,645 Type 3 (above plan).

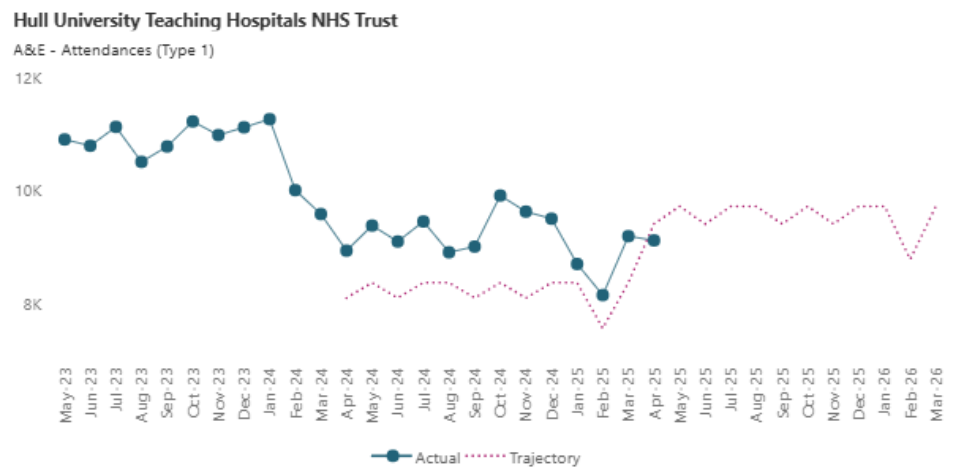
Compliance



- NLaG April 2025 – 16,135 total attendances comprising 9,088 Type 1 (below plan) and 7,047 Type 3 (above plan)

31. A&E Attendances – Type 1 Attendances

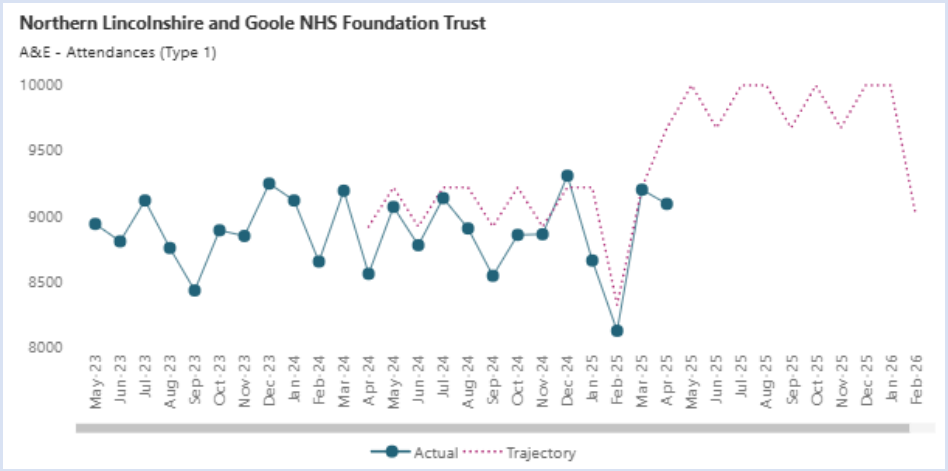
Compliance



Key Themes

- HUTH Type 1 attendances - April actuals were 9,122, below plan by 291.

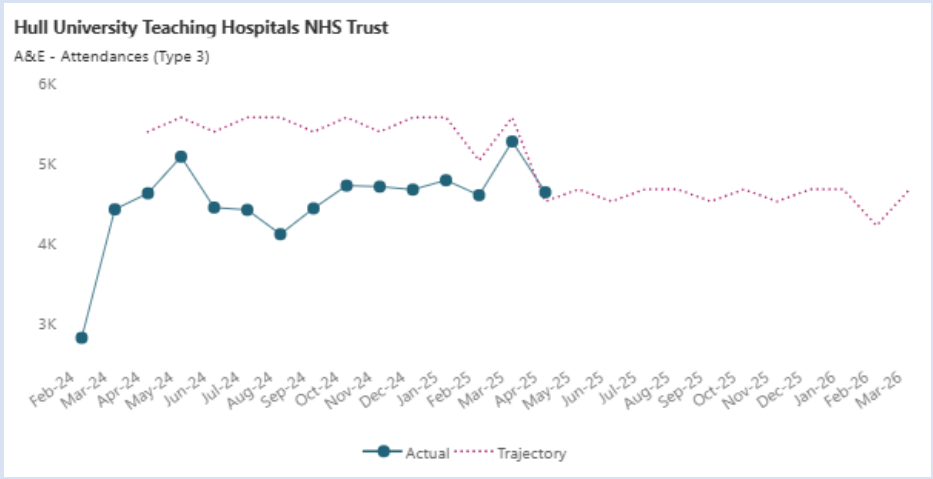
Compliance



- NLaG Type 1 attendances remain below plan.
  April actuals were 9,088 vs plan of 9,664 (576 below plan)

32. A&E Attendances – Type 3 Attendances

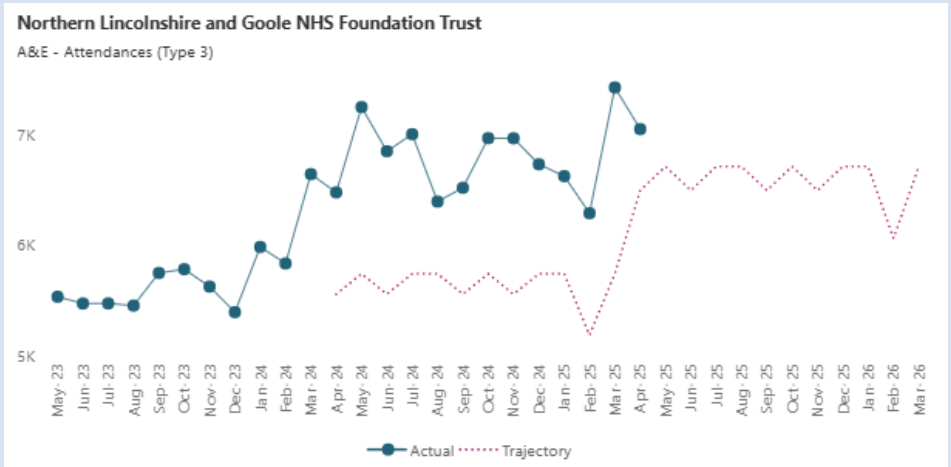
Compliance



Key Themes

- HUTH attendances at HRI – 4,645 seen in April vs plan of 4,530 (115 above plan)

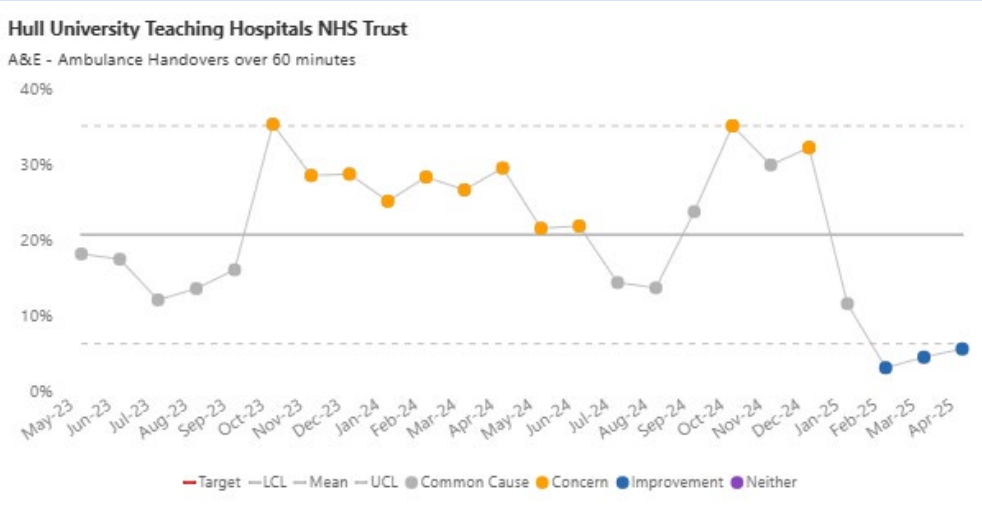
Compliance



- NLaG Type 3 attendances were 7,047 vs plan of 6,493, an increase of 554.

33. Ambulance Handovers >60 minutes - HUTH

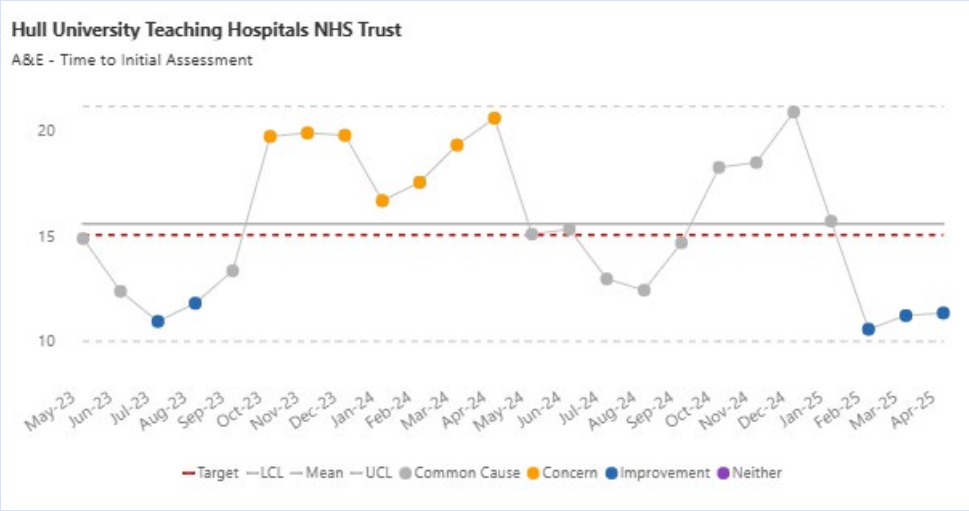
Compliance



Key Themes

- Month on month reduction in the percentage of ambulance handovers >60 minutes from Feb to August as part of recovery programme, however, notable increase in ambulance handovers over 60 minutes at HUTH from September to December 2024. Improving position from January 2025 (April – 5.5%)
- Root cause of handover delays linked to winter pressures and patient volumes in A&E, resulting in compression of available assessment spaces.

Critical Enabler

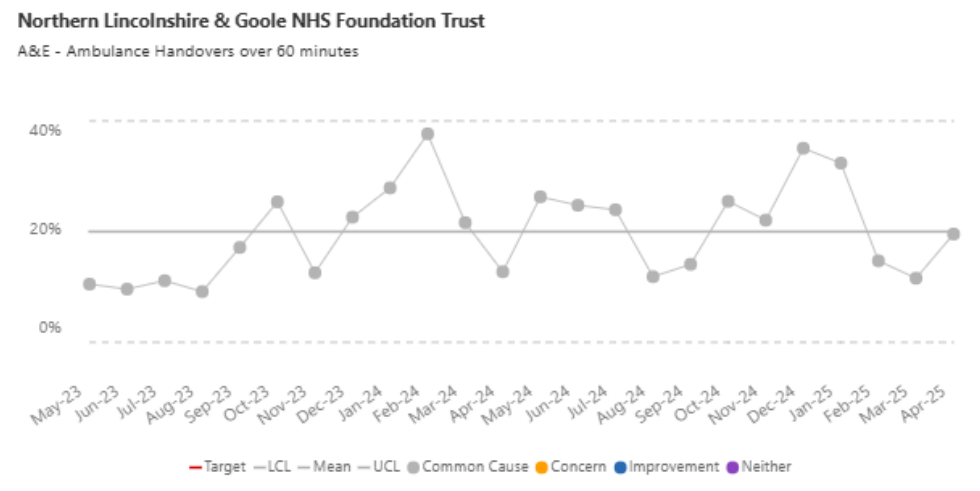


Actions

- Time to initial assessment in April 2025 was 11 minutes (target 15 mins).
- Triggers and Escalation/SOP for ambulance handovers reviewed and adapted, linked to national OPEL system, enabling 30-minute Cat 2 responses for YAS.

34. Ambulance Handovers >60 minutes - NLAG

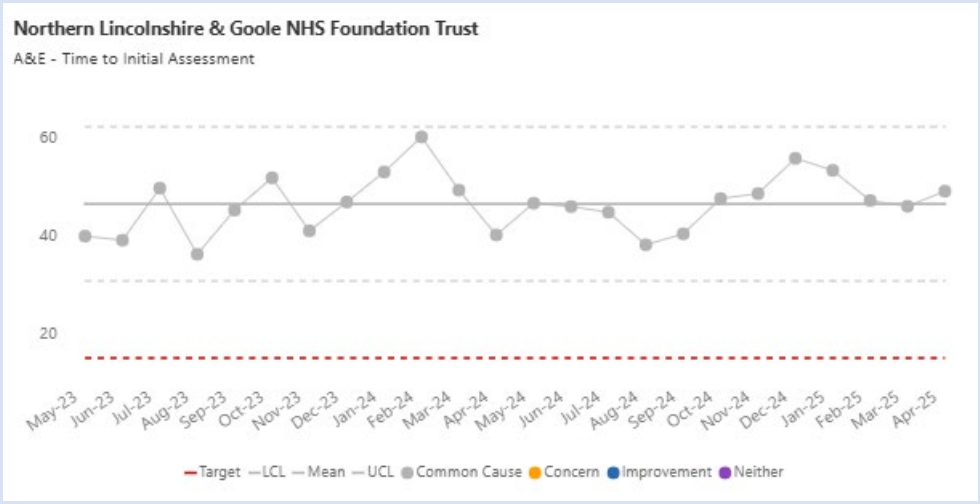
Compliance



Key Themes

- Performance in percentage of ambulance handovers >60 minutes has been within normal variation, with increases seen during winter period. April performance = 18.8%, an increase on the March position.
- Time to initial assessment in April 2025 was 49 minutes against target of 15 minutes.

Critical Enabler



Actions

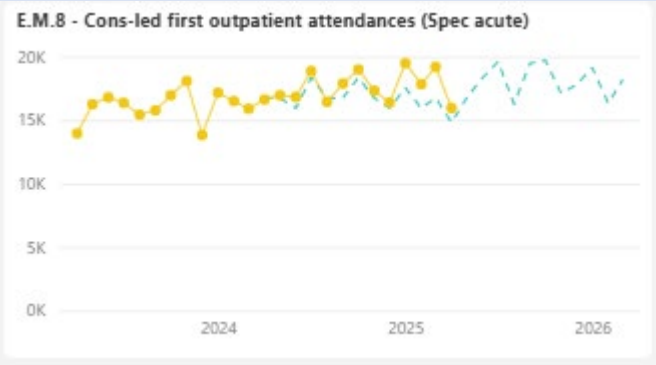
- Rapid Assessment and Treatment (RAT) model is being embedded to reduce waiting time to be seen.
- Ongoing work to deliver zero tolerance of >45-minute handover, aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.
- Improvement of flow/ LOS through Discharge rounds in wards will reduce congestion within ED
- Impact and timelines for recovery programme being finalised with system partners.

35. Activity

HUTH (Month 1)

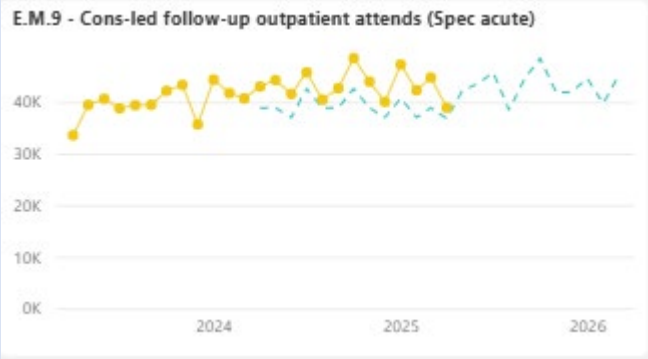
New Outpatient Attendances vs Plan

YTD New consultant-led activity is above plan at +1,141 (7.7%).



Follow up Outpatient Attendances vs Plan

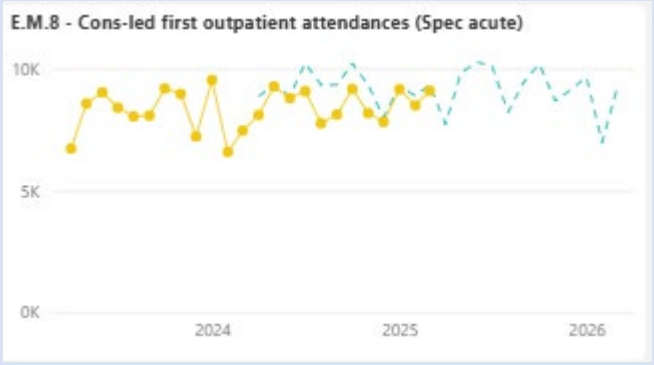
YTD Follow up activity is above plan +2,091 (5.7%).



NLAG (data shown to Month 12)

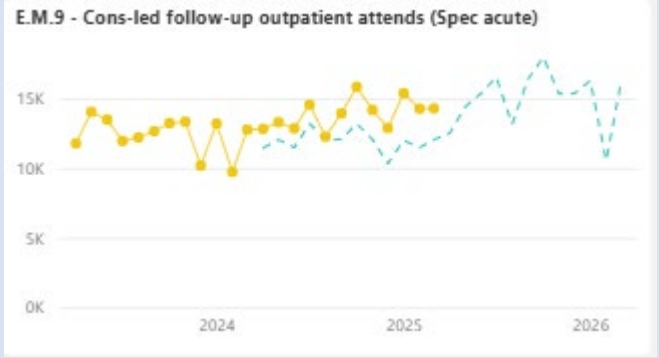
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -7,995 (-7.2%).



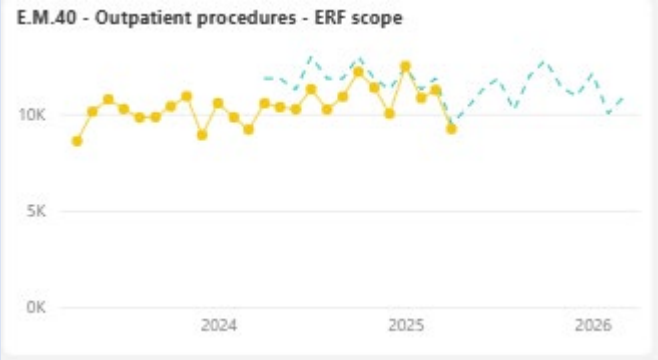
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is above plan +23,217 (16.2%).



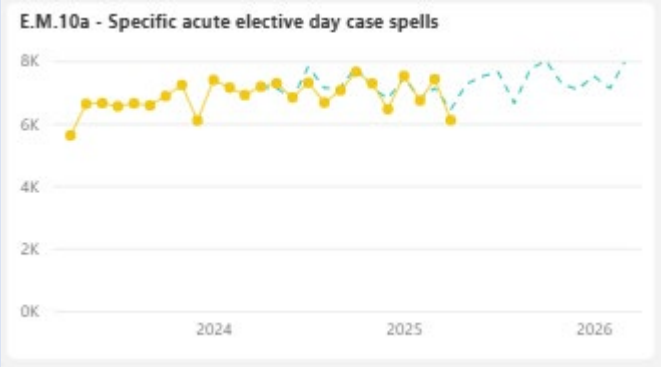
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -254 (-2.7%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



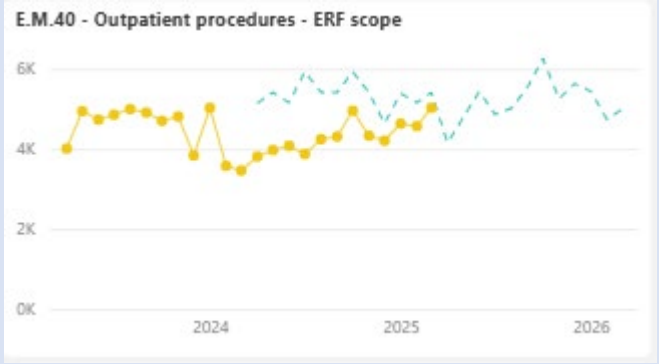
Day Case Admissions vs Plan

YTD Day case elective spells is below plan at -334 (-5.2%).



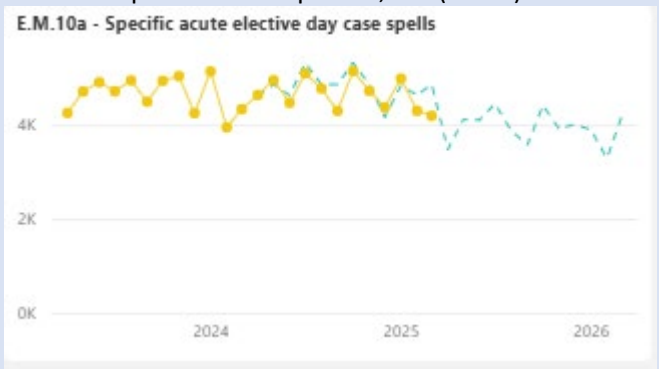
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -12,383 (-19.2%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



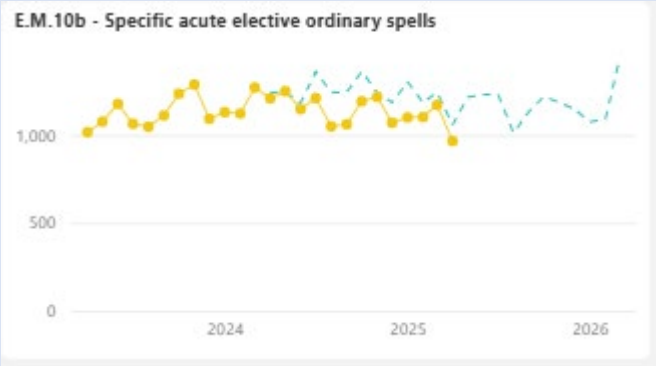
Day Case Admissions vs Plan

YTD Day case elective spells is below plan -1,871 (-3.2%).



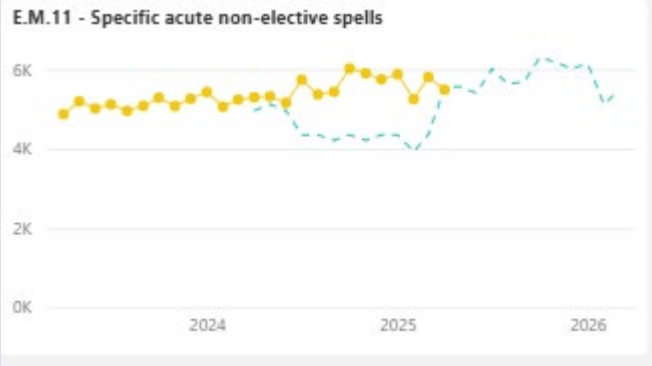
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -92 (-8.7%).



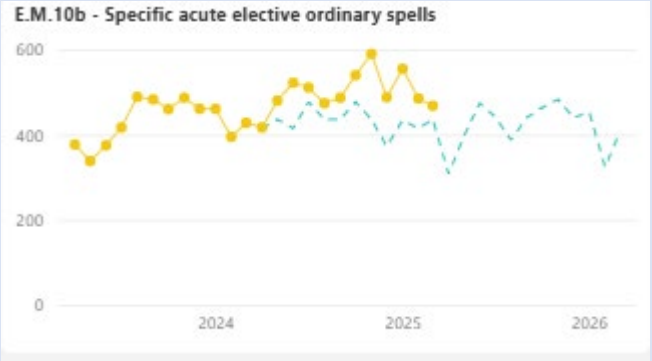
Non-Elective Admissions vs Plan

YTD non-elective spells -54 (-1.0%) under plan.



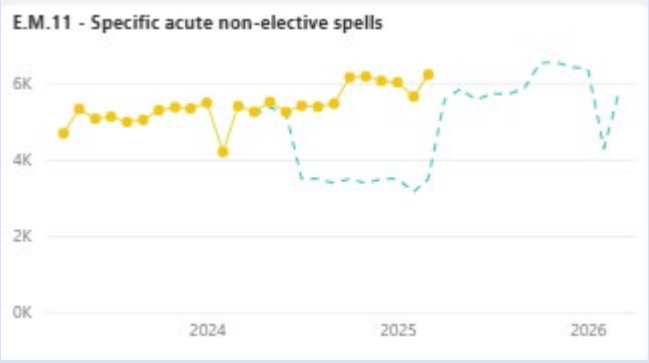
Elective Admissions vs Plan

YTD Inpatient spells is above plan +832 (16.0%), 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 +21,857 (46.9%).



36. Financial Activity Summary - HUTH

Notes
Month 1 financial data not available due to confirming the costed activity plans with commissioners. Costed activity will be available in June.

37. Financial Activity Summary - NLAG

Notes
Month 1 financial data not available due to confirming the costed activity plans with commissioners. Costed activity will be available in June.

Quality Performance Metrics

NHS
Humber Health
Partnership

April 2025

United By Compassion: Driving For Excellence

Highlights and Lowlights

NHS Humber Health Partnership

The IPR is now published following development with the Information Team, building a refreshed reporting tool for the Group. There are some datasets being worked on as DQ issues identified through deployment. Most of the report used BI data from Information Services. A glossary is provided on the last slide.

	HUTH	NLAG
Highlights	• Bacteraemia rates for Pseudomonas and Klebsiella are below trajectory. • The HSMR is improving and the downward trend tracks more recent data than SHMI, with a plateau to 103.5 in January 2025. • Incident reporting rates have increased over time, with improvement in the reporting culture. • HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.1221. This is lower than last month's value of 1.1291.	• There has been a statistically significant improvement with successive reduction in the HSMR over the past fifteen months, now plateaued at 93.1 in January 2025. • NLAG is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0078. This is higher than last month's value of 0.9910. • FFT rates for Inpatient, Maternity and Outpatients remain above the national target • E-coli and MRSA rates are below trajectory

Lowlights	• Duty of candour compliance is lower than target and undergoing a change in process to ensure compliance with Regulation 20. Some care groups have systems in place and are working effectively, while others are developing their processes.
	• For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher-than-expected SHMI for:
	  • Secondary malignancies
	  • Septicaemia
	• VTE data remains below the 95% target overall and at 14 hours from admission.
	• Safety Alert for Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls is overdue
	• NRFIT patient safety Alert is overdue, because of the specific needs for blocks to be included.
	• MRSA bacteraemia rates are over the target for the year with 3 cases in April.
	• Patient complaint rate of completion within timescales remains below target consistently.
		• Duty of candour compliance is lower over the last few months.
		• For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher-than-expected SHMI for:
		  • Septicaemia
		• VTE data remains below the 95% target overall and at 14 hours from admission.
		• NRFIT patient safety Alert is overdue, because of the specific needs for blocks to be included.
		• FFT remains below the target for ED.

Quality IPR dashboard (Safe 1)

Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | EasySPC Spotlight | Data Table | Metadata

Committee: Quality

Metric Group: Complaints | FFT | Infections | Mortality | Safe

Trust | Group

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

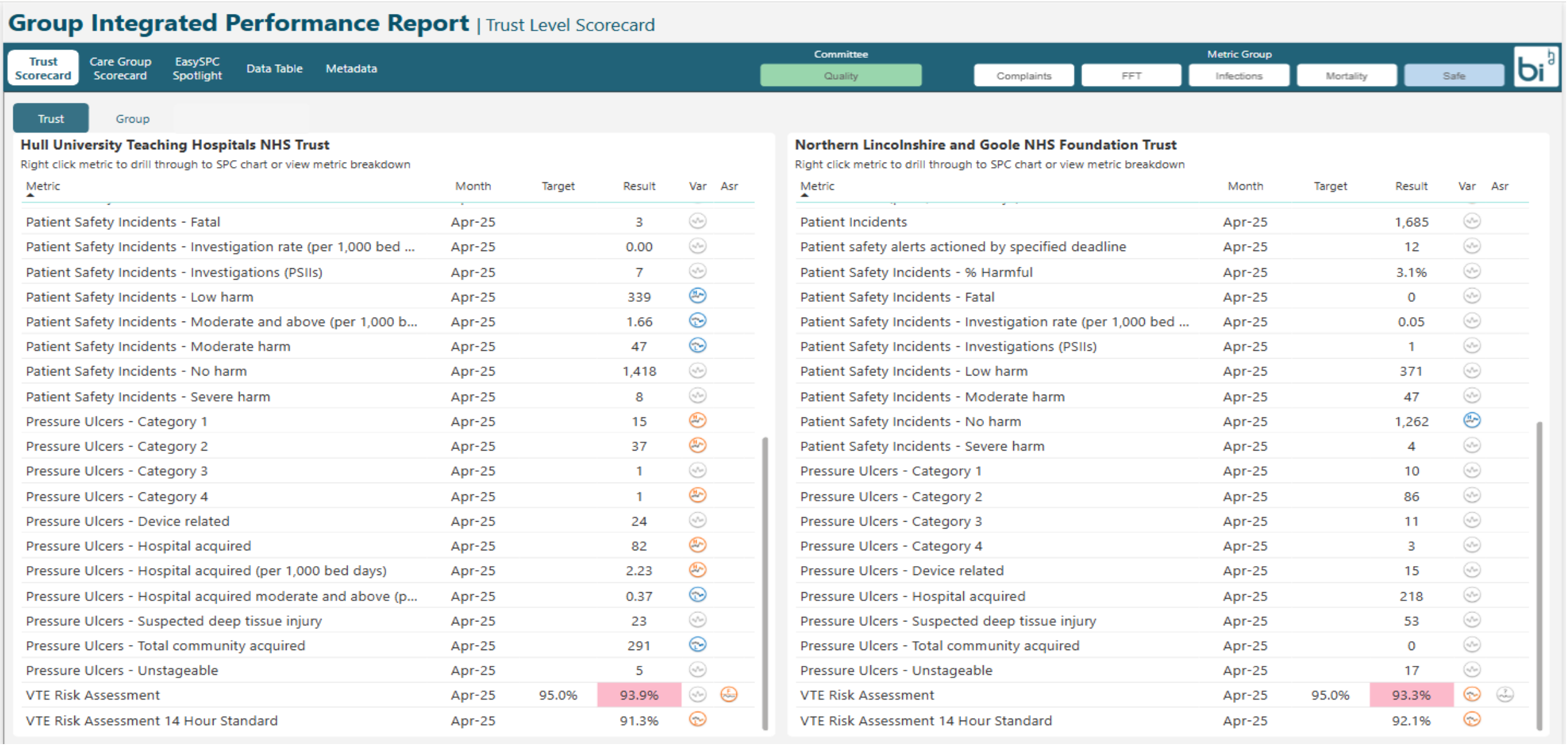
Metric	Month	Target	Result	Var	Asr
Clinical Harm Reviews - Cancer 104 day wait	Apr-25		51		
Clinical Harm Reviews - RTT 78 week wait	Apr-25		2		
Duty of Candour - Verbal apology	Apr-25	100.0%	96.4%		
Duty of Candour - Verbal apology within 10 working days	Apr-25	100.0%	67.9%		
Duty of Candour - Written apology	Mar-25	100.0%	50.0%		
Duty of Candour - Written apology within 10 working days	Mar-25	100.0%	50.0%		
Falls - Moderate and above (per 1,000 bed days)	Apr-25		0.26		
Falls - per 1,000 bed days	Apr-25		8.25		
Falls - Serious harm or death	Apr-25		4		
Falls - Serious harm or death (per 1,000 bed days)	Apr-25		0.12		
Falls - Total incidents	Apr-25		288		
Medication Incidents	Apr-25		110		
Medication Incidents - Moderate harm	Apr-25		4		
Medication Incidents - per 1,000 bed days	Apr-25		3.15		
Medication Incidents - Serious harm	Apr-25		0		
Never Events	Apr-25		2		
Never Events (per 1,000 bed days)	Apr-25		0.06		
Patient Incidents	Apr-25		1,954		
Patient Safety Incidents - % Harmful	Apr-25		3.0%		
Patient Safety Incidents - Fatal	Apr-25		3		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Apr-25		0.00		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Clinical Harm Reviews - Cancer 104 day wait	Apr-25		0		
Duty of Candour - Verbal apology	Jan-25	100.0%	84.1%		
Duty of Candour - Verbal apology within 10 working days	Jan-25	100.0%	79.5%		
Duty of Candour - Written apology	Jan-25	100.0%	84.1%		
Duty of Candour - Written apology within 10 working days	Jan-25	100.0%	70.5%		
Falls - Moderate and above (per 1,000 bed days)	Apr-25		0.10		
Falls - per 1,000 bed days	Apr-25		7.12		
Falls - Serious harm or death	Apr-25		0		
Falls - Serious harm or death (per 1,000 bed days)	Apr-25		0.00		
Falls - Total incidents	Apr-25		142		
Medication Incidents	Apr-25		79		
Medication Incidents - Moderate harm	Apr-25		3		
Medication Incidents - per 1,000 bed days	Apr-25		3.96		
Medication Incidents - Serious harm	Apr-25		1		
Mixed sex accommodation breaches	Mar-25		4		
Never Events	Mar-25		1		
Never Events (per 1,000 bed days)	Mar-25		0.05		
Patient Incidents	Apr-25		1,685		
Patient safety alerts actioned by specified deadline	Apr-25		12		
Patient Safety Incidents - % Harmful	Apr-25		3.1%		
Patient Safety Incidents - Fatal	Apr-25		0		

Quality IPR dashboard (Safe 2)



Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | EasySPC Spotlight | Data Table | Metadata

Committee: Quality

Metric Group: Complaints | FFT | Infections | Mortality | Safe

Trust | Group

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

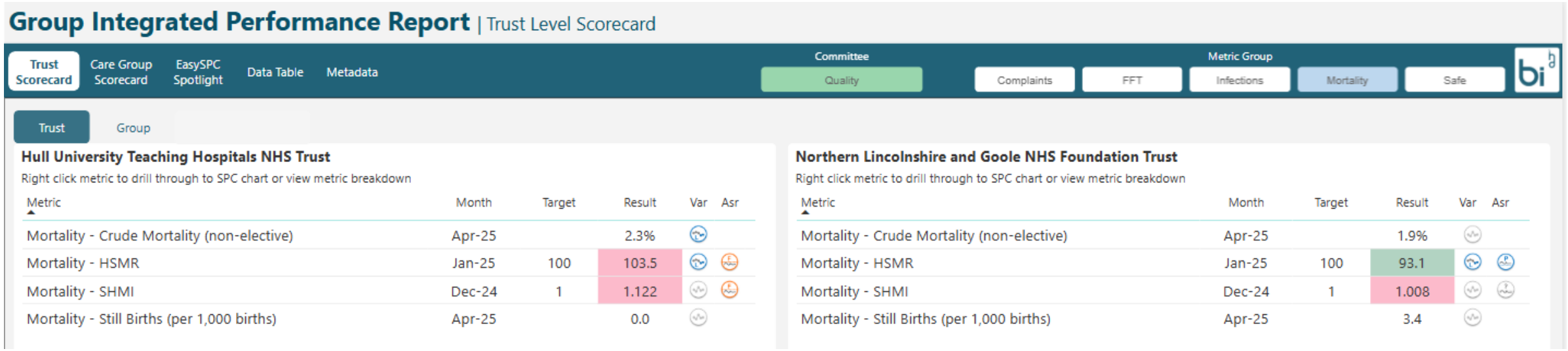
Metric	Month	Target	Result	Var	Asr
Patient Safety Incidents - Fatal	Apr-25		3		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Apr-25		0.00		
Patient Safety Incidents - Investigations (PSIIs)	Apr-25		7		
Patient Safety Incidents - Low harm	Apr-25		339		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Apr-25		1.66		
Patient Safety Incidents - Moderate harm	Apr-25		47		
Patient Safety Incidents - No harm	Apr-25		1,418		
Patient Safety Incidents - Severe harm	Apr-25		8		
Pressure Ulcers - Category 1	Apr-25		15		
Pressure Ulcers - Category 2	Apr-25		37		
Pressure Ulcers - Category 3	Apr-25		1		
Pressure Ulcers - Category 4	Apr-25		1		
Pressure Ulcers - Device related	Apr-25		24		
Pressure Ulcers - Hospital acquired	Apr-25		82		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Apr-25		2.23		
Pressure Ulcers - Hospital acquired moderate and above (p...	Apr-25		0.37		
Pressure Ulcers - Suspected deep tissue injury	Apr-25		23		
Pressure Ulcers - Total community acquired	Apr-25		291		
Pressure Ulcers - Unstageable	Apr-25		5		
VTE Risk Assessment	Apr-25	95.0%	93.9%		
VTE Risk Assessment 14 Hour Standard	Apr-25		91.3%		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Patient Incidents	Apr-25		1,685		
Patient safety alerts actioned by specified deadline	Apr-25		12		
Patient Safety Incidents - % Harmful	Apr-25		3.1%		
Patient Safety Incidents - Fatal	Apr-25		0		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Apr-25		0.05		
Patient Safety Incidents - Investigations (PSIIs)	Apr-25		1		
Patient Safety Incidents - Low harm	Apr-25		371		
Patient Safety Incidents - Moderate harm	Apr-25		47		
Patient Safety Incidents - No harm	Apr-25		1,262		
Patient Safety Incidents - Severe harm	Apr-25		4		
Pressure Ulcers - Category 1	Apr-25		10		
Pressure Ulcers - Category 2	Apr-25		86		
Pressure Ulcers - Category 3	Apr-25		11		
Pressure Ulcers - Category 4	Apr-25		3		
Pressure Ulcers - Device related	Apr-25		15		
Pressure Ulcers - Hospital acquired	Apr-25		218		
Pressure Ulcers - Suspected deep tissue injury	Apr-25		53		
Pressure Ulcers - Total community acquired	Apr-25		0		
Pressure Ulcers - Unstageable	Apr-25		17		
VTE Risk Assessment	Apr-25	95.0%	93.3%		
VTE Risk Assessment 14 Hour Standard	Apr-25		92.1%		

Quality IPR dashboard (Mortality)



Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | EasySPC Spotlight | Data Table | Metadata

Committee: Quality

Metric Group: Complaints | FFT | Infections | Mortality | Safe

Trust | Group

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

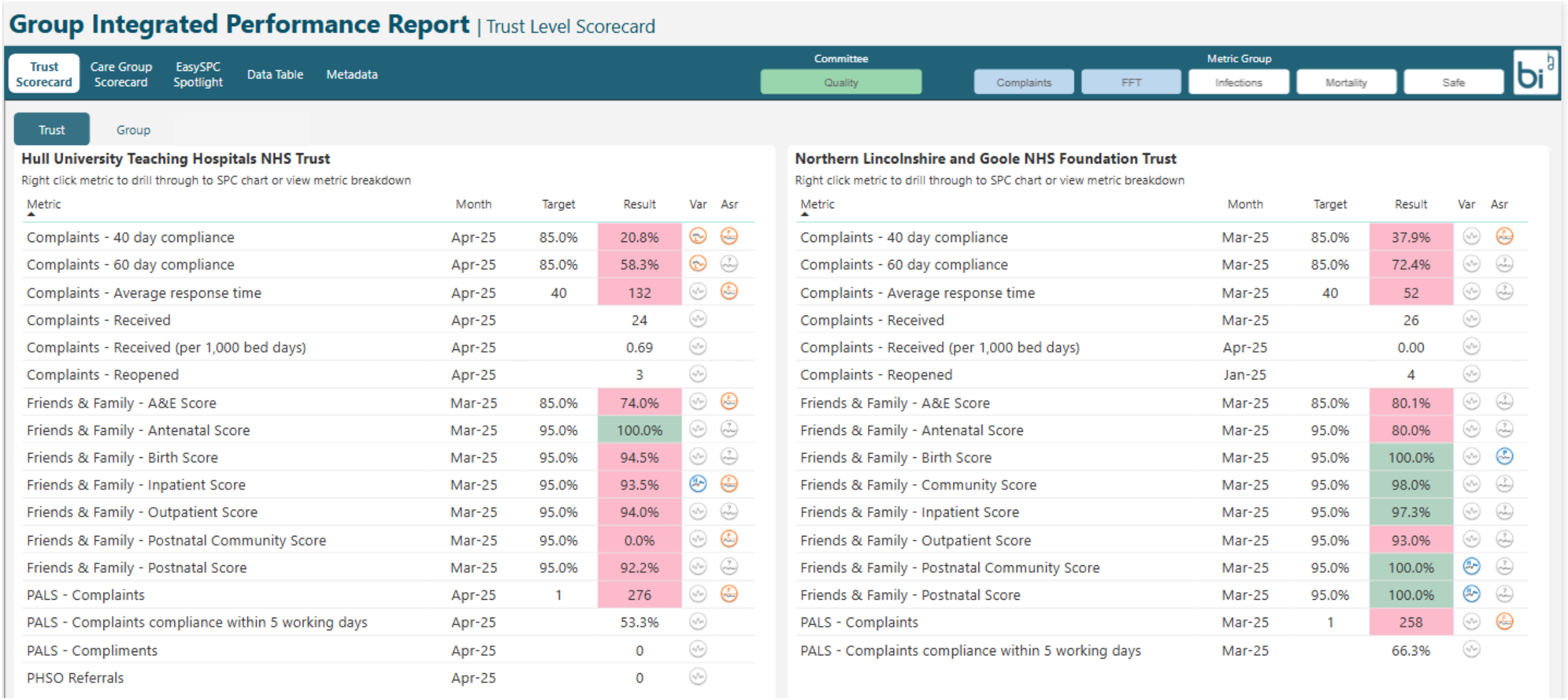
Metric	Month	Target	Result	Var	Asr
Mortality - Crude Mortality (non-elective)	Apr-25		2.3%		
Mortality - HSMR	Jan-25	100	103.5		
Mortality - SHMI	Dec-24	1	1.122		
Mortality - Still Births (per 1,000 births)	Apr-25		0.0		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Mortality - Crude Mortality (non-elective)	Apr-25		1.9%		
Mortality - HSMR	Jan-25	100	93.1		
Mortality - SHMI	Dec-24	1	1.008		
Mortality - Still Births (per 1,000 births)	Apr-25		3.4		

Quality IPR dashboard (Patient Experience)



Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | EasySPC Spotlight | Data Table | Metadata

Committee: Quality

Metric Group: Complaints | FFT | Infections | Mortality | Safe

Trust | Group

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

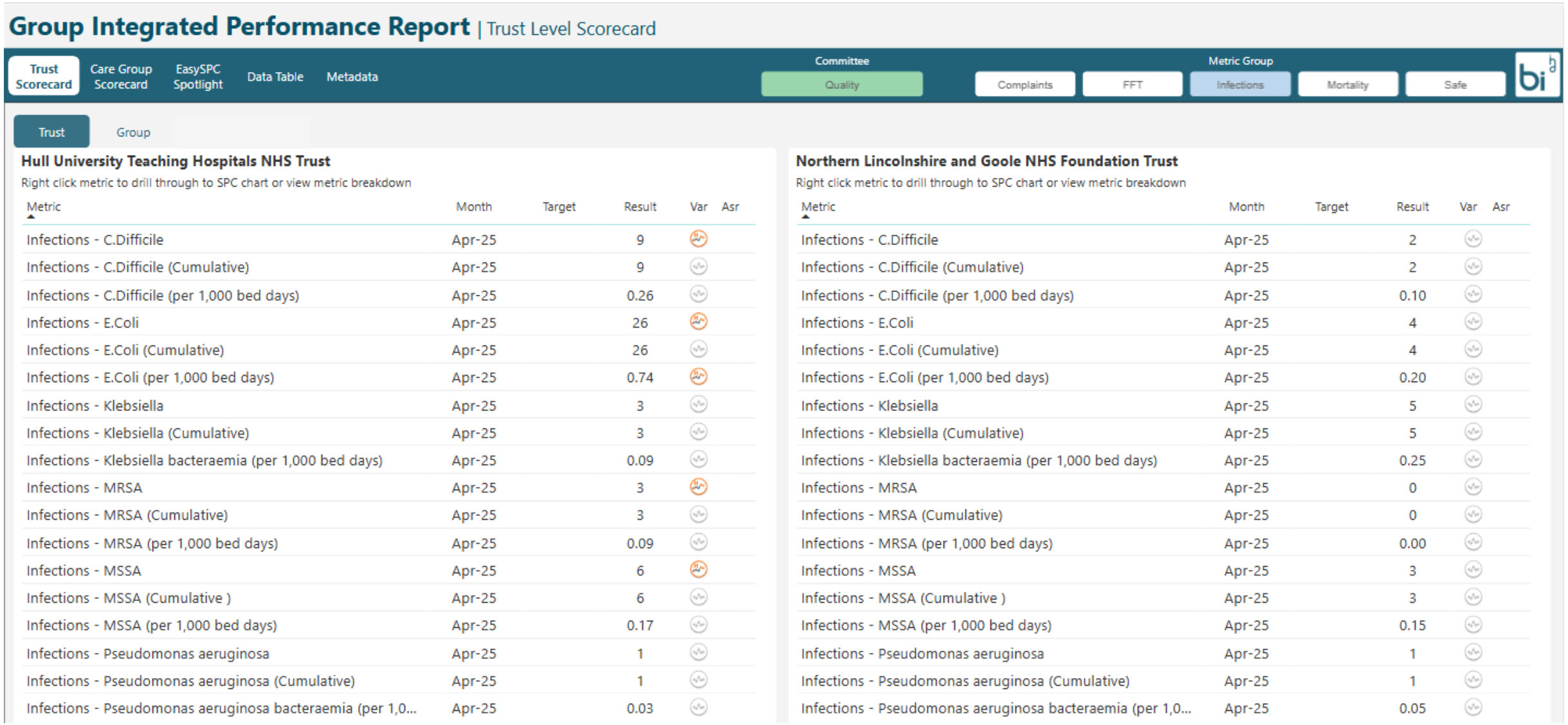
Metric	Month	Target	Result	Var	Asr
Complaints - 40 day compliance	Apr-25	85.0%	20.8%		
Complaints - 60 day compliance	Apr-25	85.0%	58.3%		
Complaints - Average response time	Apr-25	40	132		
Complaints - Received	Apr-25		24		
Complaints - Received (per 1,000 bed days)	Apr-25		0.69		
Complaints - Reopened	Apr-25		3		
Friends & Family - A&E Score	Mar-25	85.0%	74.0%		
Friends & Family - Antenatal Score	Mar-25	95.0%	100.0%		
Friends & Family - Birth Score	Mar-25	95.0%	94.5%		
Friends & Family - Inpatient Score	Mar-25	95.0%	93.5%		
Friends & Family - Outpatient Score	Mar-25	95.0%	94.0%		
Friends & Family - Postnatal Community Score	Mar-25	95.0%	0.0%		
Friends & Family - Postnatal Score	Mar-25	95.0%	92.2%		
PALS - Complaints	Apr-25	1	276		
PALS - Complaints compliance within 5 working days	Apr-25		53.3%		
PALS - Compliments	Apr-25		0		
PHSO Referrals	Apr-25		0		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Complaints - 40 day compliance	Mar-25	85.0%	37.9%		
Complaints - 60 day compliance	Mar-25	85.0%	72.4%		
Complaints - Average response time	Mar-25	40	52		
Complaints - Received	Mar-25		26		
Complaints - Received (per 1,000 bed days)	Apr-25		0.00		
Complaints - Reopened	Jan-25		4		
Friends & Family - A&E Score	Mar-25	85.0%	80.1%		
Friends & Family - Antenatal Score	Mar-25	95.0%	80.0%		
Friends & Family - Birth Score	Mar-25	95.0%	100.0%		
Friends & Family - Community Score	Mar-25	95.0%	98.0%		
Friends & Family - Inpatient Score	Mar-25	95.0%	97.3%		
Friends & Family - Outpatient Score	Mar-25	95.0%	93.0%		
Friends & Family - Postnatal Community Score	Mar-25	95.0%	100.0%		
Friends & Family - Postnatal Score	Mar-25	95.0%	100.0%		
PALS - Complaints	Mar-25	1	258		
PALS - Complaints compliance within 5 working days	Mar-25		66.3%		

Quality IPR dashboard (Infection Prevention)



Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | EasySPC Spotlight | Data Table | Metadata

Committee: Quality

Metric Group: Complaints | FFT | Infections | Mortality | Safe

Trust | Group

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Infections - C.Difficile	Apr-25		9		
Infections - C.Difficile (Cumulative)	Apr-25		9		
Infections - C.Difficile (per 1,000 bed days)	Apr-25		0.26		
Infections - E.Coli	Apr-25		26		
Infections - E.Coli (Cumulative)	Apr-25		26		
Infections - E.Coli (per 1,000 bed days)	Apr-25		0.74		
Infections - Klebsiella	Apr-25		3		
Infections - Klebsiella (Cumulative)	Apr-25		3		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Apr-25		0.09		
Infections - MRSA	Apr-25		3		
Infections - MRSA (Cumulative)	Apr-25		3		
Infections - MRSA (per 1,000 bed days)	Apr-25		0.09		
Infections - MSSA	Apr-25		6		
Infections - MSSA (Cumulative)	Apr-25		6		
Infections - MSSA (per 1,000 bed days)	Apr-25		0.17		
Infections - Pseudomonas aeruginosa	Apr-25		1		
Infections - Pseudomonas aeruginosa (Cumulative)	Apr-25		1		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Apr-25		0.03		

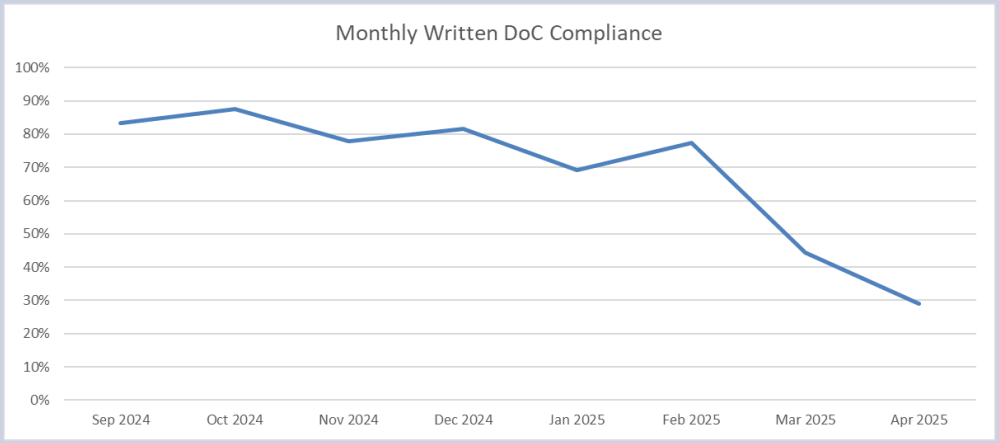
Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Infections - C.Difficile	Apr-25		2		
Infections - C.Difficile (Cumulative)	Apr-25		2		
Infections - C.Difficile (per 1,000 bed days)	Apr-25		0.10		
Infections - E.Coli	Apr-25		4		
Infections - E.Coli (Cumulative)	Apr-25		4		
Infections - E.Coli (per 1,000 bed days)	Apr-25		0.20		
Infections - Klebsiella	Apr-25		5		
Infections - Klebsiella (Cumulative)	Apr-25		5		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Apr-25		0.25		
Infections - MRSA	Apr-25		0		
Infections - MRSA (Cumulative)	Apr-25		0		
Infections - MRSA (per 1,000 bed days)	Apr-25		0.00		
Infections - MSSA	Apr-25		3		
Infections - MSSA (Cumulative)	Apr-25		3		
Infections - MSSA (per 1,000 bed days)	Apr-25		0.15		
Infections - Pseudomonas aeruginosa	Apr-25		1		
Infections - Pseudomonas aeruginosa (Cumulative)	Apr-25		1		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Apr-25		0.05		

Duty of Candour

HUTH



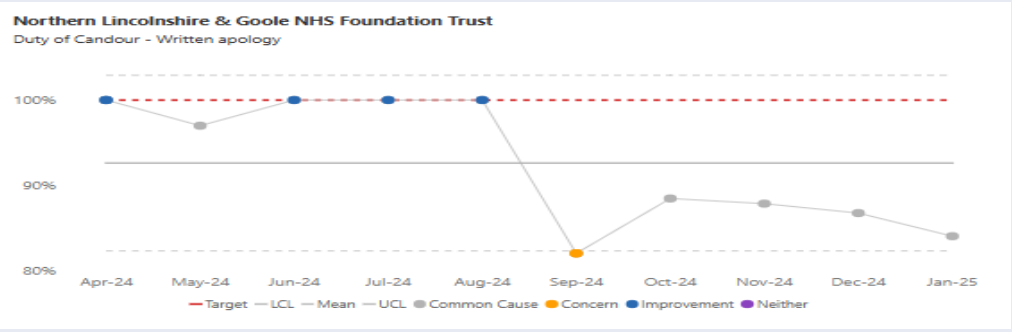
Key themes

The rate of completion for Written Duty of Candour is below compliance rate required to meet the regulations, however some care groups have been able to achieve compliance more consistently. The impact of this has improved the overall compliance rate in January and February, with some lag effect remaining for Marchand April, beyond the initial 10 days following the date the incident was reported.

HUTH specific actions taken to improve:

- Datix dashboard available and weekly reporting continues.

NLAG



NLAG Overall Performance

Month	No. Incidents DoC required in month	DoC completed	within 10 working days
Jan-25	44	36 (82%)	31 (70%)
Feb-25	81	52 (64%)	37 (45%)
Mar-25	30	21 (70%)	17 (56%)

Key themes

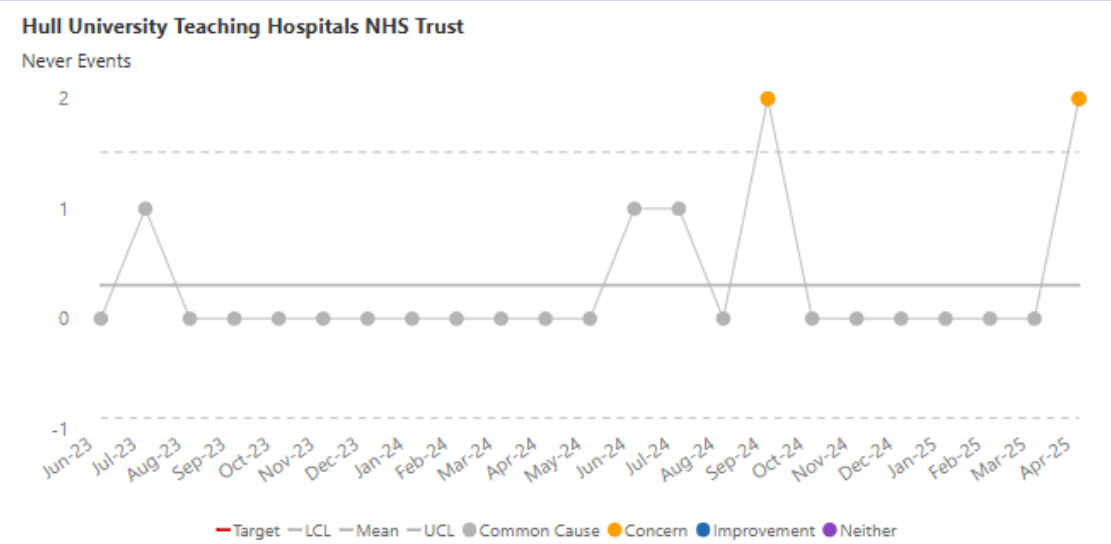
- 100% compliance of cases where there is a PSII or central team supported proportional learning response.
- The data is not being fed through to the BI report at this time, awaiting data refresh, so table of Q4 data provided.

Group Actions being taken to improve:

- Care Group weekly performance reporting through the weekly monitoring report
- Sharing of good practice.
- Further training for teams that require support.
- National Guidance document being discussed at PSLG.
- Policy for group anticipated relaunch in June 2025.

Never Events

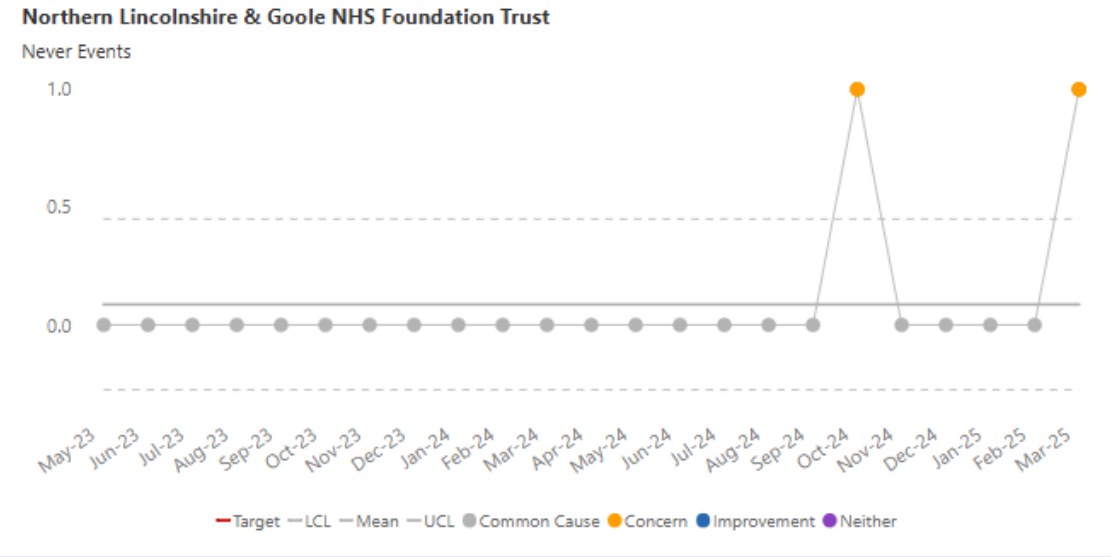
HUTH



Key themes

- There were 2 Never Events declared in April and another in May.
  - Interventional radiology retained cover from device, not removed prior to use and not recognised as being lost.
  - OPD dermatology mole removal, wrong site, patient was consented and marked but deviated from intended mole removal on their back.
  - Retained swab following abdominal surgery, returned with sepsis presentation and found on CT scan.
- The Trust has reported 7 Never Events in the rolling 12 months.

NLAG



Key themes

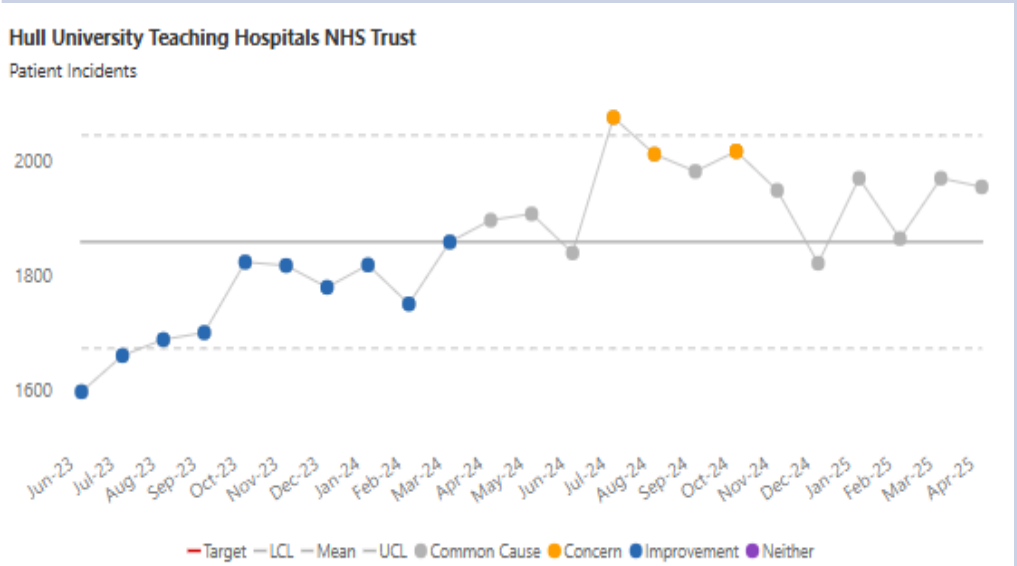
- The Trust last Never Event was in April 2025, with a retained stylet used with a specific type of two-lumen central line used for haemofiltration. No harm caused but recognised prior to use through checks to flush the line.
- Previous case was from October 2024. Retained Guidewire following CVP Line insertion. No harm identified, with thorough clinical review and assessment. Investigation underway as PSII. Following review with the service and Deputy CMO undertaken to assess immediate actions and risk.

Group wide actions

- Set up of a Safer Surgery and Interventions Group, to focus on the practices in place across interventional procedures in and outside the operating theatre.
- Introduction of a compliant NatSSips2 checklist in critical care and theatres for central line insertion.

Patient Safety Incident (PSI) reporting

HUTH

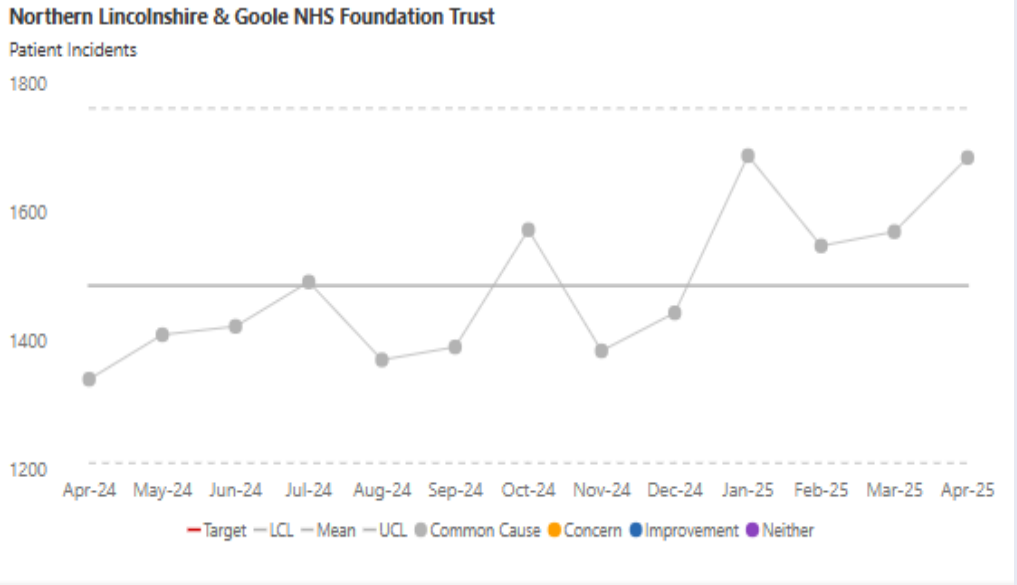


Key themes

- The rate of patient safety incident reporting has risen over time, following the CQC report publication, action planning that followed and subsequent developments of the group arrangement. If this is sustained, we will apply a step change for the control limits reflecting the change observed.
- Reporting incidents, including no harm and near misses is a property of the safety culture and so the intent is to continue promoting incident reporting.
- Benchmarking data is limited currently due to NRLS changes to LFPSE and the transition period, but is now in the pipeline from national team updates for coming months.

The quarterly report for patient safety incidents provides further analysis.

NLAG



Key themes

- The rate of reporting remains within the control limits on the chart, with a gradual rise seen since January 2025.
- The quarterly report for patient safety incidents provides further analysis.

Patient Safety Alerts

HUTH

Key themes
BI dashboard in development

Overdue – 2 alerts:

- Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts. The ICB have stood down their working group and issued a letter advising on the locally agreed approach. HUTH/ NLAG meeting monthly to progress.
    - Policy work is positioned to take forward with input from Paediatric and Maternity teams to complete and enable implementation across the Trust.
- Transition to NRFit™ connectors for intrathecal and epidural procedures, and delivery of regional blocks (due 31/1/2025) – Mainly compliant, but local anaesthesia use in ED needs clarification and advice sought from national teams, including RCEM. Confirmation received from National team that risk assessment to be completed if not using NRFit needle for all regional block procedures.

Completed since the last report– 1 alert
Discontinuation fo Promixin nebulisers

NLAG

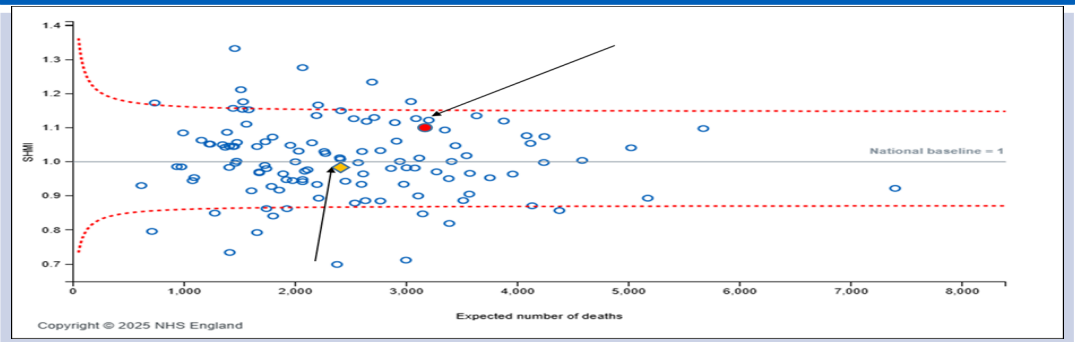
Key themes
BI dashboard in development

Overdue – 1 alerts:
Transition to NRFit™ connectors for intrathecal and epidural procedures, and delivery of regional blocks (due 31/1/2025) – Mainly compliant, but local anaesthesia use in ED needs clarification and advice sought from national teams, including RCEM. Confirmation received from National team that risk assessment to be completed if not using NRFit needle for all regional block procedures.

Completed since the last report– 1 alert
Discontinuation fo Promixin nebulisers

Mortality - SHMI

Benchmark

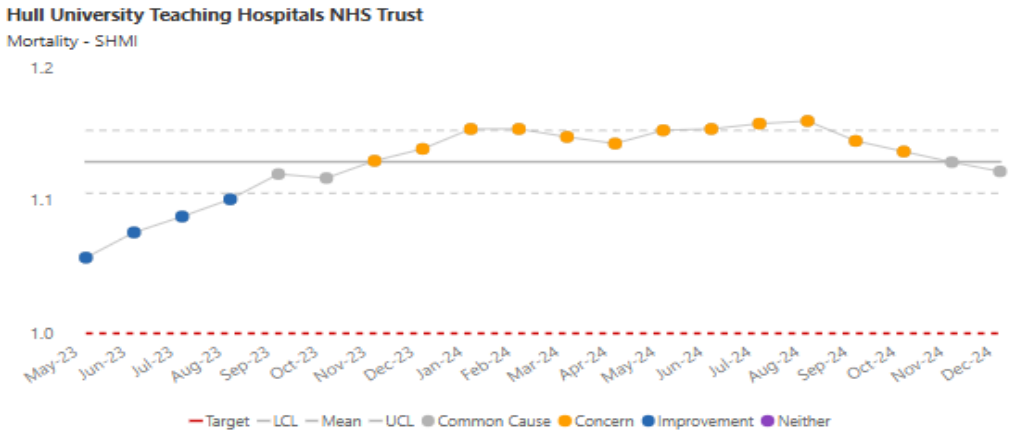


SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings.

The latest SHMI values for each site are:

- Castle Hill – 1.2000; 'higher than expected' (previously 1.2350 and 'higher than expected')
- Hull – 1.0981; 'as expected' (previously 1.0965 and 'as expected')
- Grimsby – 0.9713; 'as expected' (previously 0.9458 and 'as expected')
- Scunthorpe – 1.0409; 'as expected' (previously 1.0294 and 'as expected')
- Goole – insufficient activity for SHMI to be calculated

HUTH



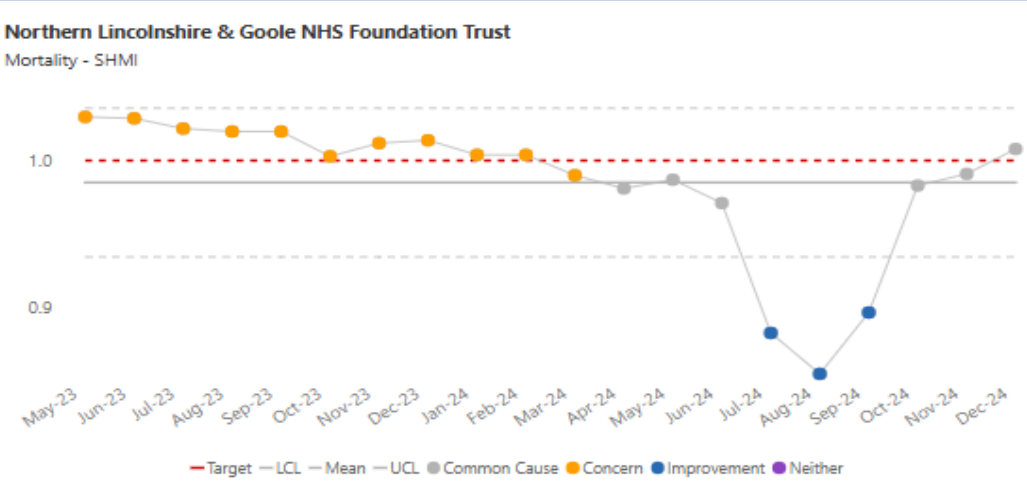
Key themes

HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.1221. This is lower than last month's value of 1.1291.

For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher than expected SHMI for:

- Secondary malignancies
- Septicaemia

NLAG



Key themes

NLAG is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0078. This is higher than last month's value of 0.9910.

For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher than expected SHMI for:

- Septicaemia

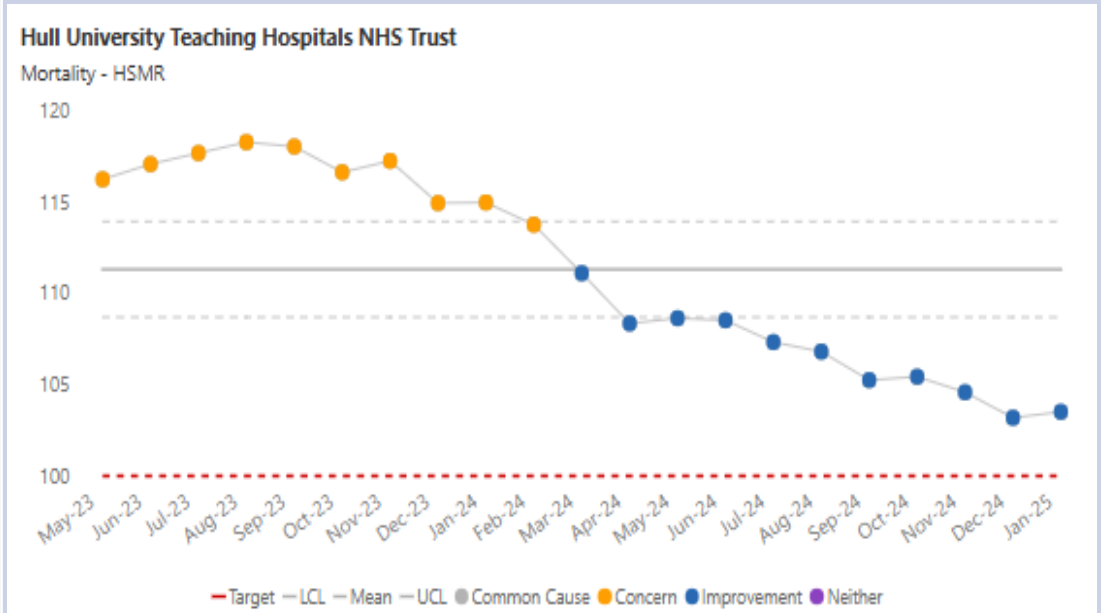
NLAG has a data issue shown in July-September 2024, which will be rectified in a few months time once processed by NHS Digital.

Actions being taken to improve across the Group:

- Septicaemia is a Quality priority for the Group and remains an area of focus through the Mortality Improvement Group.
- Mortality Improvement Group workplan and oversight of workstreams to investigate causes of concern in the data.
- Learning from deaths reporting arrangements each quarter.

Mortality - HSMR

HUTH

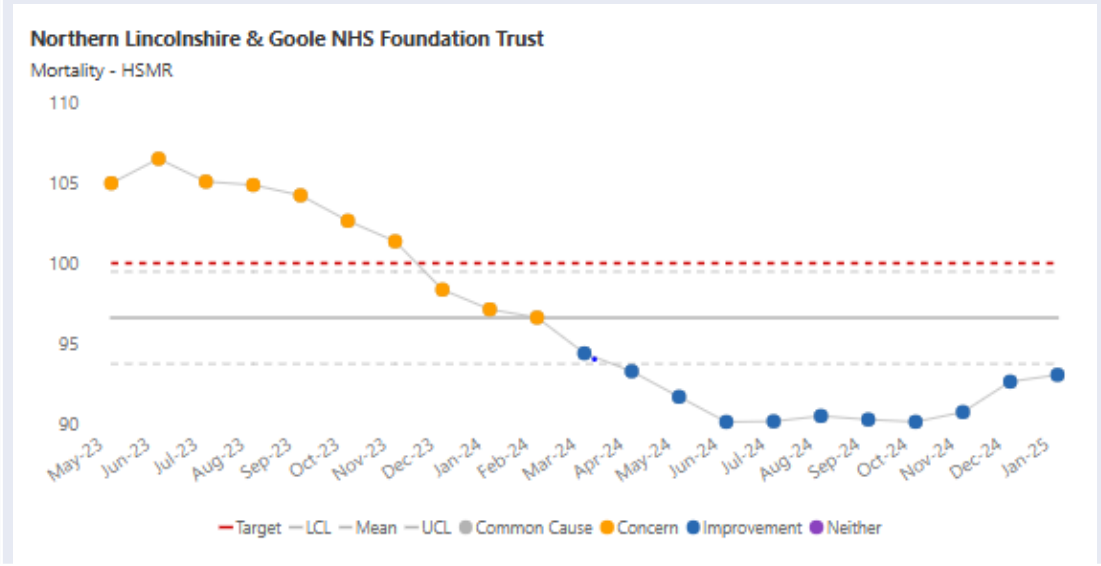


HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death. The Blue line represent the Trust and yellow line represent the peer group.

Key themes

The HSMR is improving and the downward trend tracks more recent data than SHMI, with a plateau to 103.5 in January 2025.

NLAG



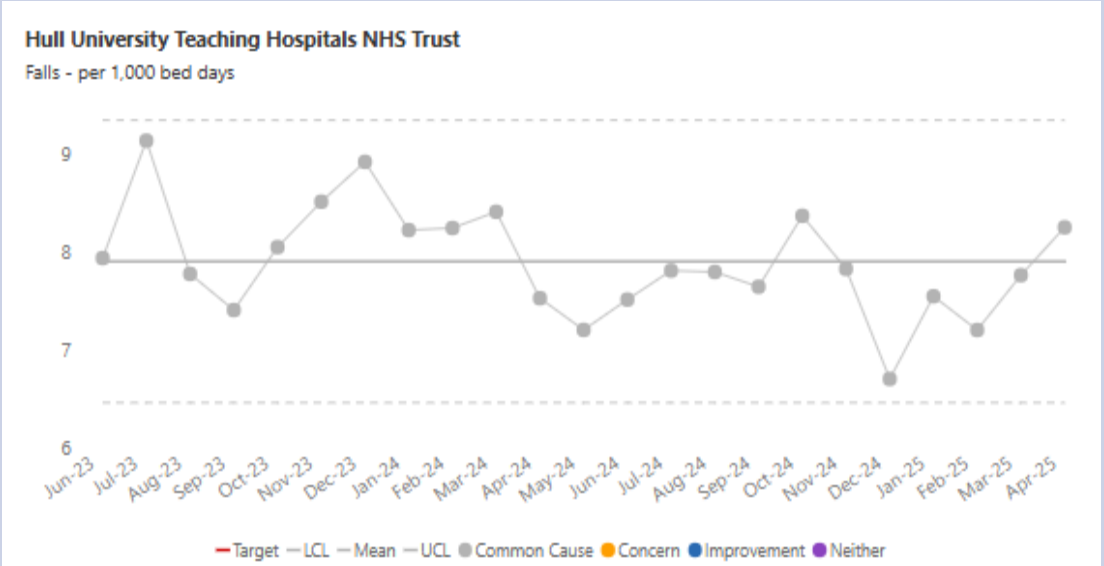
Key themes

There has been a statistically significant improvement with successive reduction in the HSMR over the past fifteen months, now plateaued at 93.1 in January 2025.

Actions are included in the same way for the SHMI description, and HSMR is used as part of the analysis of the mortality data, recognising a different methodology and risk adjustment is applied.

Falls

HUTH

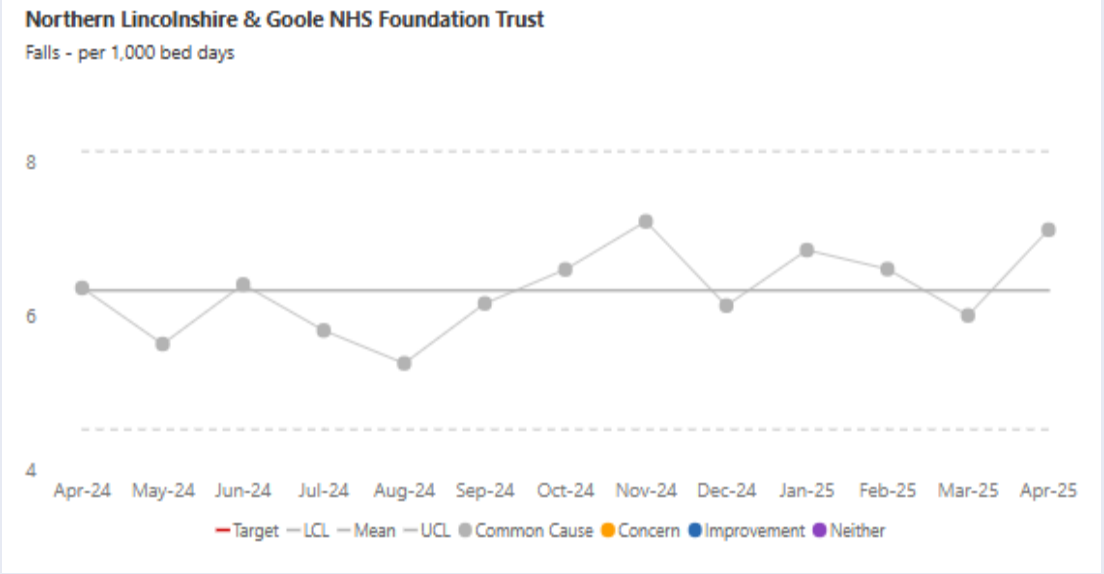


Key themes

HUTH – The Falls Improvement Programme has been successful in driving a reduction in the number of falls across the Trust, through the appointment of key leads, focus on risk assessments and environment and learning from incidents.

There is common cause variation in the rate of falls per 1000 bed days.

NLAG



Key themes

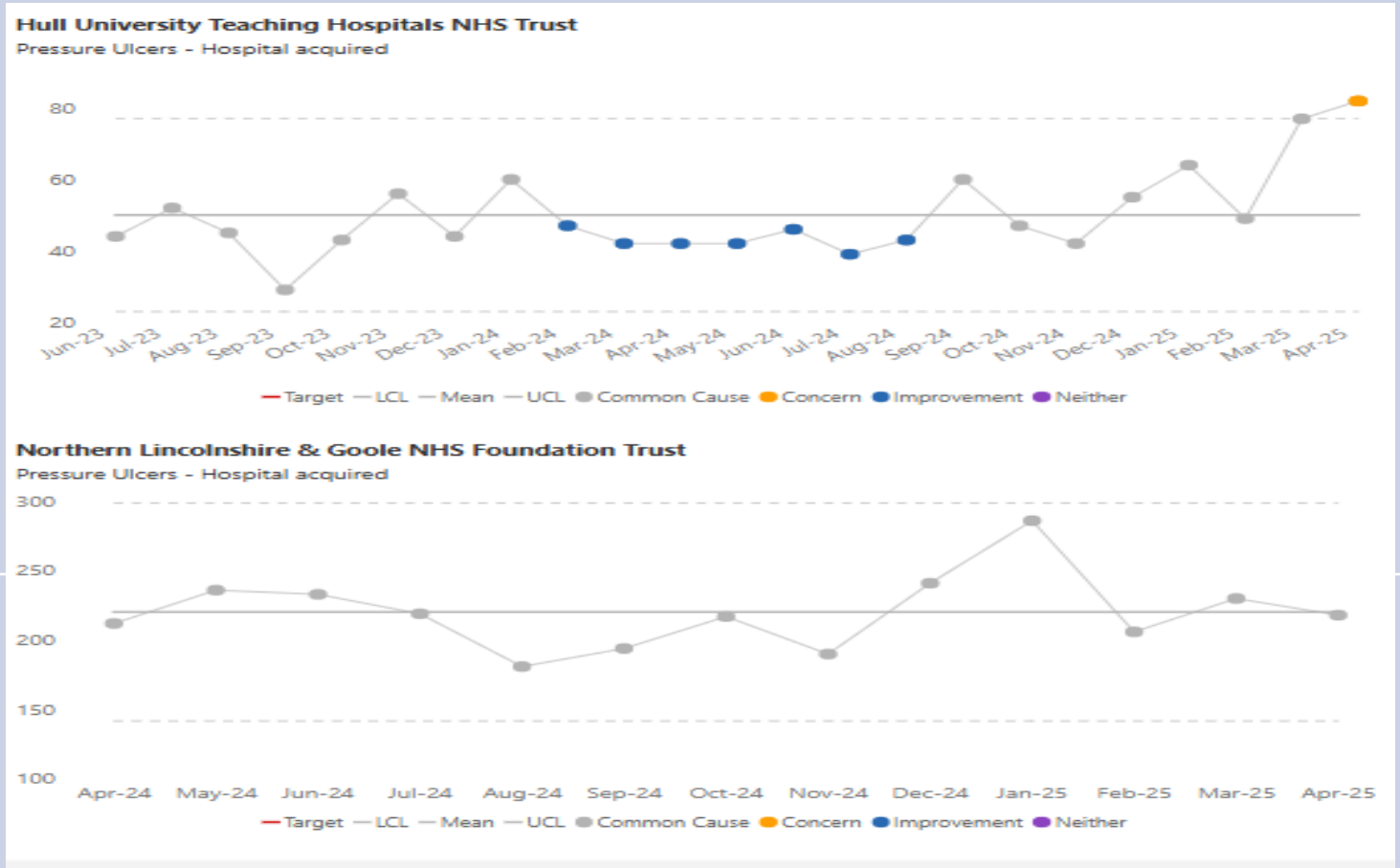
NLAG Falls rate data shows common cause variation.

Actions being taken to improve across the Group:

- A strategic action plan has been in place in NLAG and is being reviewed for the group context.
- Falls team review all repeated fall cases.
- Weekly review of all falls incidents
- Escalation of concerns, including fatal outcomes are reported to the Weekly Learning Response Panel

Pressure Ulcers

HUTH



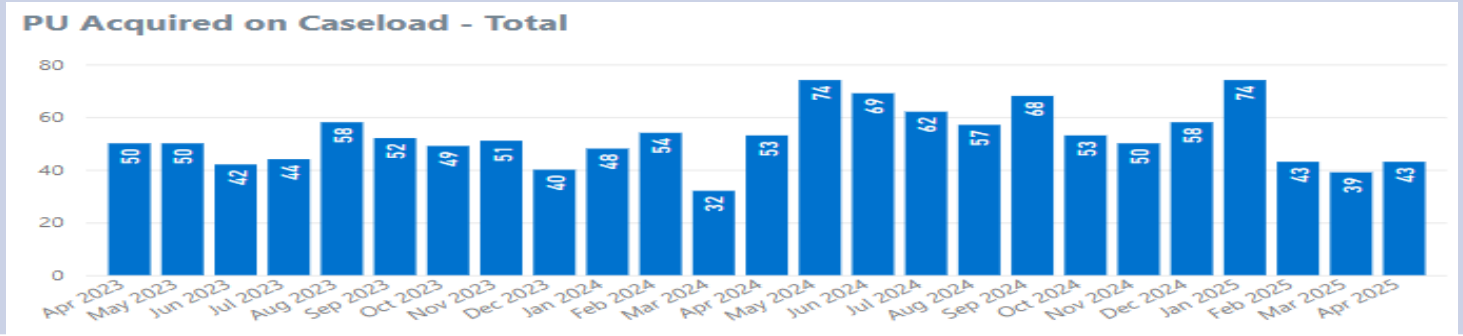
Key themes

- There is an increase in the rate of hospital acquired pressure ulcers for April 2025. This appears to reduce through validation based on similar patterns in previous months.

Actions being taken to improve across the Group:

- Groupwide Pressure Ulcer Group has been established
- Strategic Action Plan is in development
- Weekly Pressure Ulcer Incident review process.

NLAG



Key themes

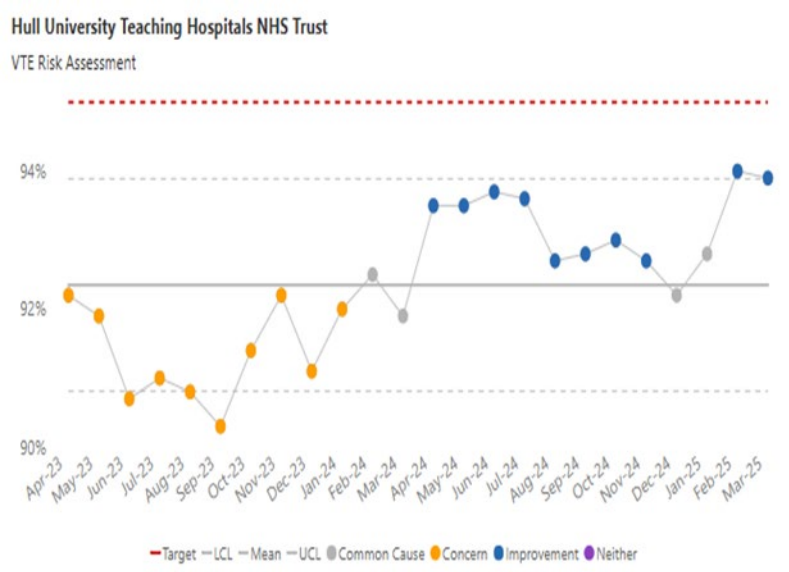
- The NLAG BI report data is provided, inclusive of inhospital and on caseload for community.
- NLAG Hospital acquired pressure ulcer rate appears static.
- North Lincolnshire Community - The bar chart illustrates the data, with some variation and a reduction since February 2025.

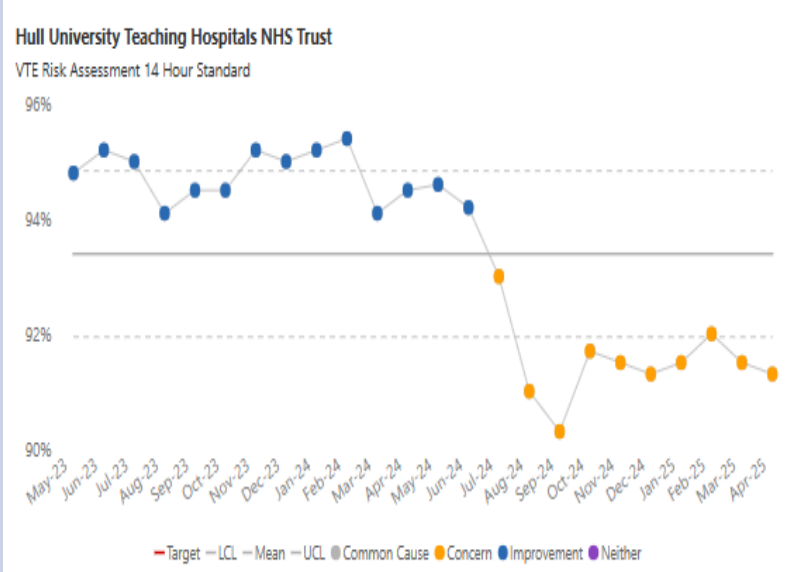
NLAG Community actions

- NL Community team have a weekly pressure ulcer group to review and monitor incidents.

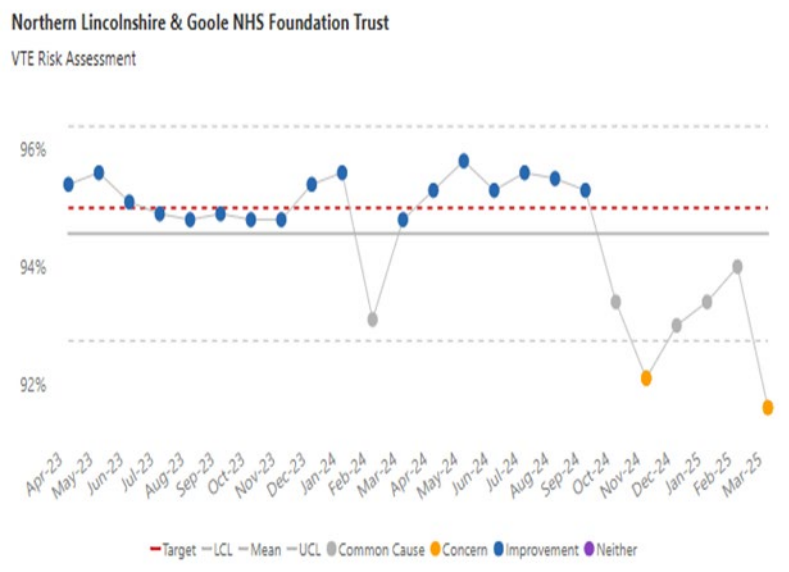
VTE Risk assessment rate

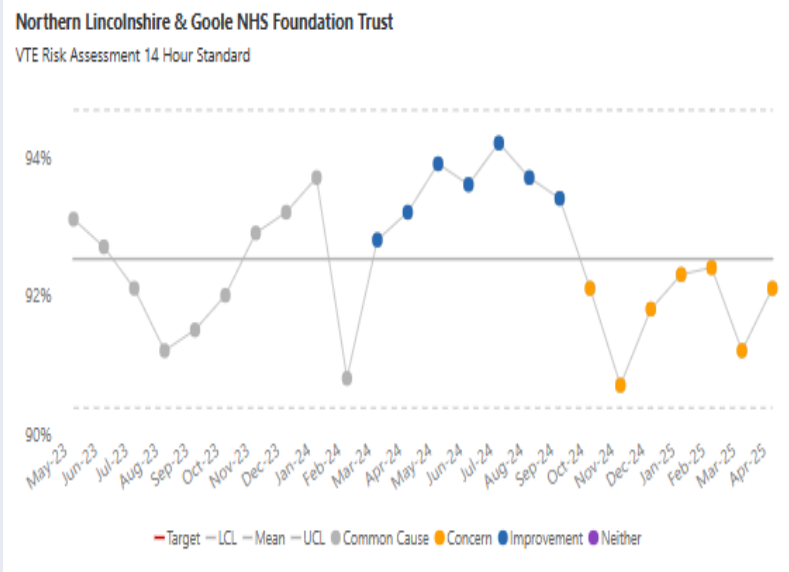
HUTH





NLAG





Key themes

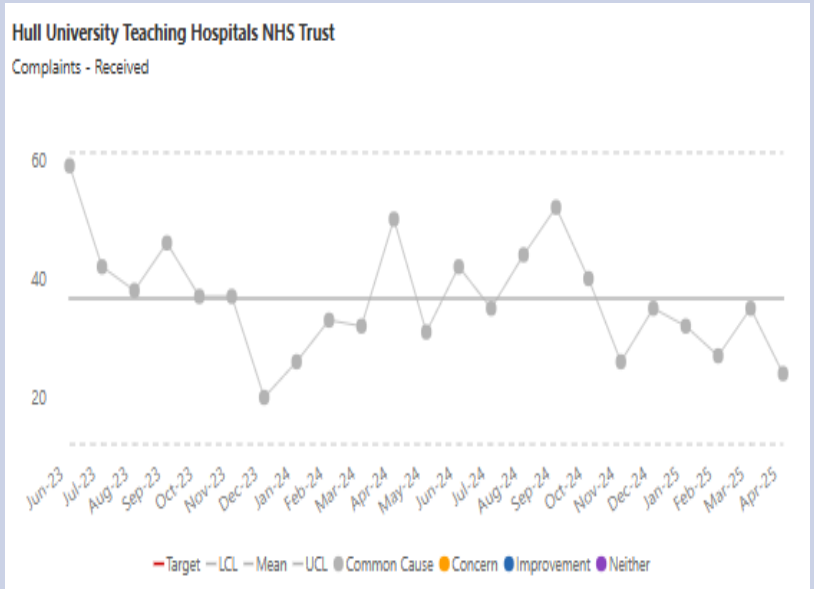
- VTE risk assessment compliance has been measured historically, which is the chart to the left, but is within one day of admission.
- With the renewal of the quarterly national data submissions in 2024, the guidance is clear that providers should submit data reflecting the percentage of assessments completed within 14 hours of admission, recognising this is the specified time to start pharmacological thromboprophylaxis should the assessment reflect this. This is illustrated on the charts to the right.
- Both NLAG and HUTH data demonstrate that the 95% target is not achieved for these measures.

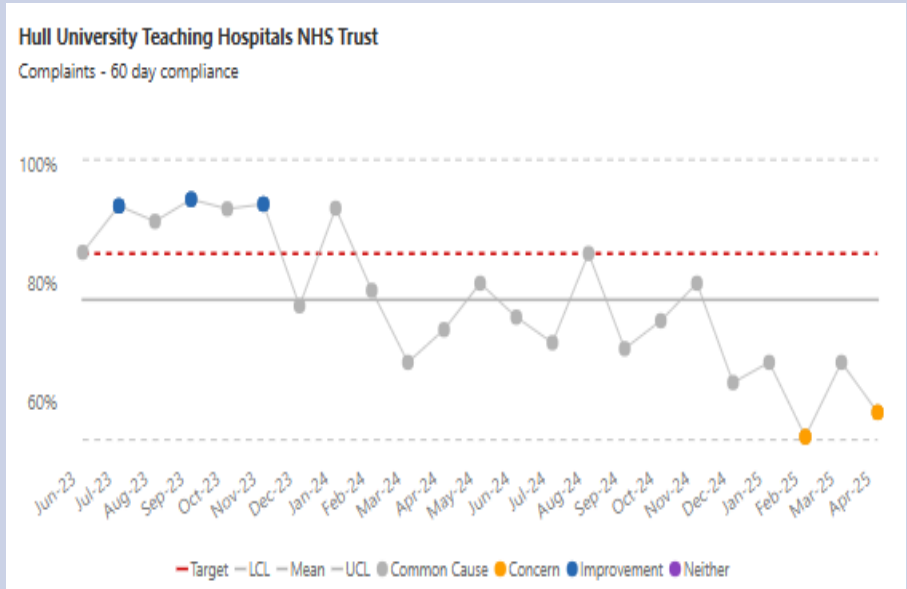
Actions being taken to improve:

- Care Group data is available to provide focus on the relevant teams to address their performance and will be used in the Performance Review meetings and at the Patient Safety and Learning Group as part of Care Group Highlight reports.

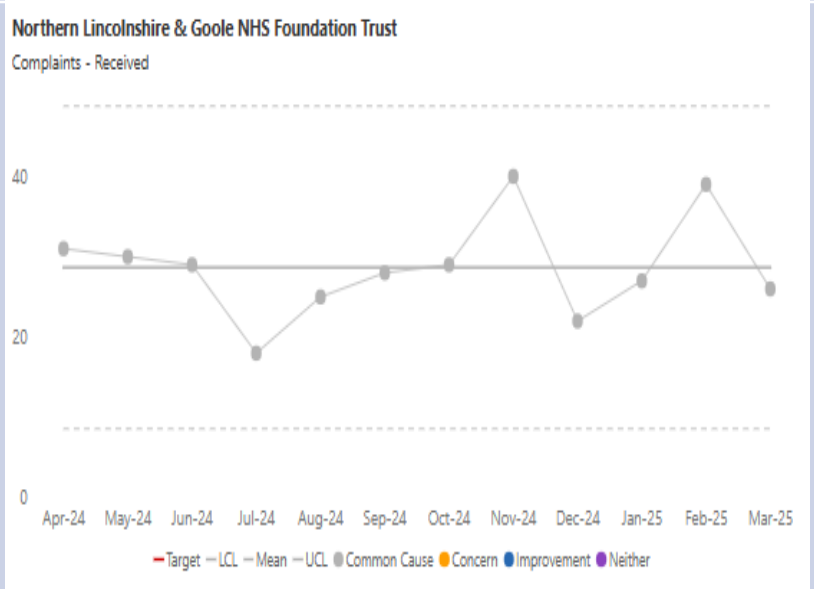
Patient Experience: Complaints – received and compliance with KPIs

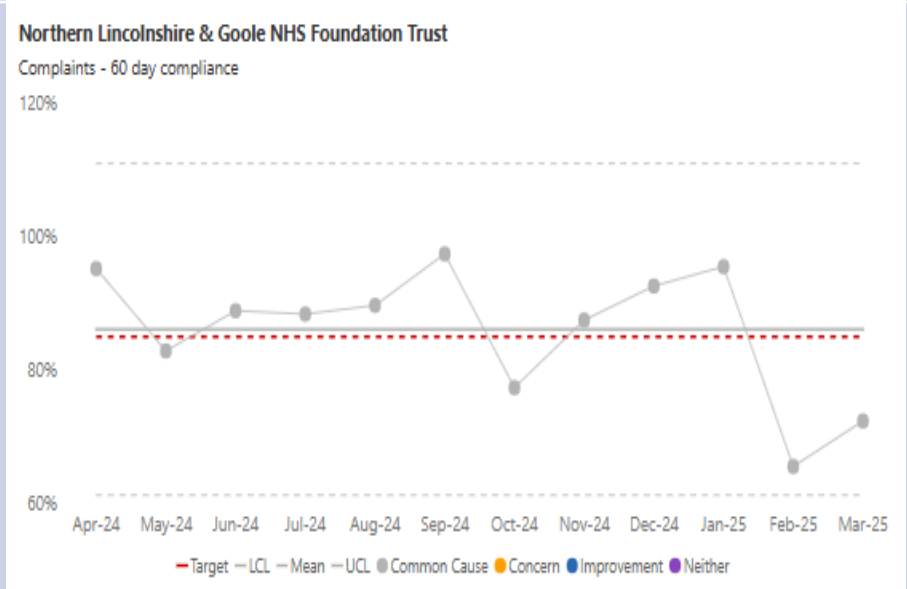
HUTH





NLAG





Key themes

- Normal variation seen across the complaints received rate.
- Compliance with timescales remains below the 85% target. A contribution to this has been the sign off process delays due the volume and the quality of the responses

Actions to improve:

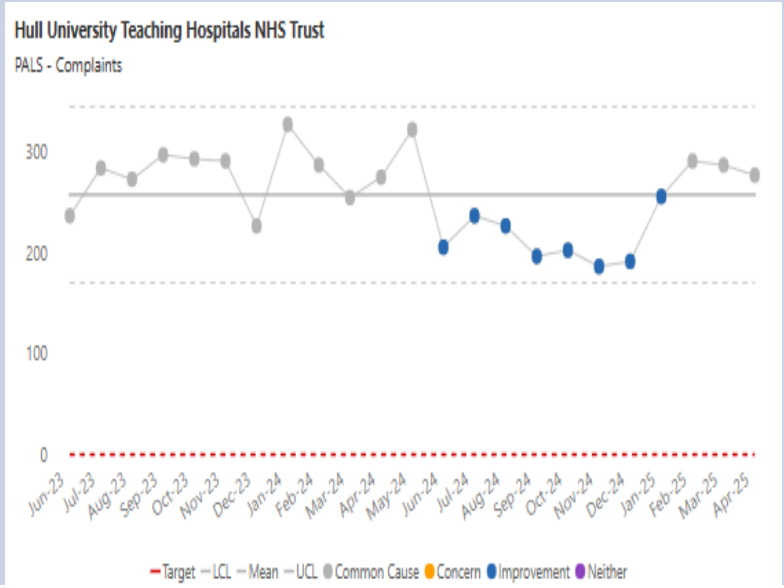
- Central team are aiming to work across the group, following the NLAG investigation and response model.
- Reporting of Care Group performance
- Weekly meetings with Care Group and Central team case handlers.
- Care Group Performance Meeting with Site Nurse Director
- Additional resource identified for AEMCG (extension of Secondment with focus on specific Care Group).
- New Complaints Facilitator started end of March 2025.
- Support & Challenge meetings set-up with team at HUTH to mirror NLaG in January.
- QI programme in development for reducing the number of complaints by acting on the learning gained from complaint themes, with Care Group accountability for their improvement plans

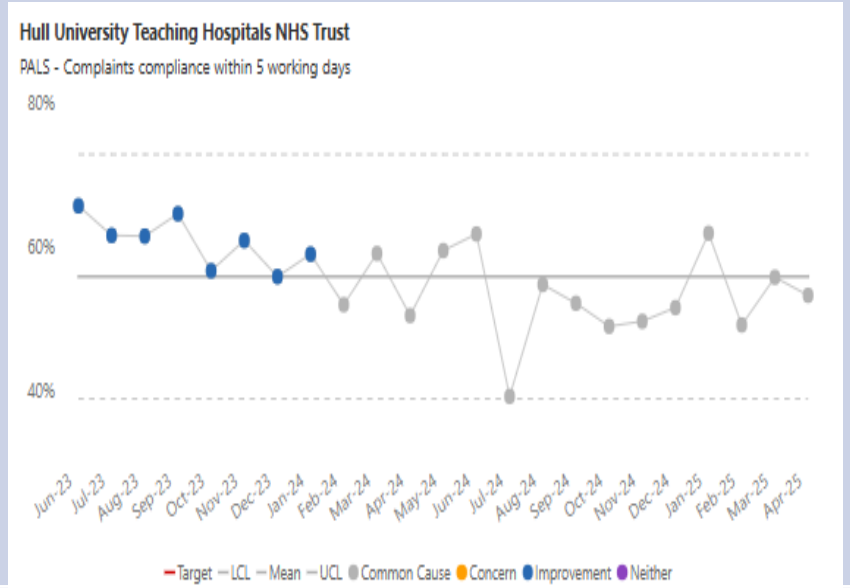
Key themes

- The rate of complaints received is within normal variation for the data.
- The NLAG performance is predominantly achieving the standard or close to it, with a dip in performance in February. A contribution to this has been the sign off process delays due the volume and the quality of the responses

PALS – received and response times

HUTH

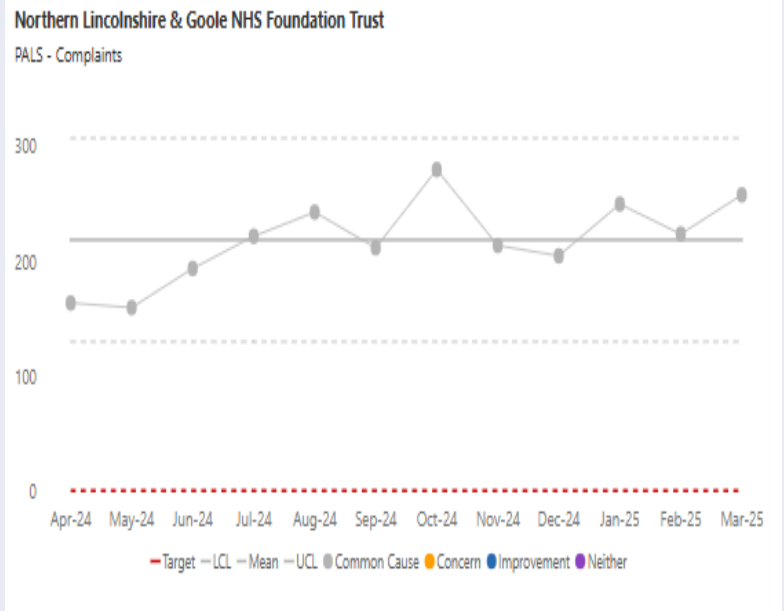


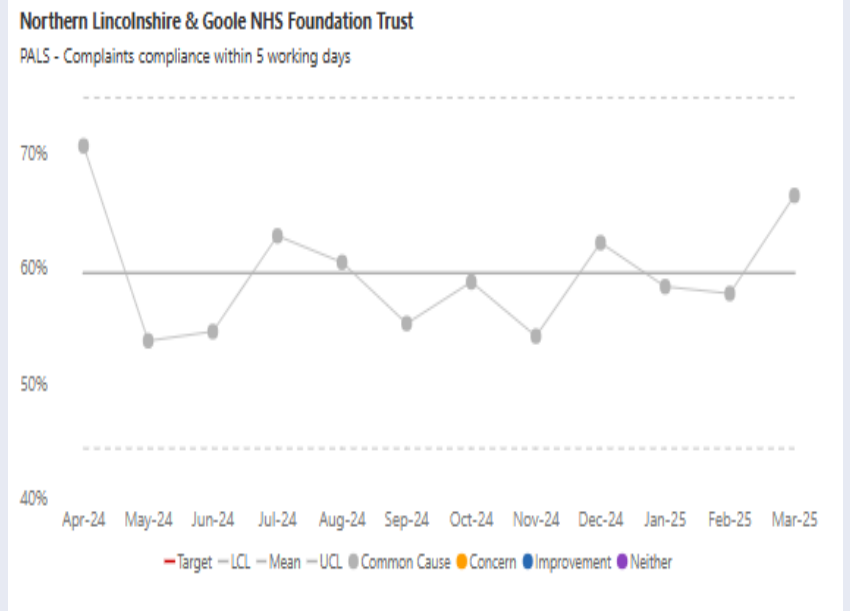


Key themes

- There is normal variation in the rate of PALS contacts for the most recent period.

NLAG



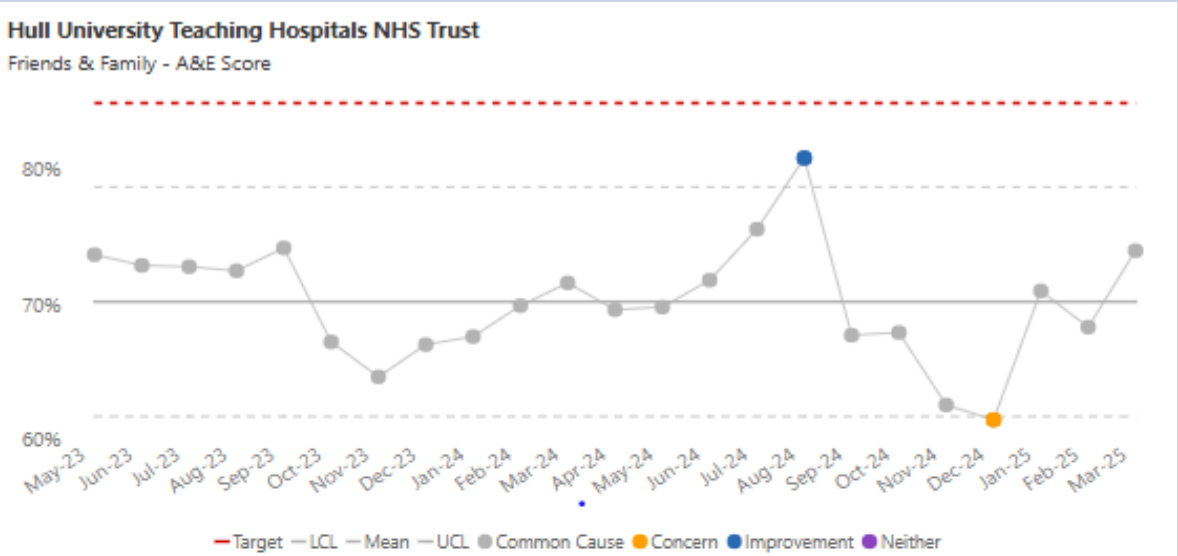


Key themes

- There is normal variation in the rate of PALS contacts.

Patient Experience – Friends and Family Test A&E

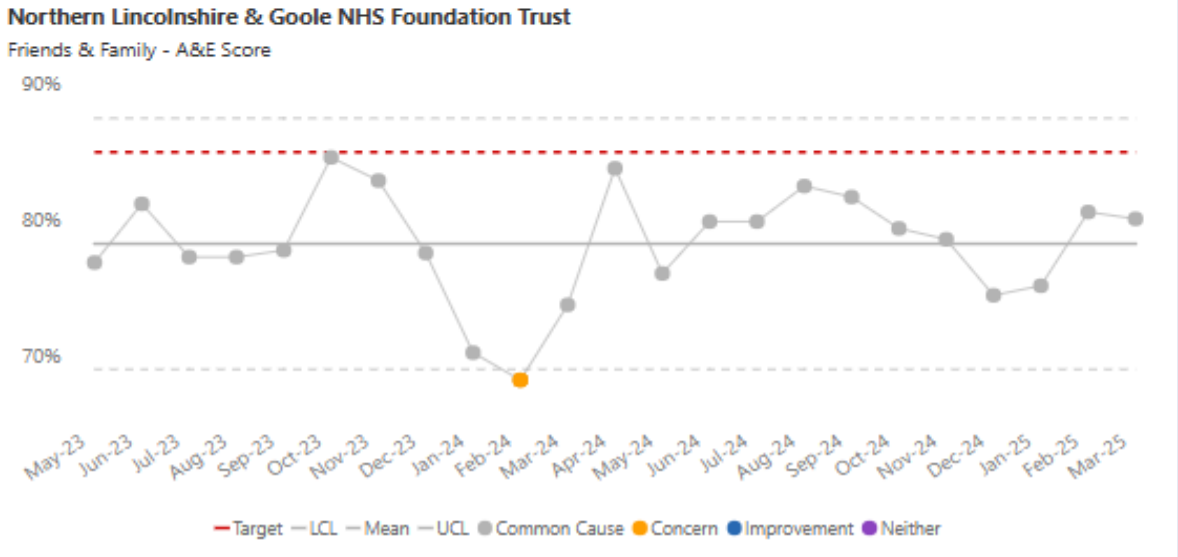
HUTH



Key themes

- Normal variation found in last 3 months.
- Remains below the target at 74% for March.

NLAG



Key themes

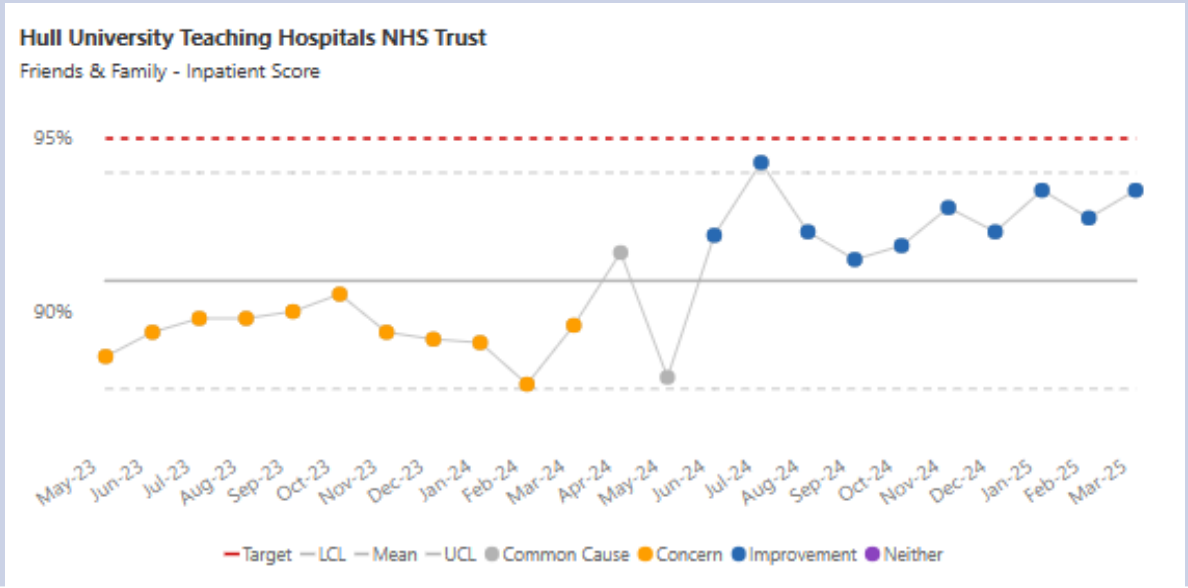
- Normal variation patterns observed for the recent period.
- Remains below the target at 80.1% for March

Actions being taken to improve across the Group:

- Performance data available in the Care Group
- Initiatives to improve timely ambulance handover delays
- Initiatives to support patients despite crowding in the EDs.

Patient Experience – Friends and Family Test Inpatient and daycase

HUTH



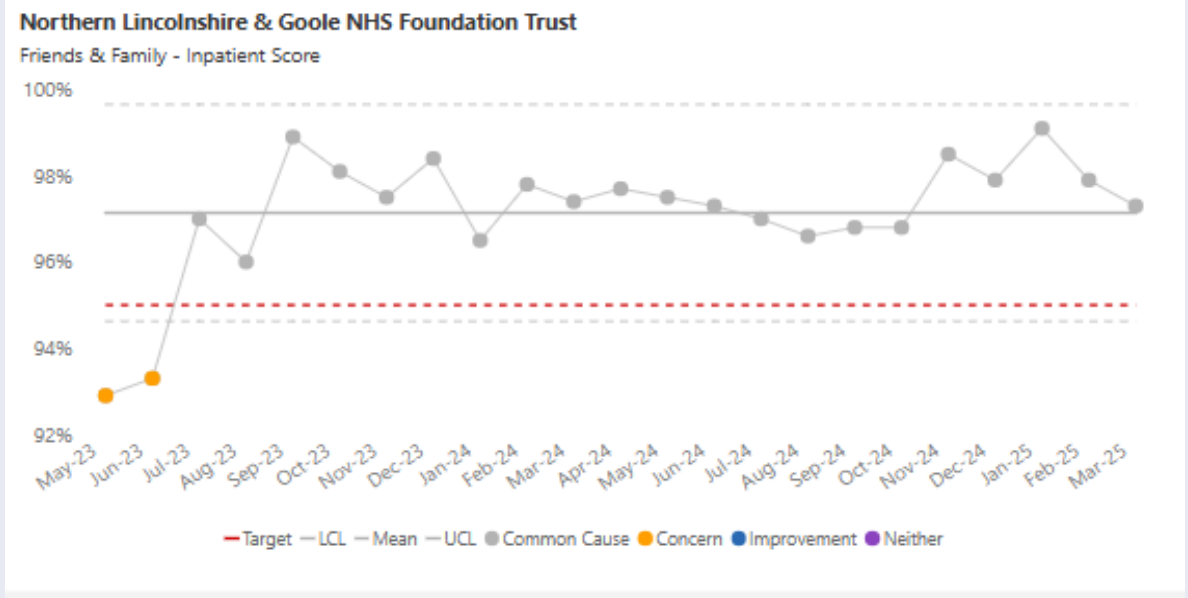
Key themes

- Improvement seen over time, with the Trust remaining below the national target of 95%, at 93.5% in March 2025.

Actions to improve:

- Negative responses are disseminated to care groups for learning which is a key focus of improvement across the themes of staff attitude, communication and environment.
- Care Group performance monitoring.

NLAG

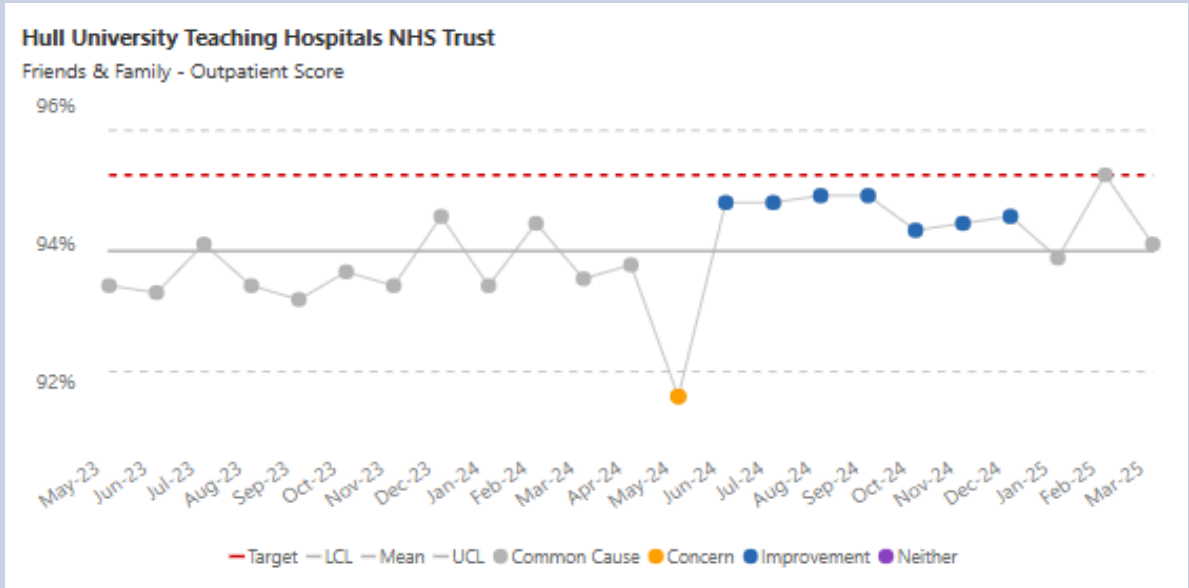


Key themes

- Consistency in achievement of the 95% target.

Patient Experience – Friends and Family Test Outpatient

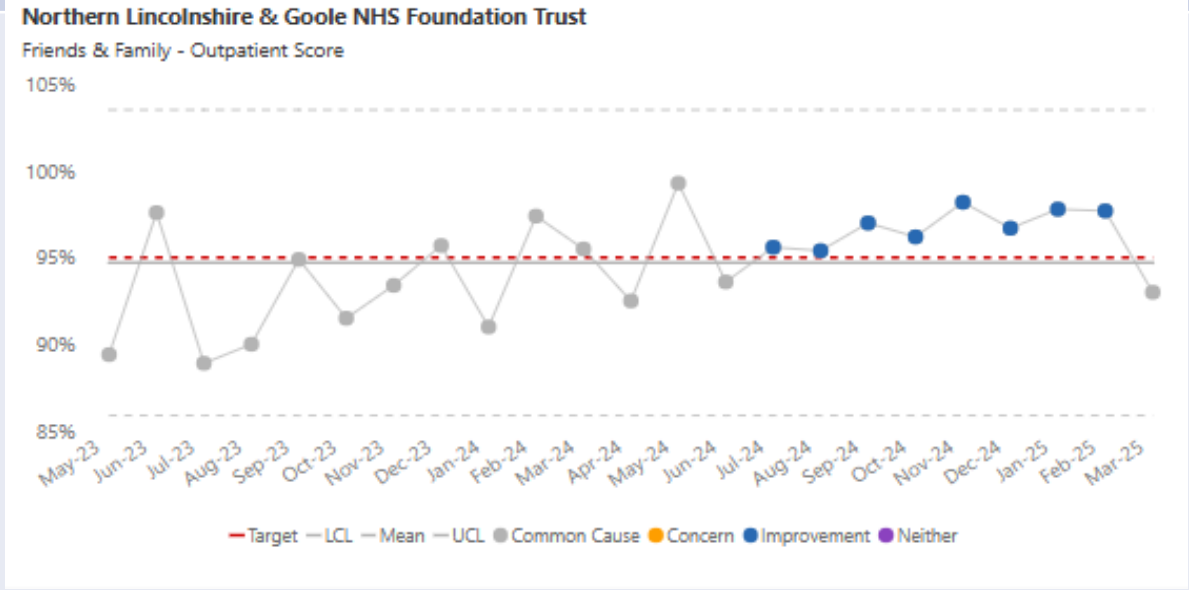
HUTH



Key themes

- The Trust's position had incrementally improved since 2022 towards the 95% target, with the exception of May 24 which was due to a supplier collection issue of our SMS responses. 94% was achieved in March 2025.

NLAG

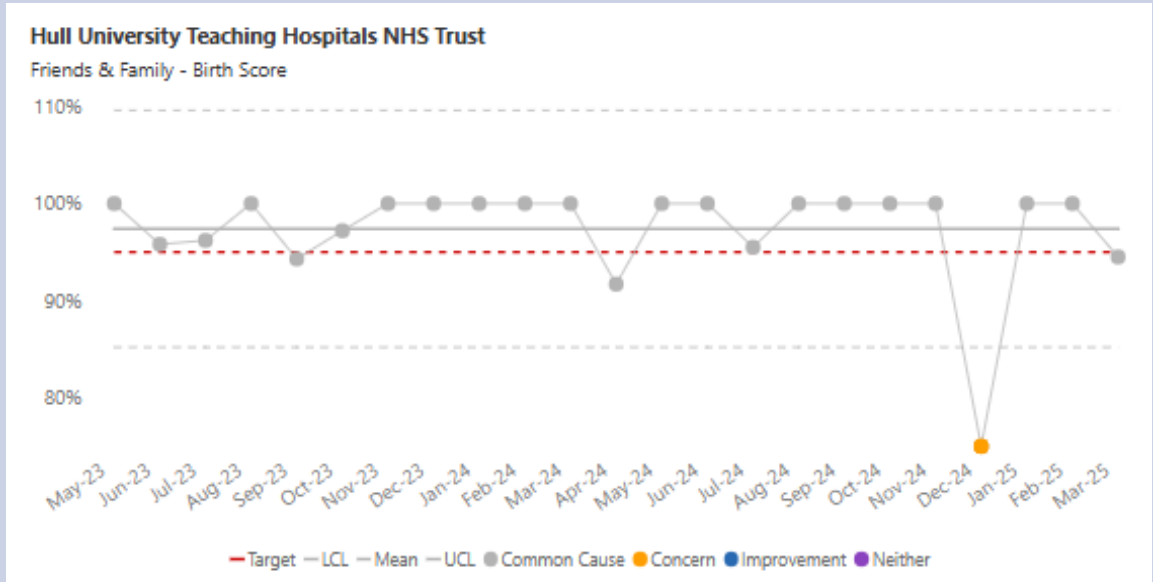


Key themes

- Previously sustained achievement over the target of 95% has dipped to 93% in March.

Patient Experience – Friends and Family Test Maternity (Birth)

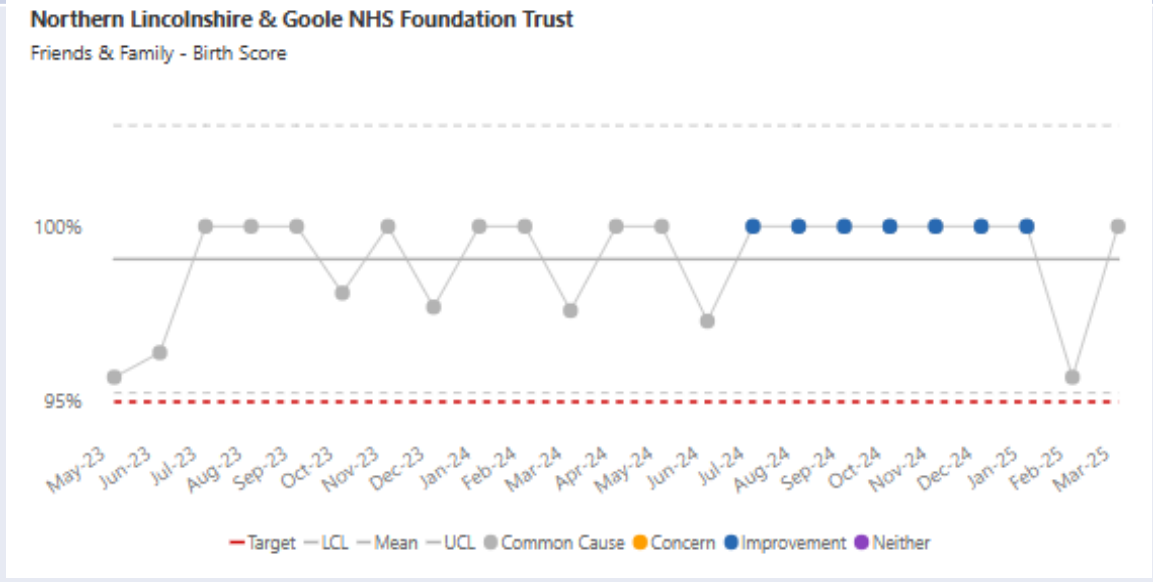
HUTH



Key themes

- Some positive results following a dip of performance in December 2024, with a rate of 94.5% in March.

NLAG

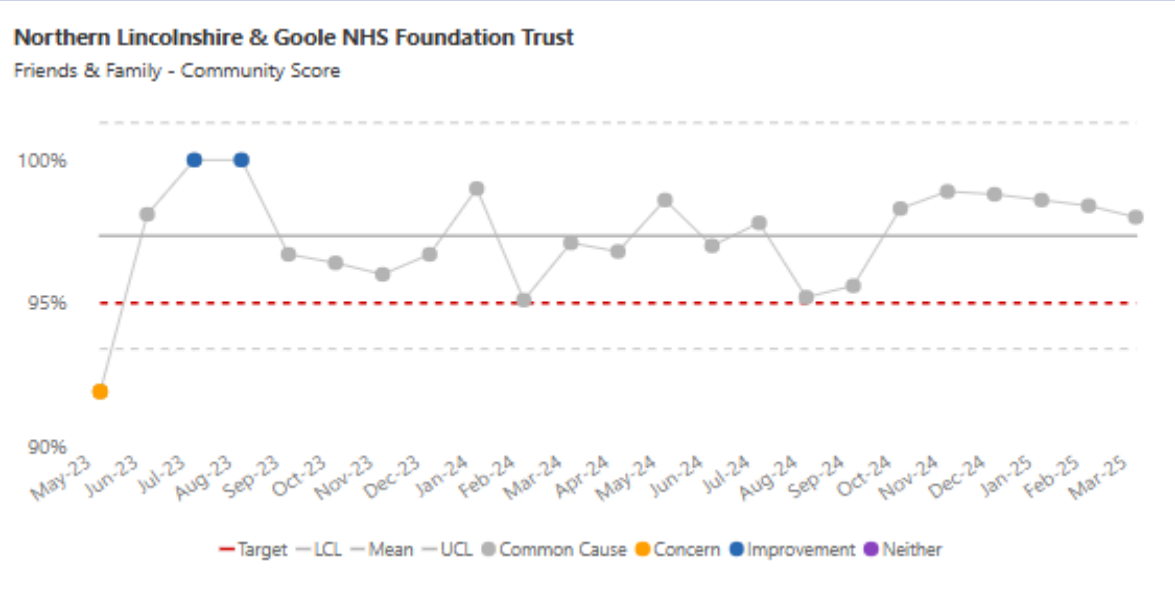


Key themes

- Sustained positive results are seen, remaining above the target.

Patient Experience – Friends and Family Test Community (NLAG only)

NLAG

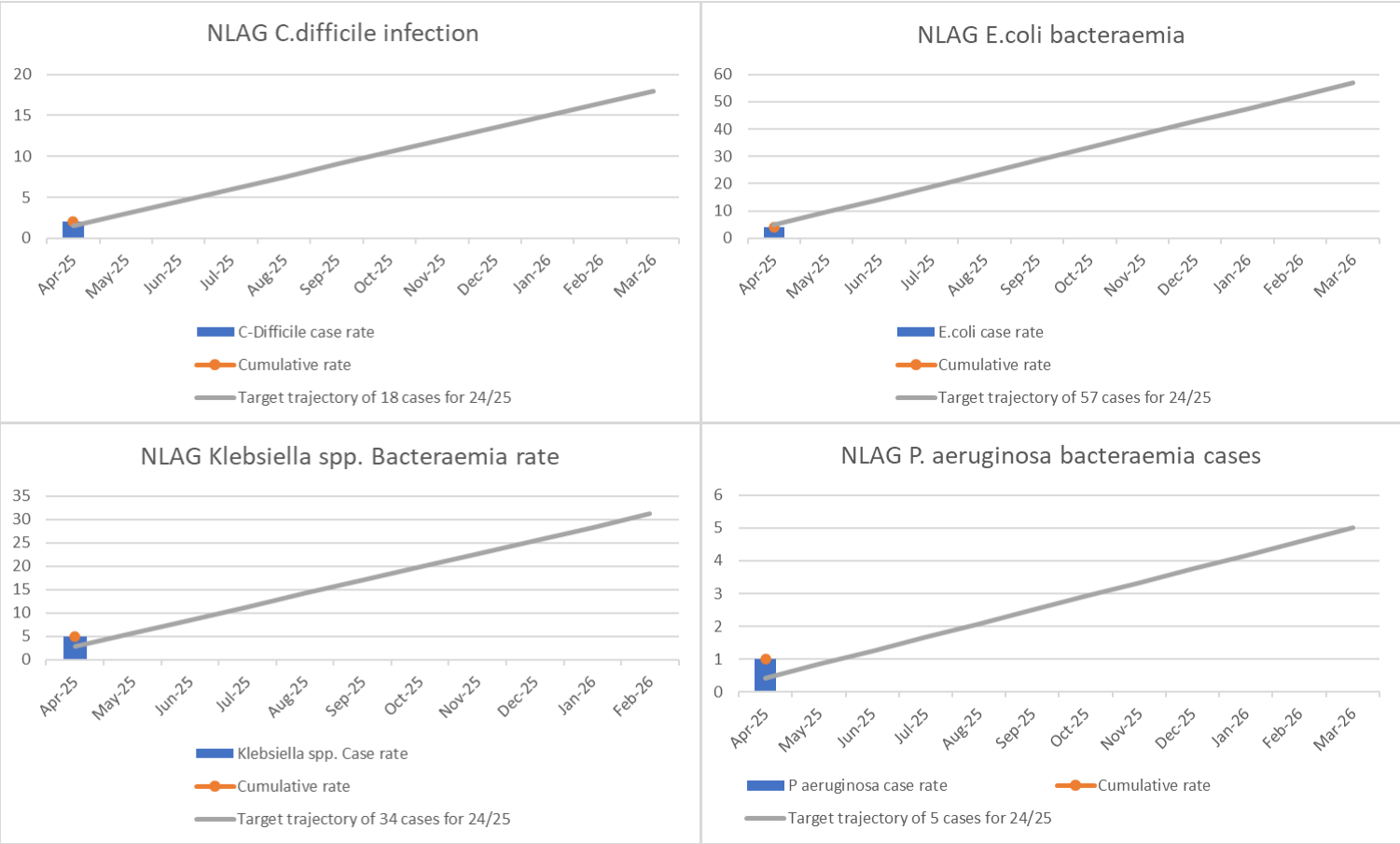


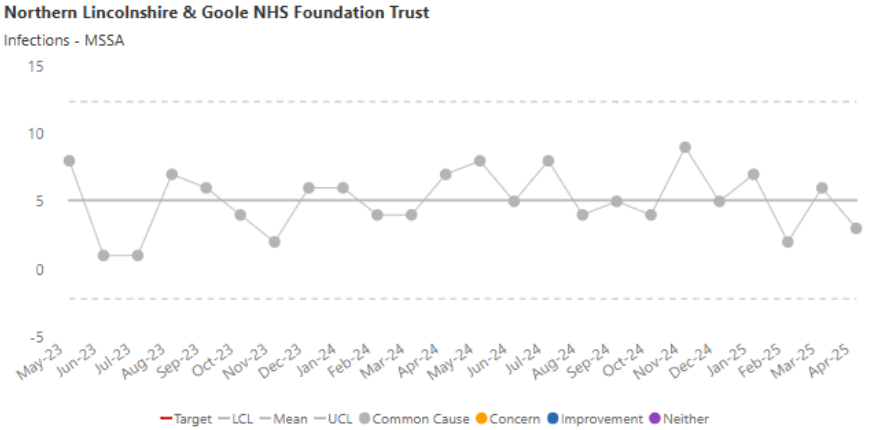
Key themes

- Normal variation pattern is found and the Trust is consistently achieving the 95% target.

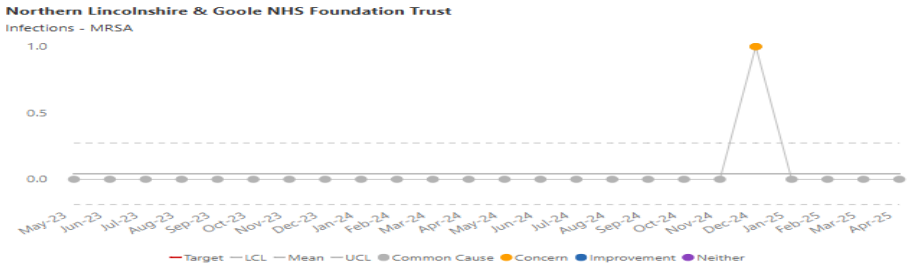
Infection Control - NLAG

Humber Health Partnership





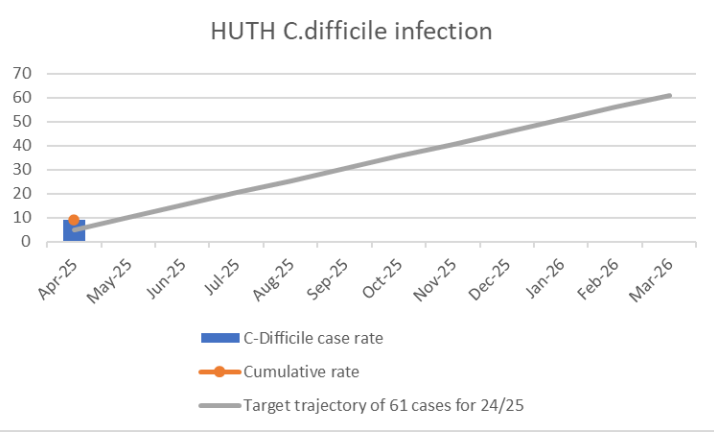
Alert organism	2024/25 Target	M1	YTD rate	Trajectory RAG
C. Difficile	18	2	2	
E. Coli	57	4	4	
P. Aeruginosa	5	1	1	
Klebsiella spp.	34	5	5	
MRSA bacteraemia	0	0	0	
MSSA bacteraemia	No target	3	3	NA
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory				

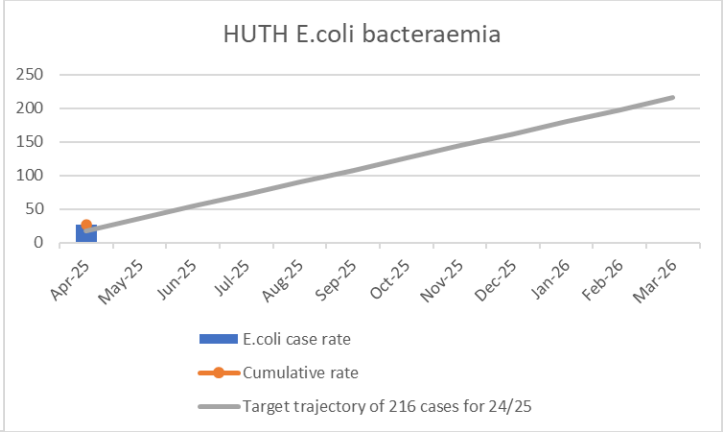


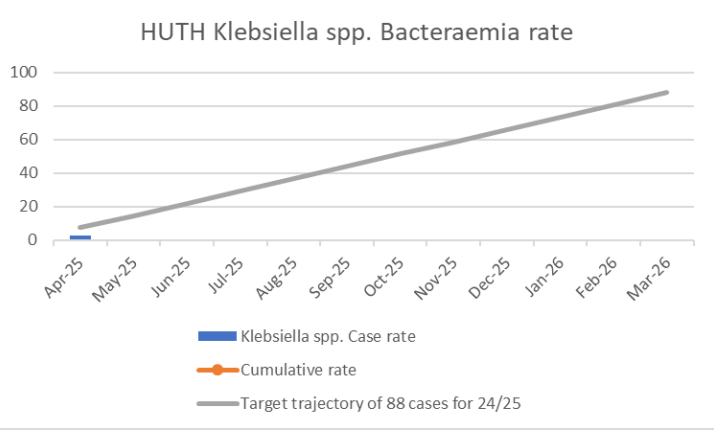
- The trajectories for 2025/26 have not been reset yet, so the previous target is used in the charts and table in the meantime.
- C.difficile, P. Aeruginosa and Klebsiella are over the month 1 trajectory, however well within the annual target from last year.
- E-coli and MRSA bacteraemia are under the annual target trajectory.
- MSSA rates remain within normal variation patterns

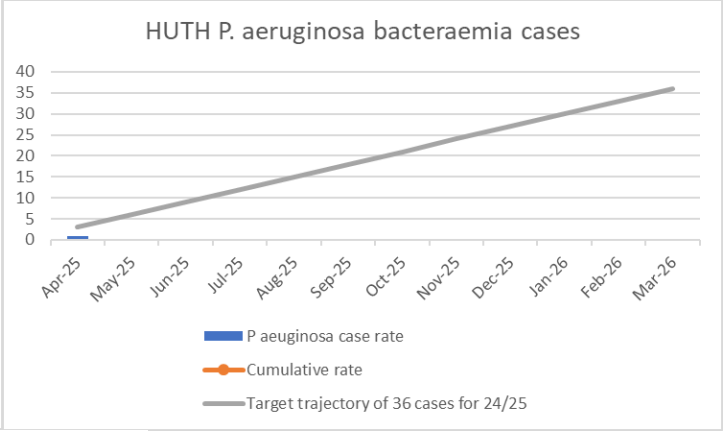
Infection Control - HUTH

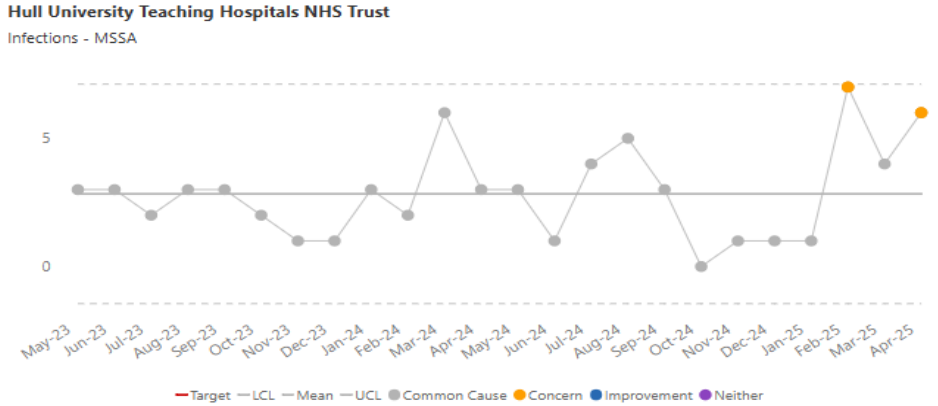
Humber Health Partnership



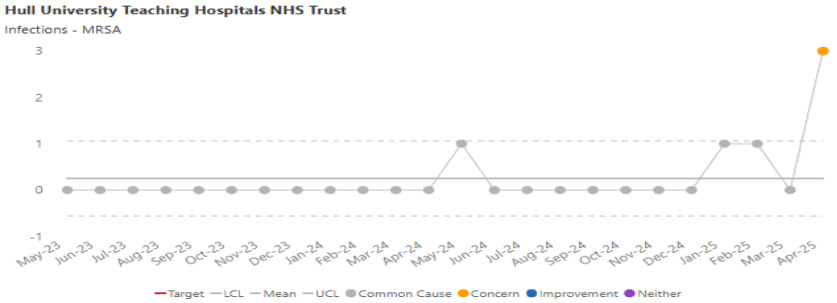








Alert organism	2024/25 Target	M1	YTD rate	Trajectory RAG
C. Difficile	61	9	9	
E. Coli	216	26	26	
P. Aeruginosa	36	1	1	
Klebsiella spp.	88	3	3	
MRSA bacteraemia	0			
MSSA bacteraemia	No target			NA
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory				



- The trajectories for 2025/26 have not been reset yet, so the previous target is used in the charts and table in the meantime.
- C.difficile, and E-coli are over the month 1 trajectory, however well within the annual target from last year.
- P Aeruginosa and Kelbsiella remain under the annual target trajectory.
- MSSA rates show a moderate rise with 3 data points over the mean.
- MRSA rate of 3 cases in April exceeds the zero annual target.

Glossary

NHS
Humber Health
Partnership

- C.difficile – clostridium difficile is a type of bacteria that can cause bowel infection
- CCS – Clinical Classification Software
- CHH – Castle Hill Hospital
- COPD – Chronic Obstructive Pulmonary Disease
- CQC – Care Quality Commission
- CT – Computerised Tomography scan, using x-ray techniques to build detailed images.
- CVP – Central Venous Pressure lines are used to monitor haemodynamic status in critically unwell patients and can also be used to provide medicines into the large veins returning blood to the heart.
- DPOW – Diana Princess of Wales Hospital, Grimsby
- E.coli – Escherichia coli are a group of bacteria that are found in the gut of nearly all people, but can cause infections if gets into new areas, such as wounds, urinary catheter sites and can cause blood stream infections.
- ED/ A&E – Emergency Department
- FFT – Friends and Family Test
- GDH – Goole District Hospital
- HHP – Humber Health Partnership
- HSMR – Hospital Standardised Mortality Ratio, a measure to assess the in-hospital death rate
- HRI – Hull Royal Infirmary
- HUTH – Hull University Teaching Hospitals NHST
- ICB – Integrated Care Board
- IPC – Infection prevention and control
- Klebsiella – Klebsiella Pneumoniae are normally harmless bacteria that are found in the gut but can cause infections in the blood stream and pneumonia.
- LFPSE – Learning from Patient Safety Events is a national database that provider organisations automatically submit patient safety incidents to from their incident reporting systems.
- MRSA – Methicillin-resistant Staphylococcus aureus, which is resistant to the normal treatments for staphylococcus infections and can be difficult to treat in wound and blood stream infections.
- Never Event/NE – Considered to be wholly preventable due to safety measures available from national safety notices and defined by the Never Event List provided by NHS England.
- NLAG – Northern Lincolnshire and Goole NHSFT
- NPSA – National Patient Safety Alert
- NRFIT – An injection connection device to specifically reduce risk of error for spine and other anaesthetic blocks.
- PALS – Patient Advice and Liaison Service
- PIR – Post Infection Review
- Pressure Ulcer/PU – Tissue damage from pressure from prolonged pressure from sitting, laying or devices causing ulceration.
- PSI – Patient Safety Incident
- PSII – Patient Safety Incident Investigation, a detailed investigation as part of the response to an incident where there may be significant learning.
- RAG – Red, Amber, Green colour coded ranking, worst to best,
- RCEM – Royal College of Emergency Medicine
- SGH – Scunthorpe General Hospital
- SHMI – Summary Hospital-level Mortality Indicator, a measure to assess the in-hospital and for 30 days following discharge death rate.
- VTE – Venous thromboembolism, linked with risk assessment and prophylaxis.

NHS
Humber Health
Partnership

Group People Directorate
Workforce Integrated
Performance Report

April 2025

Workforce Intelligence

HR Workforce Reports - Power BI Report Server (hey.nhs.uk)

Exception Report

Vacancy Rate

The overall vacancy rate for the Group is currently at 4.8%, showing a increase of 0.2% compared to the previous month. NLAG has a vacancy factor of 7.1% and HUTH 3%. When adjusted for bank and agency usage, the Group vacancy factor is 30.9 WTE. NLAG's adjusted vacancy factor is -27.94 WTE, reflecting a slight increase in establishment growth and higher usage of temporary staff due to absences, increased activity and escalation beds. In contrast, HUTH's adjusted vacancy factor of 58.1 WTE. Among the staff groups, Add Prof Scientific and Technic shows the highest vacancy factor at 13.9%,50.2 WTE. However, when adjusted for temporary staffing, this rate drops to 12.2%.

Current actions in place?

Consultant recruitment continues to be a priority, with a current vacancy rate of 16.4%. There are 14 Consultants in the recruitment pipeline, awaiting start dates. Once these positions are filled, the vacancy rate is expected to decrease. Operations North is the primary area of concern with a 71.8 FTE vacancy factor, this is predominately across the Theatres, Anaesthetics and Critical care.
Measures to address this include redesigned sourcing campaigns, driving continuous recruitment activity, engaging previous candidates, networking, marketing, establishment reviews, converting locum Consultants to substantive roles, and establishing different workforce models including the use of Specialists. Work is currently underway to convert 2 agency locum Consultants in Acute Medicine to substantive roles via AAC appointment. 35 Specialist roles have been established across the group, the majority of these are as alternatives to consultants in the short term to create development posts which allow autonomous practice and will be disestablished upon the potholder qualifying to take up the substantive Consultant role. 23 Specialists now within Operations South and 12 within Operations North.

The overall medical and dental vacancy rate has improved significantly, now holding steady at approximately 5.3%. Progress in SAS recruitment and a stronger market for resident doctor roles have been key contributors.

The registered nurse vacancy rate has also improved, with a current substantive vacancy of 48.3 WTE—down by 9 WTE compared to the previous month. At NLAG, nursing and midwifery vacancies stand at 38.9 WTE, while at HUTH, they are at 29.3 WTE. The 2025 Newly Qualified Nurse (NQN) recruitment campaign is progressing well. At HUTH, offers have been made to 121 adult nurses, 15 Paediatric nurses, and 24 midwives. At NLAG, 79 adult nurse offers have been made, with a further 40 candidates scheduled for interview. This intake is expected to significantly reduce WTE vacancies by September/October 2025. Challenges continue in the Additional Clinical Services area due to current market conditions, especially for unregistered nursing roles. To address this, a redesigned cohort recruitment approach targeting specific areas has now launched . Additionally, campaigns for priority roles in the Additional Scientific and Technical Staff group are being prepared for launch this month.

Other

Agency usage has increased over the past three months, peaking at 169.6 WTE in March across the Group, primarily due to the need to cover absences increased activity and escalation beds. This month, usage has slightly decreased to 167.13 WTE.
Staff retention remains below the Group target of 10%, currently standing at 8.1%. By site, NLAG is at 9% and HUTH at 7.5%.
Sickness absence continues to exceed the 4% target, with the Group reporting a current rate of 4.7%. NLAG is higher at 5.5%, while HUTH is at 4.1%. The leading cause of absence remains Anxiety, Stress, Depression, and other psychiatric illnesses. The main staff groups with high absence rates are Nursing and Midwifery Registered and Additional clinical services.

Operational Planning

The final workforce plans have now been submitted, incorporating adjustments to align with the Group's target of a 30% agency reduction and a 169 WTE corporate workforce reduction over a four-year period. This equates to an annual reduction of 42.25 WTE, to be delivered through strengthened vacancy control, MARS, and IT-enabled efficiencies. The Group Executives are currently working through an options appraisal to reduce corporate spend which is being targeted against 2018 levels. Early indications suggest the majority of spend increase during this period relates to non pay.

Current actions in place?

Focus will now shift to implementation and monitoring, with work underway to embed controls across Care Groups and ensure year-one targets remain on track. Progress will be reviewed regularly, with governance through the Workforce Transformation Board.

Role Specific Training

NLAG reports a role-specific compliance rate of 82.9% as of the latest update, reflecting a 0.04% improvement from the previous report in February. However, this is still 2.1% below the Trust's target. HUTH reports a role-specific compliance rate of 82.6%, showing a 0.7% increase from February, but still 2.4% below the required target of 85%.
The following two areas remain significantly below the Trust's compliance target of 85%, though both have shown improvement over the past two months:
Medical and Dental compliance stands at 73.1%, a 2.1% increase from the previous report, though still well below the target.

What actions are in place to mitigate?

Resuscitation training compliance is currently 77.8% at HUTH and 69.9% at NLAG, with DNA rates remaining high at 17.7% and 15% respectively. Despite targeted actions since March 2025 to reduce DNAs for Level 2 sessions at NLAG, there has been little improvement. Availability of sessions is being addressed to reduce wait listing and improve compliance.
The Learning & Development teams are working with HRBPs to review and cleanse required learning, starting with a pilot in Emergency and Acute Medicine. Induction is being revised to a half-day welcome, with the North piloting a Clinical Safety Day to deliver practical training for new starters and refresher learners through scenario-based learning.

This slide represents the workforce of the NHS Humber Health Partnership Group. It includes details related to Staff in Post, Headcount and Establishment

April 25 Workforce Position

Headcount 19,501

HUTH 10,831 NLAG 8,670

March 25 **19,551**

HUTH 10,841 NLAG 8,710

February 25 **19,691**

HUTH 10,847 NLAG 8,844

Est WTE 16,201.3

HUTH 9119.2 NLAG 70082.2

March 25 **16,237.6**

HUTH 9092.9 NLAG 7144.7

February 25 24 **16,230.6**

HUTH 9088.5 NLAG 7142.1

SIP WTE 15,426

HUTH 8844.4 NLAG 6681.6

March 25 **15,488.6**

HUTH 8842.9 NLAG 6645.8

February 25 **15517.9**

HUTH 8841.6 NLAG 6676.3

Leavers WTE (12m Avg) 1127.7

HUTH 601.0 NLAG 526.7

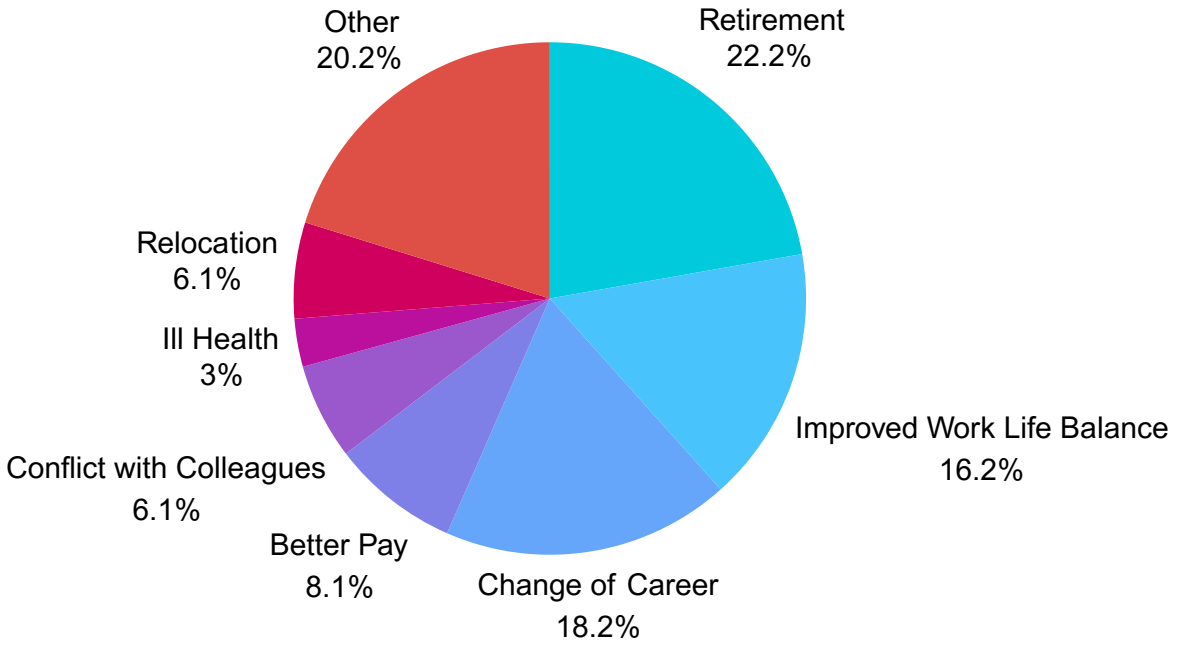
March 25 **1140.0**

HUTH 621.4 NLAG 518.6

February 25 **1168.0**

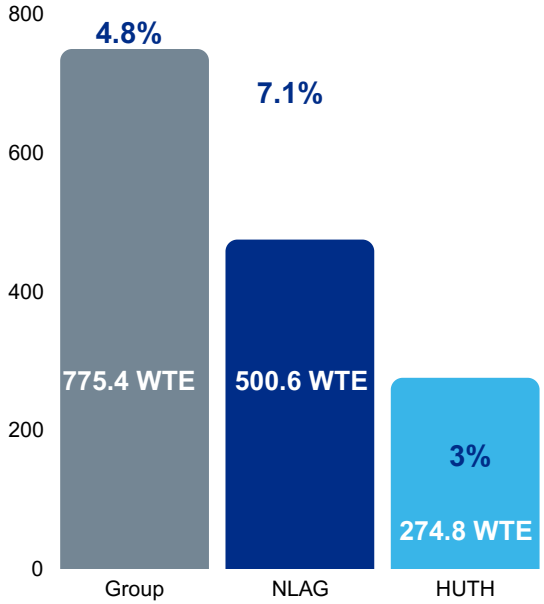
HUTH 642.5 NLAG 525.5

Humber Health Partnership Exit Questionnaire Data

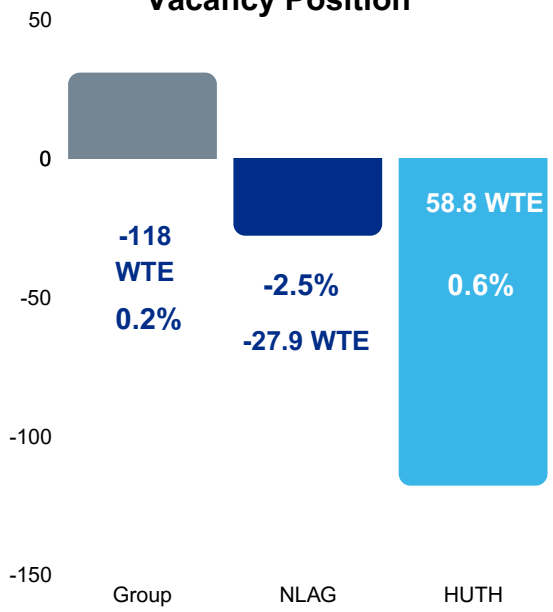


The next two slides represents the vacancy and recruitment activity of the NHS Humber Health Partnership Group. It includes details related to specific staff groups and pipeline information

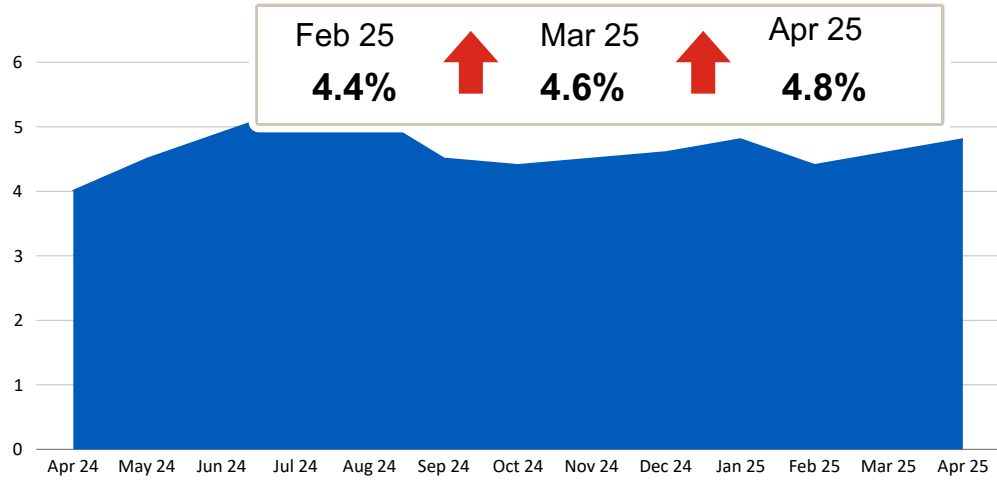
April Group Overall Vacancy Position



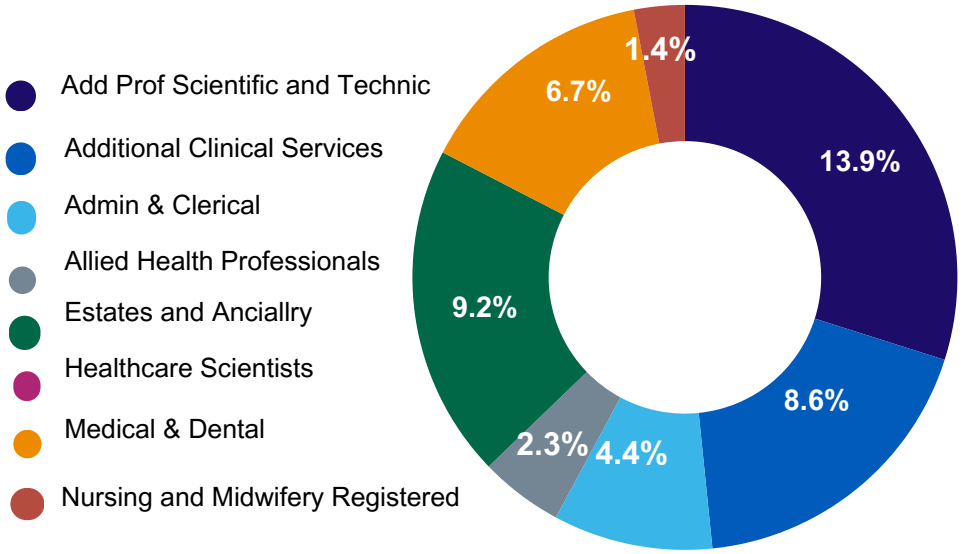
April Group Overall Adjusted Vacancy Position



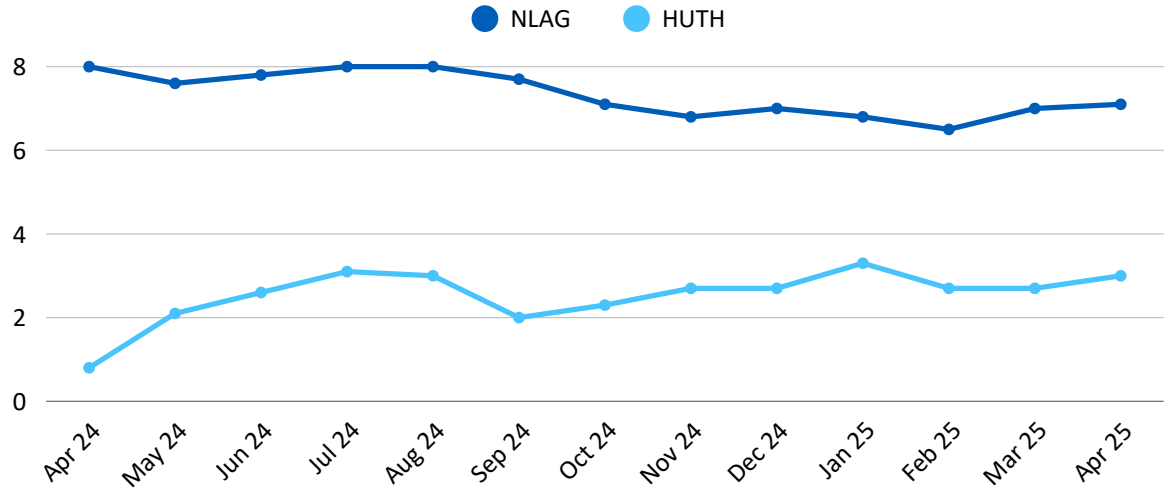
Group Overall Vacancy Trend



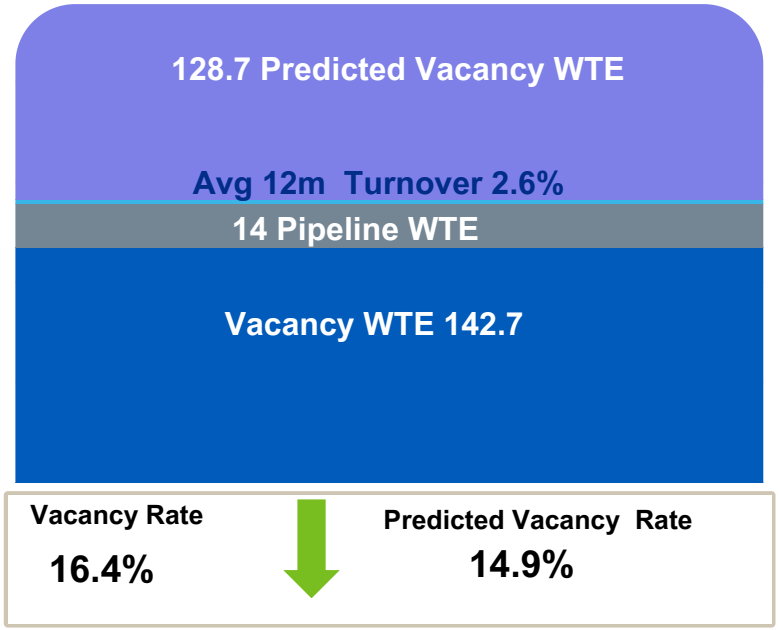
April Group Overall Vacancy by Staff Group



Group Overall Vacancy Trend by Trust



Group Consultant Vacancy 3 Month Predication



*New Starters are demonstrated as headcount and will include Bank Staff that are represented as 0WTE

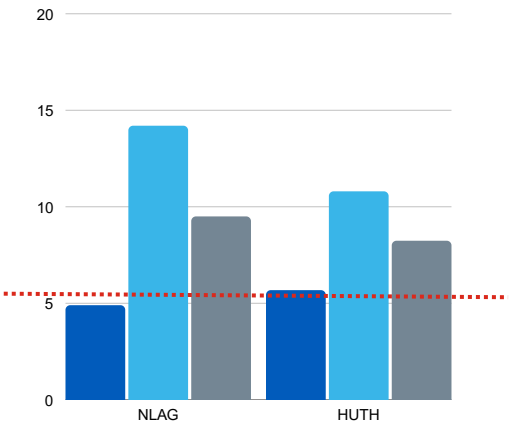
Group Recruitment KPI Overview

Recruitment KPI Overview	HUTH	NLAG	Total
Number of Active Vacancies	302	136	438
Number of Applications recived	6652	3814	10,466
Number of Conditional Offers Issued	221	209	430
Number of New Starters	143	131	274

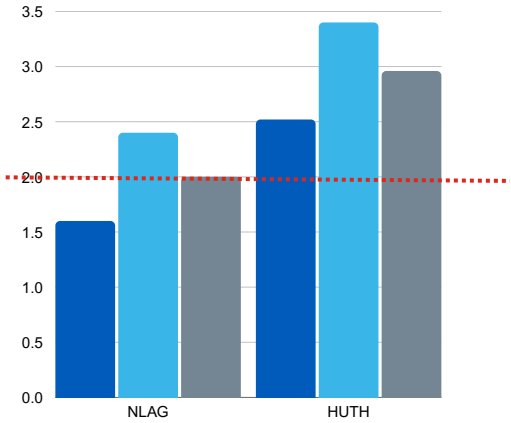
Recruitment Team Metrics

April Appointing Manager Metrics

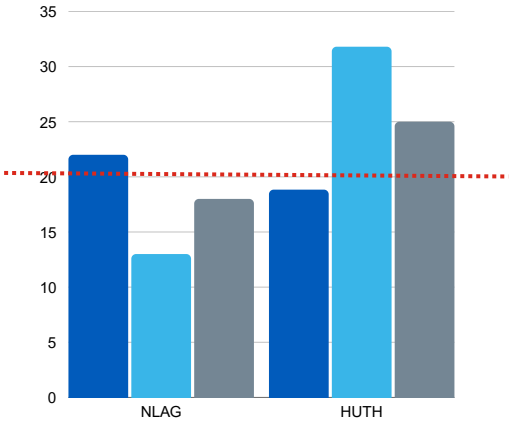
Time Taken to Shortlist (Target 5 Working Days)



Time taken to provide interview outcome (Target 2 Working days)



Time to Hire (Target 20 working days)

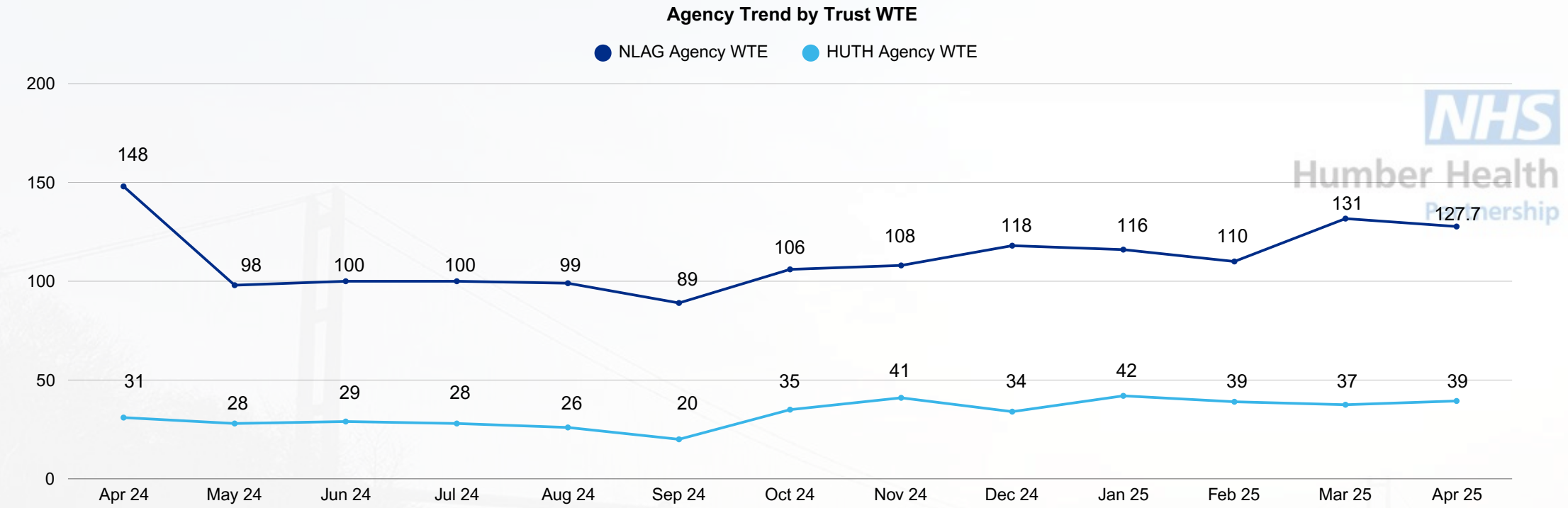


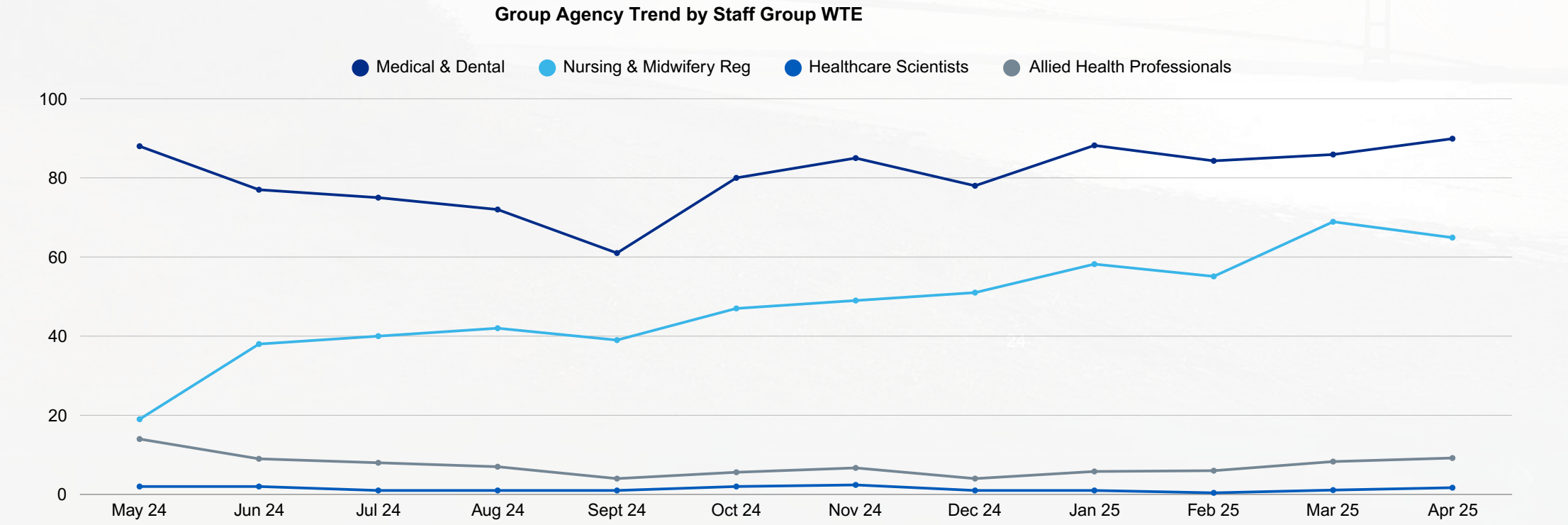
General Staffing

Medical Staffing

All Staffing

The next slide represents the Agency performance of the NHS Humber Health Partnership Group.





The next slide represents the performance management activity of the NHS Humber Health Partnership Group. It includes details related to appraisals, training and Job Planning.

AfC Appraisals

82.7%

Medical & Dental Appraisals

88.2%

Core Mandatory Training

89.2%

Role Specific Training

82.8%

Job Planning

39.8%

NLAG AfC Appraisals

1,007 overdue appraisals

83.5%

HUTH AfC Appraisals

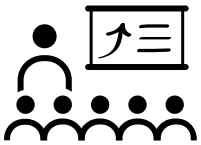
1,416 overdue appraisals

82.1%

0.03%

March 25

83%



NLAG Role Specific Training

23,119 overdue courses

82.9%

HUTH Role Specific Training

23,987 overdue courses

82.6%

0.03 %

March 25

82.83%

Group Job Planning

39.8%

1.2%

March 25

41%

The next slide represents the performance management activity of the NHS Humber Health Partnership Group split by Care Group It includes details related to appraisals, training and Job Planning.

Performance Score Card

Scores explained - Each KPI will be scored as per below

Score 2 Exceeds/ Meets Target - Fully meets or exceeds target.
Score 1 Slightly Below Target
Score 0 Significantly Below Target/ Critical -

Green - 75% and above the maximum score
Amber - 50% 74% of the maximum score
Red - Below 50% of the maximum score

Operations North	Vacancy %	Adjusted Vacancies %	Sickness %	Turnover %	PADR %	Core Training %	Role Specific %	Job Planning %	Performance Score Card	Total Possible Score	Performance %	RAG
Cancer Network	6.9%	5.9%	4.0%	8.8%	84.9%	94.9%	84.6%	NA	12	14	86%	
Cardiovascular	7.1%	4.8%	3.7%	5.1%	77.7%	85.2%	78.9%	16.7%	9	16	56%	
Digestive Diseases	1.0%	-4.3%	5.1%	5.7%	82.4%	86.2%	82.2%	24.6%	6	16	38%	
Head & Neck	8.2%	5.1%	3.9%	6.0%	85.7%	90.3%	85.4%	42.7%	12	16	75%	
Major Trauma Network	8.3%	2.7%	5.9%	7.4%	88.9%	90.0%	82.9%	0.0%	8	16	50%	
Patient Services	4.7%	1.0%	5.6%	10.8%	81.3%	95.8%	94.0%	NA	8	14	57%	
Specialist Cancer and Support Services	7.0%	4.7%	3.5%	6.9%	76.3%	91.5%	85.0%	50.0%	12	16	75%	
Theatres, Anaesthtics and Critical Care	2.3%	0.0%	5.0%	6.4%	85.9%	89.9%	85.4%	56.3%	12	16	75%	
Target & Total Score	<7%	0>%	<4%	<10%	>85%	>85%	>85%	>90%	84	124	68%	

Operations South	Vacancy %	Adjusted Vacancies %	Sickness %	Turnover %	PADR %	Core Training %	Role Specific %	Job Planning %	Performance Score	Total Possible Score	Performance %	RAG
Acutre and Emergency Medicine	6.9%	-5.9%	5.4%	9.5%	91.5%	86.1%	80.3%	63.7%	8	16	50%	
Community, Frailty and Therapy	2.4%	-2.4%	5.2%	9.2%	84.9%	90.1%	82.3%	35.7%	7	16	44%	
Family Services	4.9%	0.6%	5.5%	7.1%	81.2%	85.7%	82.5%	24.0%	8	16	50%	
Neuroscience	4.3%	-1.5%	3.4%	6.1%	87.0%	85.3%	79.8%	26.3%	8	16	50%	
Pathology Network Group	2.3%	-1.3%	4.3%	10.7%	84.8%	91.1%	88.2%	22.2%	8	16	50%	
Site Management and Discharge	20.3%	8.7%	4.9%	10.0%	79.8%	91.3%	82.6%	NA	6	14	43%	
Specialist Medicine	3.1%	-4.4%	5.1%	5.6%	85.2%	90.7%	86.1%	29.4%	10	16	63%	
Specialist Surgery	2.8%	-3.7%	4.5%	9.0%	88.8%	86.5%	81.1%	33.6%	9	16	56%	
Target & Total Score	<7%	0>%	<4%	<10%	>85%	>85%	>85%	>90%	66	126	52%	

Highest Performing Care Group

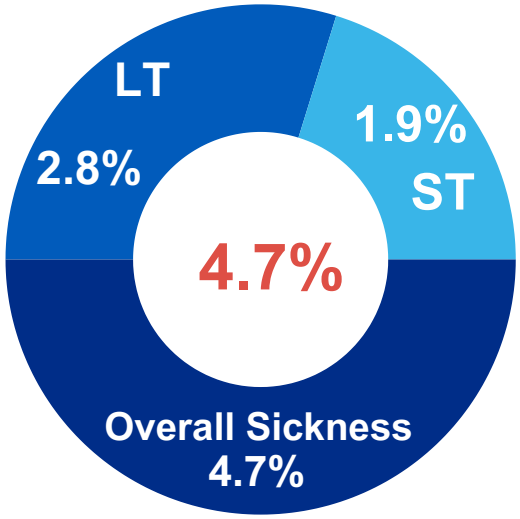
Cancer Network, Head and Neck, Specialist Cancer and Support Services, & Theatres, Anaesthetics ad Critical Clare

Lowest Performing Care Group

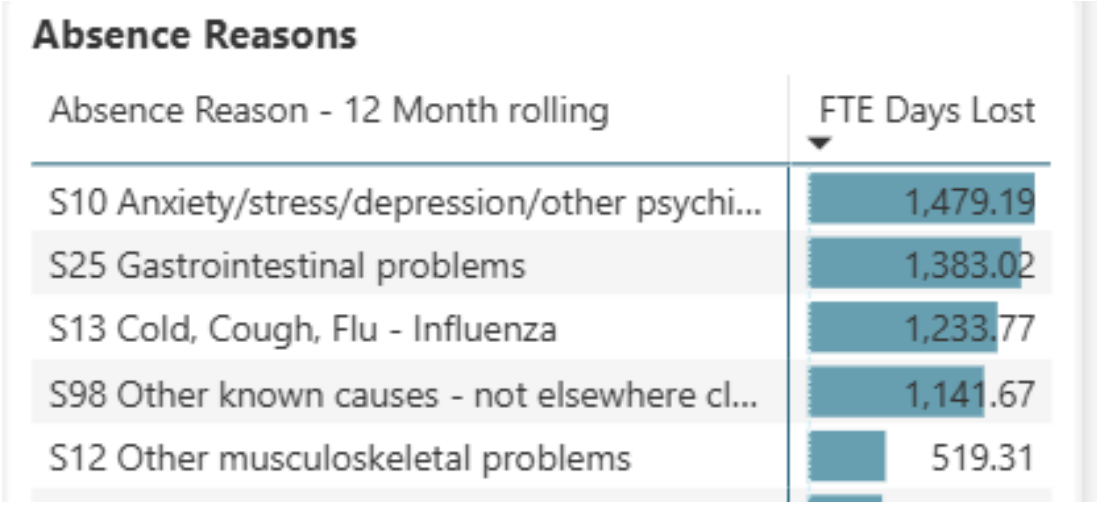
Digestive Diseases, Community, Frailty and Therapy & Site Management and Discharge

The next two slide represents the employee wellbeing and retention activity of the NHS Humber Health Partnership Group. It includes details related to Turnover, absence rates and retention.

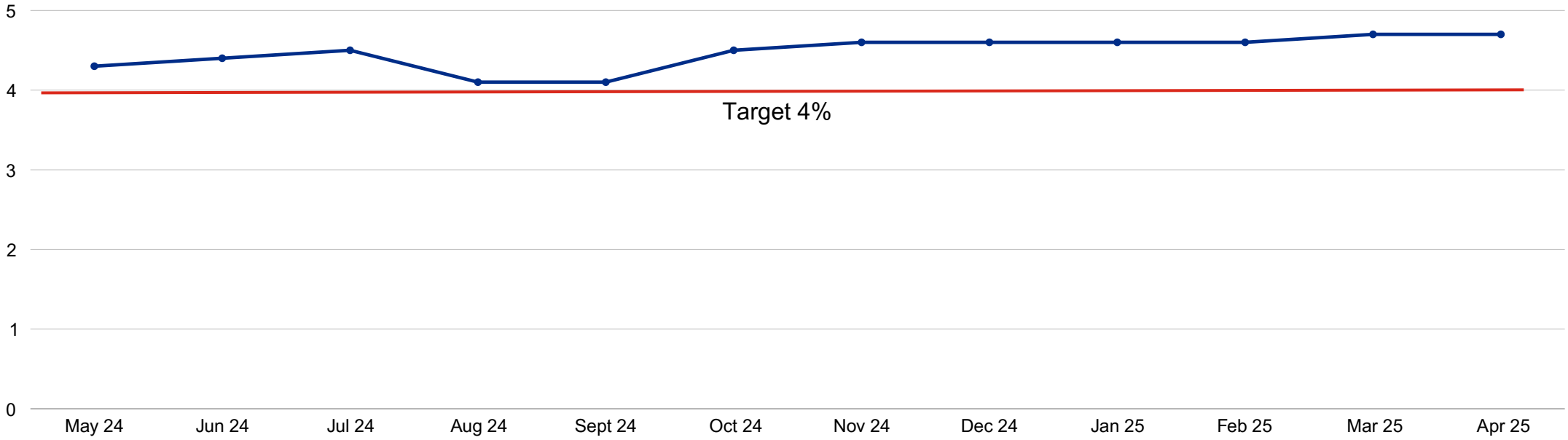
Group April Sickness Position



Group Top 5 Reasons for Sickness

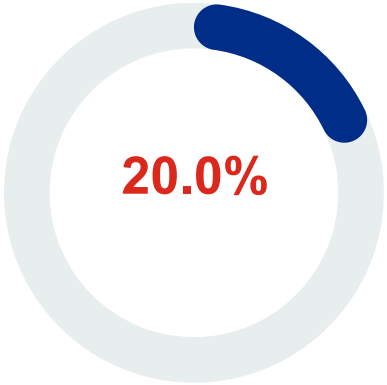


Group Sickness Trend

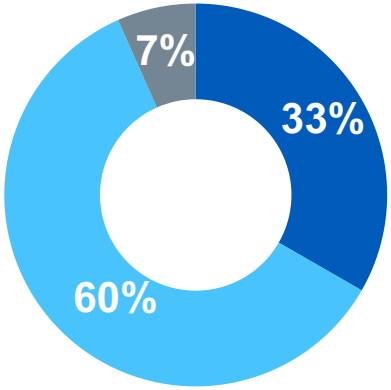


Group April Turnover Position

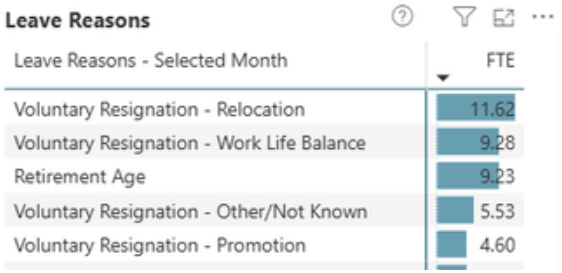
% First Year Leavers

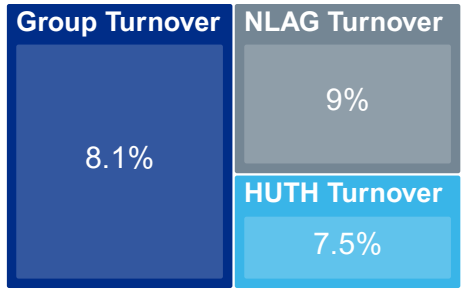


12month Avg Retention

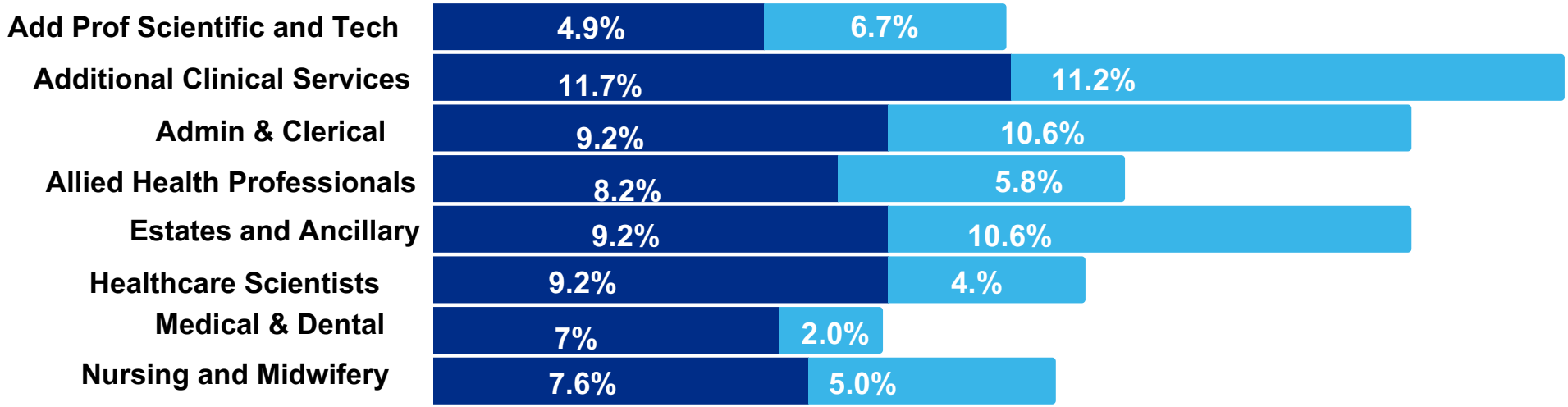


Group Top 5 Reasons for Leaving April



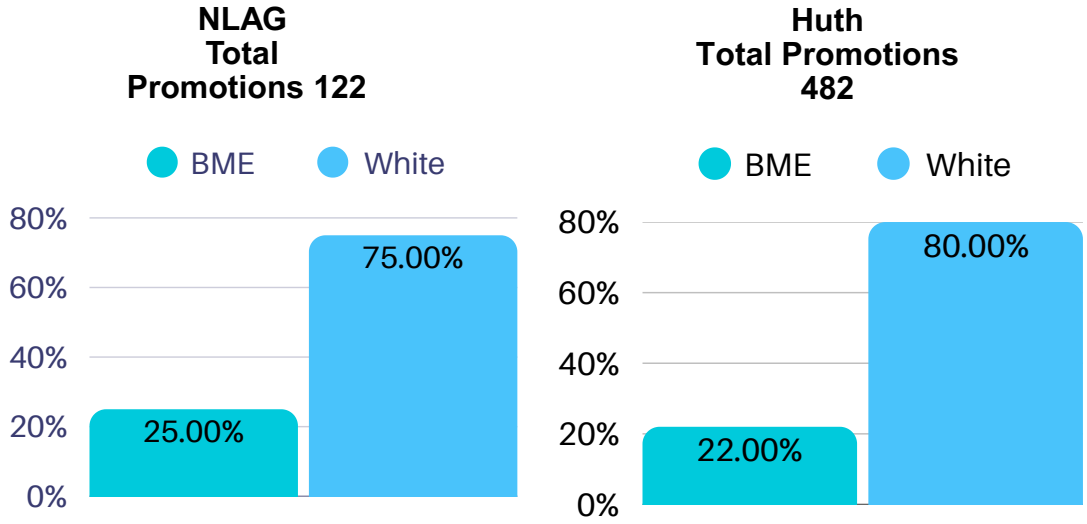


Group Retention Rates by Staff Group

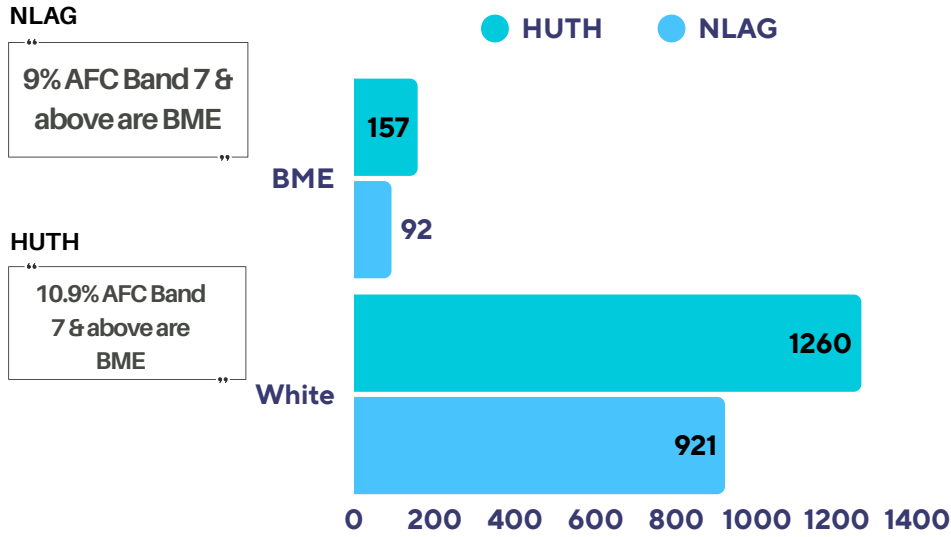


The next slide represents the EDI - Ethnicity Headlines

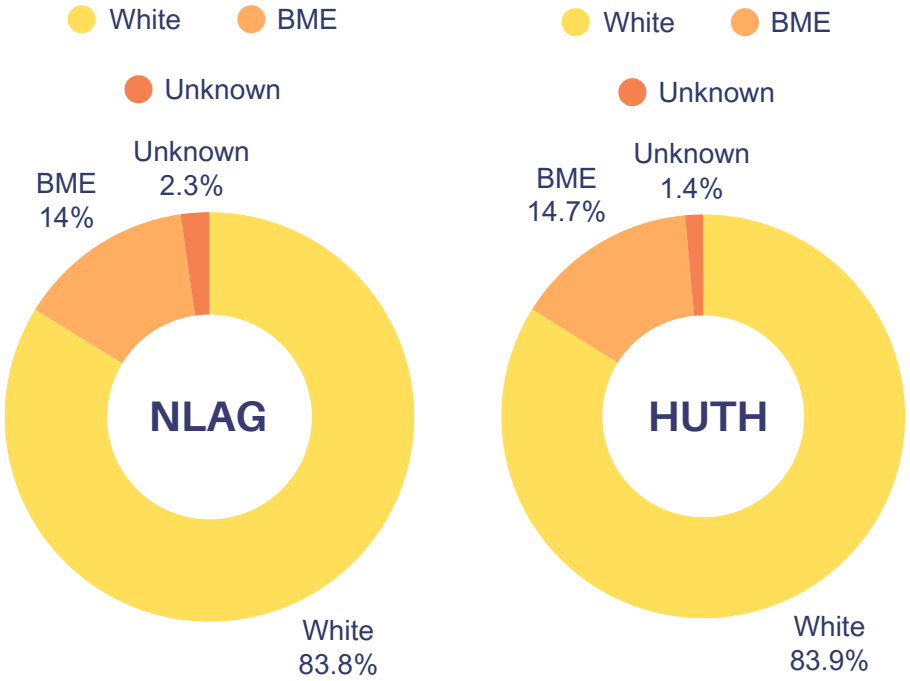
Latest 12m (May 24 - Apr 25) Internal Promotions % by ethnicity



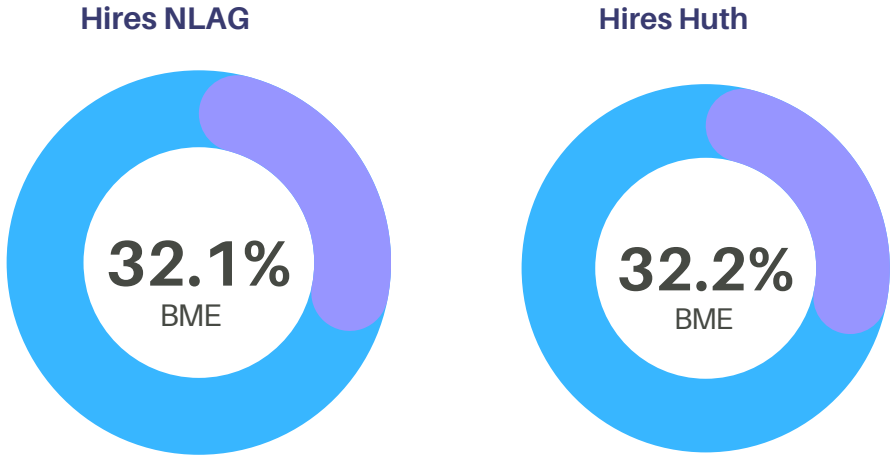
Current AFC workforce band 7 and above



12m Leavers Demographics Breakdown



12m Hires - BME Workforce



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(25)109

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	12 June 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	Trust Boards-in-Common & Committees Meeting Cycle
Executive Summary	The attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2025 and December 2025. The report also includes the schedule for January - December 2026.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format.
Prior Approval Process	None
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE - 2025 - V15

MEETING	Quarter 4 (24/25) Jan	Feb	Mar	Quarter 1 (25/26) Apr	May	Jun	Quarter 2 (25/26) Jul	Aug	Sep	Quarter 3 (25/26) 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**	02.10.25 11.30 am - 1.00 pm **HUTH Annual General Meeting**	09.10.25 **Boardroom, HRI**		11.12.25 **Boardroom, DPOW**
Board Development (Thursdays - 9.00 am - 5.00 pm)			13.03.25 **Boardroom, DPOW**		08.05.25 **Boardroom, HRI**		10.07.25 **Boardroom, DPOW**		11.09.2025 **Boardroom, HRI**		13.11.25 **Boardroom, DPOW**	
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	Meeting falls in December 2024 due to previous reporting cycle	04.02.25 **Boardroom, DPOW**	04.03.25 **Boardroom, HRI**	01.04.25 **Nightingale, SGH**	06.05.25 **Boardroom, HRI**	03.06.25 **Boardroom, CHH**	01.07.25 **Boardroom, DPOW**	05.08.25 **Nightingale, SGH**	02.09.25 **Boardroom, HRI**	30.09.25 **(please note falls in September)** **Boardroom, CHH**	04.11.25 **Boardroom, DPOW**	02.12.2025 **Nightingale, SGH**
Capital & Major Projects (9.00 am - 12.00 pm)	30.01.25 **Conference Room, GDH**			22.04.25 **TBC, CHH**		18.06.25 **Boardroom, DPOW**		20.08.25 **Nightingale, SGH**		22.10.25 **Boardroom, HRI**		16.12.25 **Boardroom, HRI**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		27.02.25 **Nightingale, SGH**	27.03.25 **Boardroom, DPOW**	29.04.25 **Boardroom, HRI** (Tuesday)	29.05.25 **TBC, CHH**	26.06.25 **Nightingale, SGH**	24.07.25 **Boardroom, HRI**	28.08.25 **Boardroom, DPOW**	25.09.25 **TBC, CHH**	30.10.25 **Nightingale, SGH**	27.11.25 **Boardroom, HRI**	18.12.25 **Boardroom, DPOW**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		05.02.25 (Meeting cancelled)				17.06.25		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 **Boardroom, DPOW**	30.04.25 **To be held Virtually**	28.05.25 **Boardroom, DPOW**	25.06.25 **Boardroom, HRI**	23.07.25 **Nightingale, SGH**	27.08.25 **Boardroom, CHH**	24.09.25 **Boardroom, DPOW**	29.10.25 **Boardroom, HRI**	26.11.25 **Nightingale, SGH**	17.12.25 **Boardroom, 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 **Boardroom, DPOW**			14.10.25		
HUTH (9.00 am - 12.00 pm)		06.02.25			07.05.25			07.08.25			06.11.25	
Executive Team Meetings												
Group Cabinet Meeting (Tuesdays - 2.00 pm - 5.00 pm)	07.01.25 14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25	01.04.25 08.04.25 15.04.25 22.04.25 29.04.25	13.05.25 20.05.25 27.05.25	03.06.25 10.06.25 17.06.25 24.06.25	08.07.25 15.07.25 22.07.25 29.07.25	05.08.25 12.08.25 19.08.25 26.08.25	09.09.25 16.09.25 23.09.25 30.09.25	07.10.25 14.10.25 21.10.25 28.10.25	11.11.25 18.11.25 25.11.25	02.12.25 09.12.25 16.12.25 23.12.25
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	09.01.25	25.02.25 (10.00 am - 11.00 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)	21.01.25 (9.00 am - 11.00 am)	18.02.25	18.03.25	15.04.25	22.05.25 (Thursday - 1.00 pm - 3.00 pm)	17.06.25 (meeting cancelled)	15.07.25	19.08.25	16.09.25	21.10.25	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	
Care Group Performance & Assurance Meetings												
Cardiovascular Care Group	17.01.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	25.02.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**		07.04.25 **9.00 am – 10.30 am** **Boardroom, DPOW**	20.05.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	30.06.25 **10.00 am – 11.30 am** **Boardroom, DPOW**		12.08.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	24.09.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		03.11.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	
Family Services Care Group	14.01.25 **8.30 am – 10.00 am** **Boardroom, Main Admin Block, CHH**	27.02.25 **2.00 pm – 3.30 pm** **Exec Meeting Room, SGH**		08.04.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	22.05.25 **10.00 am – 11.30 am** **Boardroom, HRI**		03.07.25 **10.00 am – 11.30 am** **Boardroom, HRI**	12 August 2025 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	25.09.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		06.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Neuroscience Care Group	22.01.25 **2.30 pm – 4.00 pm** **Boardroom, HRI**		03.03.25 **11.00 am – 12.30 pm** **Boardroom, DPOW**	14.04.25 **2.00 pm – 3.30 pm** **Boardroom, HRI**	28.05.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		07.07.25 **1.30 pm – 3.00 pm** **Boardroom, DPOW**	20.08.25 **2.00 pm – 3.30 pm** **Exec Meeting Room, SGH**		01.10.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	10.11.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	
Specialist Cancer and Support Services	23.01.25 **3.30 pm – 5.00 pm** **Boardroom, HRI**		06.03.25 **11.00 am – 12.30 pm** **Boardroom, HRI**	16.04.25 **9.00 am – 10.30 am** **Boardroom, DPOW**	29.05.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		07.07.25 **3.30 pm – 5.00 pm** **Boardroom, DPOW**	21.08.25 **9.00 am – 10.30 am** **Boardroom, HRI**		02.10.25 **9.00 am – 10.30 am** **Boardroom, HRI**	11.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Care Group for Theatres, Anaesthetic and Critical Care	27.01.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**		10.03.25 **11.00 am – 12.30 pm** **Boardroom, DPOW**	23.04.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		02.06.25 **9.00 am – 10.30 am** **Boardroom, DPOW**	14.07.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	27.08.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		06.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	19.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Community, Frailty and Therapy Care Group	27.01.25 **11.00 – 12.30 pm** **Boardroom, Main Admin Block, CHH**		10.03.25 **3.00 pm – 4.30 pm** **Boardroom, DPOW**	23.04.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		02.06.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	14.07.25 **3.30 pm – 5.00 pm** **Boardroom, DPOW**	28.08.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		07.10.25 **10.00 – 11.30 am** **Boardroom, Main Admin Block, CHH**	19.11.25 **1.00 pm – 2.30 pm** **Boardroom, Main Admin Block, CHH**	
Head and Neck Care Group		05.02.25 **1.00 pm – 2.30 pm** **Boardroom, HRI**	19.03.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	30.04.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		09.06.25 **10.00 am – 11.30 am** **Boardroom, DPOWH**	23.07.25 **2.00 pm – 3.30 pm** **Exec Meeting Room, SGH**		01.09.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	13.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	24.11.2025 **10.00 am – 11.30 am** **Boardroom, DPOW**	
Digestive Diseases		06.02.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	20.03.25 **10.00 am – 11.30 am** **Boardroom, HRI**		01.05.25 **10.00 am – 11.30 am** **Boardroom, HRI**	10.06.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	24.07.25 **2.00 pm – 3.30 pm** **Boardroom, HRI**		04.09.25 **9.00 am – 10.30 am** **Boardroom, DPOWH**	15.10.25 **10.00 am – 11.30 am** **Boardroom, HRI**	25.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Acute and Emergency Medicine Care Group		11.02.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	25.03.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		09.05.25 **10.00 am – 11.30 am** **Boardroom, HRI**	18.06.25 **3.00 pm – 4.30 pm** **Boardroom, DPOW**	30.07.25 **10.00 am – 11.30 am** **Boardroom, HRI**		09.09.25 **8.30 am – 10.00 am** **Boardroom, Main Admin Block, CHH**	20.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**		01.12.25 **10.00 – 11.30 am** **Boardroom, DPOW**
Pathology Care Group		11.02.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	26.03.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		09.05.25 **1.00 pm – 2.30 pm** **Boardroom, HRI**	19.06.25 **10.00 am – 11.30 am** **Exec Meeting Room, SGH**	30.07.25 **2.00 pm – 3.30 pm** **Boardroom, HRI**		08.09.25 **10.30 am – 12.00 pm** **Boardroom, Main Admin Block, CHH**	23.10.25 **10.00 am – 11.30 am** **Boardroom, HRI**		04.12.25 **10.00 am – 11.30 am** **Boardroom, HRI**
Specialist Medicine		19.02.25 **10.00 am – 11.30 am** **Boardroom, HRI**		02.04.25 **2.00 pm - 3.30 pm** **Exec Meeting Room, SGH**	12.05.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	24.06.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		04.08.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	15.09.25 **11.00 am – 12.30 pm** **Boardroom, HRI**	27.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**		08.12.2025 **10.30 am – 12.00 pm** **Boardroom, DPOW**
Specialist Surgery		20.02.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		03.04.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	15.05.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	26.06.25 **3.00 pm – 4.30 pm** **Boardroom, Main Admin Block, CHH**		07.08.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	15.09.25 **3.00 pm – 4.30 pm** **Boardroom, HRI**	28.10.25 **10.30 am – 12.00 pm** **Boardroom, Main Admin Block, CHH**		12.12.25 **11.00 am – 12.30 am** **Boardroom, HRI**
Major Trauma Network		03.02.25 **9.00 am – 10.30 am** **Boardroom, DPOW**			13.05.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**			07.08.25 **1.00 pm – 2.30 pm** **Boardroom, Main Admin Block, CHH**			06.11.25 **8.30 am – 10.00 am** **Boardroom, Main Admin Block, CHH**	
Cancer Network		03.02.25 **11.00 am – 12.30 pm** **Boardroom, DPOW**			13.05.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block CHH**			11.08.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**			06.11.25 **1.00 pm - 2.30 pm** **Boardroom, Main Admin Block, CHH**	

MEETING SCHEDULE - 2026 - 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)		12.02.26		09.04.26		11.06.26		13.08.26	**HUTH Annual General Meeting - TBC**	08.10.26		10.12.26
Board Development (Thursdays - 9.00 am - 5.00 pm)			12.03.26		14.05.26		09.07.26		10.09.26		12.11.26	
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	06.01.26	03.02.26	03.03.26	07.04.26	05.05.26	02.06.26	07.07.26	04.08.26	01.09.26	29.09.26 **(please note falls in September)**	03.11.26	01.12.26
Capital & Major Projects (9.00 am - 12.00 pm)		18.02.26		21.04.26		17.06.26		19.08.26		21.10.26		15.12.26
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	29.01.26	26.02.26	26.03.26	30.04.26	28.05.26	25.06.26	23.07.26	27.08.26	24.09.26	29.10.26	26.11.26	17.12.26
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		04.02.26			26.05.26			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	28.01.26	25.02.26	25.03.26	29.04.26	27.05.26	24.06.26	22.07.26	26.08.26	23.09.26	28.10.26	25.11.26	16.12.26
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	22.01.26			23.04.26 (subject to NHSE Submission Deadline)		22.06.26 HUTH & NLaG **Annual Accounts** Monday - 9.00 am - 12.00 pm (subject to NHSE Submission Deadline)	30.07.26				11.11.26 (Wednesday)	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	15.01.26			01.04.26			08.07.26			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			10.11.26	
Executive Team Meetings												
Group Cabinet Meeting (Tuesdays - 2.00 pm - 5.00 pm)	06.01.26 13.01.26 20.01.26 27.01.26	03.02.26 10.02.26 17.02.26 24.02.26	03.03.26 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 14.04.26 21.04.26 28.04.26	05.05.26 12.05.26 19.05.26 26.05.26	02.06.26 09.06.26 16.06.26 23.06.26 30.06.26	07.07.26 14.07.26 21.07.26 28.07.26	04.08.26 11.08.26 18.08.26 25.08.26	01.09.26 08.09.26 15.09.26 22.09.26 29.09.26	06.10.26 13.10.26 20.10.26 27.10.26	03.11.26 10.11.26 17.11.26 24.11.26	01.12.26 08.12.26 15.12.26 22.12.26
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	08.01.26	24.02.26 (9.00 am - 11.00 am) **NED & Governor only Meeting**		15.04.26			16.07.26		03.09.26 (1.30 pm - 5.00 pm) **AMM & Highlight Reports**		04.11.26	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm)			10.03.26			02.06.26				06.10.26		01.12.26
Appointments & Remuneration Committee (Thursdays - 3.00 pm - 4.30 pm)		19.02.26			28.05.26				24.09.26			
NED & CEO Meetings												
NED & CEO Meetings (Tuesdays - 10.00 am - 12.00 pm)	13.01.26	17.02.26	17.03.26	14.04.26	12.05.26	16.06.26	14.07.26	18.08.26	15.09.26	13.10.26	17.11.26	08.12.26
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	19.01.26	16.02.26	16.03.26	20.04.26	18.05.26	15.06.26	20.07.26	17.08.26	14.09.26	19.10.26	16.11.26	14.12.26
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	08.01.26		05.03.26		07.05.26		02.07.26		03.09.26		05.11.26	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 12.30 pm - 2.00 pm)	20.01.26	17.02.26	17.03.26	21.04.26	19.05.26	16.06.26	21.07.26	18.08.26	15.09.26	20.10.26	17.11.26	15.12.26
LNC - HUTH (Wednesdays - 10.00 am - 1.00 pm)	14.01.26		18.03.26		20.05.26		15.07.26		16.09.26		18.11.26	

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(25)119

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 June 2025
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 – January 2025 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 23 January 2025, approved at the ARG CiC meeting on 24 April 2025.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 23 January 2025
Prior Approval Process	ARG CiC meeting – 24 April 2025
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, 23 January 2025 at 9.00am to 12.30pm
Boardroom, Hull Royal Infirmary and via MS Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

Jane Hawkard	Chair of ARG CIC (HUTH) / Non-Executive Director
Simon Parkes	Chair of ARG CIC (NLaG) / Non-Executive Director
Tony Curry	Non-Executive Director (HUTH) (via MS Teams)
Helen Wright	Non-Executive Director (HUTH)
Gill Ponder	Non-Executive Director (NLaG)
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Emma Sayner	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Rebecca Thompson	Group Deputy Director of Assurance
James Collins	Director (Forvis Mazars) – External Audit HUTH
Brian Clerkin	Managing Director (SumerNI) – External Audit NLAG
Jason McCallion	Associate Director (SumerNI) – External Audit NLAG
Helen Higgs	Managing Director of Internal Audit (Audit Yorkshire)
Danielle Hodson	Internal Audit Manager (Audit Yorkshire) – NLaG
Laura Gough	Internal Audit (RSM) - HUTH
Mike Smith	Senior Head of Finance – Cost Imp. & Efficiency (item 7.3)
Fran Moverley	Freedom to Speak Up Guardian - HUTH (item 9.1)
Liz Houchin	Freedom to Speak Up Guardian - NLAG (item 9.2)
Matt Overton	Group Operations Director (EPRR) (item 9.3)
Edd James	Director of Procurement (item 9.4)
Sue Meakin	Group Data Protection Officer and IG Lead (items 13.1 to 13.3)
Andy Haywood	Group Chief Digital Officer (items 13.1 to 13.3)
Mike Bateson	NLAG Governor Observer
Jo Palmer	PA to Committees-in-Common (Minutes)

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.

1. Welcome and Apologies for Absence

Jane Hawkard, HUTH Audit, Risk and Governance Committees-in-Common (ARG CIC) Chair welcomed those present to the meeting and introductions were made. Apologies for absence were received from: Sally Stevenson, Assistant Director of Finance – Compliance & Counter Fraud and Nicki Foley, Local Counter Fraud Specialist.

2. Declarations of Interest

Jane Hawkard asked for any declarations of interest in respect of any agenda items and none were made.

3. Minutes of the previous Audit, Risk and Governance CIC meeting held on 1 October 2024

3.1 Public Minutes

The minutes were approved as a true and accurate record of the meeting.

3.2 Private Minutes

The minutes were approved as a true and accurate record of the meeting.

4. Matters Arising and Review of ARG CiC Action Tracker

The Committee Chair invited members to raise any matters requiring discussion not already captured on the agenda. The following items were discussed:

- Jan 24 – Item 12 - Helen Wright referred to the Finance staff consultation and asked if this had been concluded. Emma Sayner replied to say it had concluded with some changes but the gaps (from vacancies) were under review to ensure there were no risks to flag at this stage. Action closed.
- July 24 – Item 17.3 – Jane Hawkard felt an implementation date was needed and David Sharif advised he was working with Amanda Stanford and liaising with the Care Groups to work on the draft Group Risk Management Strategy and that this should be ready before the end of the financial year so an April 2025 date was agreed.
- Oct 24 – Item 12.1 – as this was on the Overdue Recommendations report, it was agreed to remove from the tracker.
- Oct 24 – Item 12.2 Group – as this was on the Overdue Recommendations report, it was agreed to remove from the tracker. Sally Stevenson had emailed all those with overdue recommendations and Simon Parkes had also spoken with the Group Chief Executive. Action closed.

All other actions were either confirmed as closed or due at the April 2025 meeting. Gill Ponder asked that a clearer method of itemising the action plan is used.

Action: Sally Stevenson

5. HUTH External Audit (Forvis Mazars)

5.1 Progress Report (Audit Strategy Memorandum 2024/25 to be circulated March 2025)

Due to technical issues accessing the meeting, James Collins was unable to present the paper at this point.

Jane Hawkard took the paper as read and had one query with regards to cloud services and would speak with Andy Haywood as to whether the Group has the correct management and assurance around this area. Upon arrival in the meeting James Collins stated he had nothing further to add to the contents of the paper.

5.2 HUTH External Audit Recommendations Action Plan Update

Emma Sayner advised that considerable work had taken place, with some still ongoing, with an aim for processes to be in place by the year end. Gill Ponder asked whether high stock holdings at HUTH lead to higher wastage and was aware that this had not previously been reported. Jane Hawkard suggested Edd James be asked the question when he attended later in the meeting. Tony Curry recalled previous issues on consignment stock and considering Scan for Safety was well established on the HUTH site, he questioned how the stock situation was being managed, the position generally on Scan for Safety and how well linked the processes were with Procurement. Emma Sayner agreed to investigate and liaise with Edd James but also considered whether there was a legitimate high level of stock purely due to the nature of the business being more specialised. Emma Sayner also referred to the Performance & Assurance meetings which had recently been implemented with the Care Groups and the potential to address what could partly be a cultural issue. Emma Sayner felt it was important to note what impact any change to the stock levels would have on the financial position. In conclusion, Jane Hawkard believed that assurance had been given.

James Collins left the meeting.

6. NLaG External Audit (Sumer NI)

6.1 Audit Planning Report 2024/25

Brian Clerkin took the paper as read but highlighted some key areas. Regarding significant audit risks, the steer is taken from the National Audit Office however these risks are not yet published but are not expected to change from the previous year. Brian Clerkin drew the ARG CIC's attention to page 12 of the PDF document and Sumer NI's obligations to make enquiries in respect of fraud or suspected fraud and invited the ARG CIC to consider whether there was anything to raise, acknowledging that they saw the counter fraud reports.

Brian Clerkin also referred to section 5 on page 13 of the PDF document in that NHSE guidance on accounts submission timelines was now available for NHS Foundation Trusts in line with last year, with an anticipated start of 28 April 2025 followed by the ARG CIC meeting to consider the audited accounts and associated reports on 20 June 2025, with the NHSE deadline for submission of accounts by 30 June 2025.

A separate audit planning letter had been issued in relation to the Health Tree Foundation accounts.

Jane Hawkard asked the ARG CIC if there were any other matters of fraud to be brought to the External Auditors attention which were not already identified in the counter fraud reports, and there were none raised.

7. Internal Audit – Group (Audit Yorkshire and RSM)

7.1 Group Internal Audit Progress Report 24/25 YTD

Jane Hawkard asked that focus was given to the two reports with limited assurance, which were the CIP and Lorenzo reports. Danielle Hodson commented that the CIP report was being discussed at 7.3 of the agenda and therefore updated the ARG CIC regarding the audit report on the implementation of the Lorenzo system. It was well recognised what the issues had been but on a positive note, lessons were being learned from the project closure report and Andy Haywood, Group Chief Digital Officer had taken on board the audit recommendations. Gill Ponder commented that because of the proximity to the year end when the CIP report was issued, it had also been discussed at the Performance, Estates and Facilities (PEF) CiC meeting.

Danielle Hodson was pleased to report that there had been good progress and positive links with RSM performing the Group Internal Audit plan during the year. The Care Group Governance review was planned to commence in February 2025 and the Data Security and Protection Toolkit (DSPT) review in March 2025. Updates had also been provided from both Audit Yorkshire and RSM against the new Global Internal Audit Standards (GIAS) to provide assurance as to how the Trust's Internal Audit teams have complied with them. Jane Hawkard commented that it was good to see that most of the 2024/25 plan was complete.

Jane Hawkard stated there was a particularly good GIAS summary on page 17 of the PDF paper, which gave the ARG CIC some key questions to ask themselves and be assured against. Jane Hawkard advised that she had asked Sally Stevenson to review the questions and bring back a report to the next ARG CIC for further discussion. Jane Hawkard believed that one of the biggest issues was getting recommendations actioned within the timescales agreed, and one of the questions was around what more could be done in respect of this.

Action: Sally Stevenson

7.2 Group IA Recommendations Status Report

Laura Gough reported that there had been considerable movement with the actions, however some were still overdue, and some had further revised implementation dates which caused concern, however those from pre 2022/23 had now been closed following Assam Hussain's conversations with relevant action owners. It was noted that for the Group as a whole, there were a number of overdue actions with no agreed revised target dates.

Simon Parkes noted there were some potentially worrying overdue recommendations such as nutrition and hydration, despite there being an obvious need for an immediate plan. Simon Parkes stated that there should be a further push on clearing some of these actions, particularly at NLAG. David Sharif, as the owner of a couple of overdue risks, commented on his major concern on Care Group risk registers, in that measures had been put in place to make

improvements but was unsure whether despite this effort, risks would indeed always be reviewed when they were due as per the policy.
Jane Hawkard asked if the Group Cabinet Risk & Assurance Committee (GCRAC) could be approached to look at the moderate risks and give an update at the next meeting and that the minor ones should be dealt with and closed. David Sharif agreed to take this action, advising it had been discussed at GCRAC previously.

Action: David Sharif

Julie Beilby questioned whether the original targets were unrealistic or whether there were genuine capacity or prioritisation issues and secondly, regarding the major risk in the IT Disaster Recovery Plan and her concerns as to whether there were enough resources in IT to drive the agenda forward and where to have that discussion. Simon Parkes added that colleagues had been reminded to be realistic with their target dates and that there should be evidence that plans are in place which will be reviewed, and stressed that management should work with Internal Auditors to ensure the recommendations are actionable and that responses are not over-engineered resulting in delays to closure of actions. Simon Parkes also stated that Internal Audit colleagues could assist management in helping to ensure that the recommendations were capable of being resolved in a reasonable period and don't require an endless loop of proof. Simon Parkes agreed to write out again to all Executive Directors requesting realistic timeframes but also to ensure that the recommendations had a finality about them.

Action: Simon Parkes

Tony Curry observed that there was a definite increase in dependence on IT in day-to-day care, particularly by the bedside which requires a bigger response to the Disaster Recovery Plan and secondly, questioned what escalation took place when action implementation dates were missed. Helen Higgs noted it was good practice to invite the responsible officer to the ARG CIC to explain why the action was outstanding, noting it happened at other Trusts they had clients for. Simon Parkes commented that this had been attempted previously. Helen Wright spoke about the closing of risks and agreed there had been some good activity around risk management and capture, however, was unsure that the right mitigations were in place to reduce the score to a tolerable level and asked that these both be considered separately. Gill Ponder suggested that there be a highlight on any recommendation where the date has been moved twice or more thus specifically escalating these to the ARG CIC to build some momentum in closing actions. Jane Hawkard asked that future reports specifically highlight this.

Action: Internal Audit

Mike Smith arrived in the meeting.

Jane Hawkard stated that when the next report was received for the April ARG CiC meeting it would be reviewed, and the relevant Director(s) with overdue recommendations would be asked to attend.

Action: ARG CiC Chairs / Sally Stevenson

7.3 Group CIP/Waste Reduction IA Report Update

Emma Sayner was asked to comment particularly on the Equality and Quality Impact Assessment's (EQIAs) and advised the ARG CIC that Sally Stevenson had contacted Sue Liburd to follow this recommendation up, and was awaiting a response, which would hopefully close the action. Emma Sayner added that her team had implemented a decision support group which was agreed at Group Cabinet earlier that week to ensure everything being done is multidisciplinary in nature, as there could be a financial or process decision made which could have a significant impact from a quality perspective and in addition, was working with Dr Kate Wood and Amanda Stanford to ensure that clinicians and nursing staff were included. Emma Sayner stated that quality is vital and central to everything the Group does, and particularly as the Group is setting the plan for 2025/26 and its strategy going forward, and she would therefore be expecting a more rigorous and robust demonstration of this.

Gill Ponder understood that as part of cost improvement programmes, there should be two assessments, namely a quality impact assessment as well as an equality impact assessment. Jane Hawkard confirmed that the Group performed this jointly under the term EQIA. Gill Ponder asked that it be made clear that it was one integrated report as both aspects need to be considered. Jane Hawkard questioned how the ARG CIC could be assured this would happen. Simon Parkes suggested that it would be appropriate to ask the Quality & Safety CIC to seek appropriate assurance on how they receive assurance on the appropriate and compliant completion of EQIA's in relation to CIP projects, and add to the Quality and Safety CIC workplan and then close the action from the ARG CiC perspective. This would also go in the Highlight Report to the Boards-in-Common.

Action: Jane Hawkard

Emma Sayner stated there was a need to improve describing the Group's ambition around cost improvement and productivity and this was an ongoing development. Simon Parkes stressed it needed to be clear in the Highlight Report what the ARG CiC was providing assurance on, it was not providing assurance that the CIP plan was adequate or on track as this was a PEF CiC matter, it was providing specific assurance on the recommendations around processes in the CIP report.

Emma Sayner noted that Mike Smith had joined the meeting via MS Teams and Jane Hawkard asked him if there was anything he wished to add. Mike Smith advised that since the time of the report there had been subsequent engagement with PA Consulting and an ask to extend their remit which he understood had been approved, and points raised within the report were to be more comprehensively addressed, as the Trust was looking to set up a CIP programme management office (PMO). Additionally with reference to the EQIAs, these would become part of the PMO remit as all CIP projects have a PID and also an EQIA. Jane Hawkard thanked Mike Smith for the report.

Mike Smith left the meeting.

8.

Counter Fraud - Group

8.1 Group LCFS Progress Report

There was an initial discussion around the frequency of this report on the workplan as it currently comes to each meeting. It was noted that the LCFS Progress Report was not in the papers on Team Engine and it was considered that this may be due to workforce issues. Emma Sayner agreed to check with Sally Stevenson on her return from annual leave. Simon Parkes stated that in the absence of the usual report they could reasonably take assurance that there were no serious frauds being dealt with by the LCFS as they would have been escalated to the Group Chief Financial Officer and the ARG CiC Chairs.

Post meeting note: The LCFS Progress Report had been prepared and submitted for the papers by Sally Stevenson, but due to an oversight it had not been uploaded to Team Engine. It had however been circulated to the auditors / NLAG Governor in their meeting paper bundle. The report was subsequently circulated to all ARG CiC members by Sally Stevenson on 29.1.25.

9. *Fran Moverley and Liz Houchin joined the meeting. Helen Higgs left the meeting.*

Management Reports for Assurance

9.1 Annual Review of HUTH Arrangements for Raising Concerns/Freedom to Speak Up

Jane Hawkard noted that both reports were comprehensive and asked if there was anything new that Fran Moverley would like to add to the HUTH report. Fran Moverley highlighted assurance around Group working, although this was covered in the report. Jane Hawkard highlighted the difference in the number of concerns raised between the two Trusts, and an increase of 100% from 2023/24 at HUTH. Fran Moverley explained this was due to the fact that the role was now a stand-alone role, not an add on to someone else's role, and the capacity had also been increased. Additionally, there was now more engagement, with better links to the Communications team with more of a push in varying communication channels, etc. which may have all contributed to the increase in the number of concerns raised.

9.2 Annual Review of NLaG Arrangements for Raising Concerns/Freedom to Speak Up

Liz Houchin highlighted that the internal audit review had resulted in significant assurance around the Freedom to Speak Up processes.

Matt Overton joined the meeting.

Gill Ponder noted the increase in numbers of staff speaking up and stated this should be applauded as it showed that people felt safe to speak up. However, Gill Ponder asked for assurance that no one suffers any detriment from speaking up and questioned why there was a reference to assurance from Human Resources (HR) that no disciplinary cases had been brought against someone who had spoken up. Gill Ponder questioned whether there may be a need for a more detailed check into whether there have been any disciplinary cases brought against the person as opposed to the reason why. Fran Moverley replied to say that the 2024 NHS Audit Committee Handbook now included a section on this and

that Audit Committees should ask for assurance about the HR processes and they had spoken to Simon Nearney, Group Chief People Officer as to how this assurance could be given. However, the FSUG's do not have access to HR cases due to confidentiality and, likewise, HR do not have access to the names of people who have spoken up, so it is difficult to know. Liz Houchin agreed that it was difficult to provide complete assurance but after discussion with Simon Nearney it was decided this was the best way to give some level of assurance. Liz Houchin added that if someone informed them that they felt they had suffered a detriment as a result of speaking up, there was a process in place whereby Non-Executive Directors look at the case and unpick it to assess whether any detriment has indeed occurred.

Liz Houchin also echoed Fran Moverley's comments around the excellent work with the Communications team in communicating to staff about the safe process of speaking up without suffering any detriment. Liz Houchin acknowledged Gill Ponders comments and advised she was happy to take any suggestions from the ARG CIC on how to gain assurance.

Julie Beilby noted the good reports and work in putting the Group in a good place with regards to Freedom to Speak Up. However, Julie Beilby commented that what was missing was triangulation of data from the various processes that happen across the organisation and advised that she would raise this at the Workforce, Education and Culture (WEC) CiC in the first instance. Julie Beilby questioned whether there were hotspots (areas / departments) where the culture had become acceptable, adding that there is a need to triangulate Freedom to Speak Up intelligence with other workforce data, to ensure that it does not sit in isolation but assists, acknowledging the confidentiality aspects, with the overall picture of the organisation in terms of whistleblowing, Freedom to Speak Up and grievances. Julie Beilby agreed to discuss at WECC when the staff survey is discussed. Referral to WECC.

Action: Julie Beilby

Edd James joined the meeting.

Simon Parkes was not sure that the ARG CIC could be assured on the wording of the paragraph in the report, and suggested that Simon Nearney who should have access to both sides of the issue, would be the officer to provide assurance that no one had suffered detriment as a result of speaking up. Simon Parkes also concurred with Julie Beilby's comments about seeing things in isolation and potentially missing a bigger picture about how staff are feeling within the organisation. Simon Parkes added that there was still uncertainty around how the ARG CiC could be assured that a sufficient proportion of staff were confident in speaking up when considering the evidence of the staff survey for example, and there needed to be broader sense checking around how open the organisation is to such feedback. Jane Hawkard concluded that Simon Nearney should be asked to respond to this, to provide assurance that no member of staff who has spoken up has been subject to a disciplinary or performance review as a result.

Action: Jane Hawkard

Liz Houchin added that the internal audit did refer to triangulation and that across the region, as well as nationally, there was emphasis on how the FSUG data was not looked at in isolation and she and Fran Moverley were working with the Care

Group Triumvirates to send out quarterly information and work with them with the expectation that they perform triangulation work which would ultimately appear in Power BI. Liz Houchin concluded there was more work to do and recognised the gap.

Jane Hawkard stated that the ARG CIC did have assurance about the speaking up process and noted that people were raising concerns at NLAG, more so than at HUTH, but that NLAG was smaller. The expectation was that this would re-balance. Jane Hawkard confirmed this would be raised at the WEC CIC. Fran Moverley also referred to the Model Hospital data and noted that both Trusts are in the upper quartile for the number of concerns raised, with NLAG actually being in the top ten.

David Sharif stated that the data for NLAG fluctuated and felt that staff perhaps draw on it as and when required. However, Liz Houchin responded that since she commenced in the role five years ago, it had always been an upwards trend with an increase in the number of concerns raised, which she believed was down to a new awareness of the role and the dedicated support of the Communications team, along with the publishing of the outcomes that shows people that speaking up does make a difference. Tony Curry observed that historically, the NHS faced problems with people speaking out often facing a non-positive outcome and a history of inaction.

Jane Hawkard thanked Fran Moverley and Liz Houchin for their reports and they left the meeting.

9.3 Group EPRR Highlight Report

Jane Hawkard asked Matt Overton if there was anything he particularly wished to highlight before questions. Matt Overton advised that the coastguard helicopter could no longer land at the Hull Royal Infirmary (HRI) helipad but a mitigation was in place with the provision of a secondary transfer. Simon Parkes added that this was due to the size and power of the helicopter being used, so not something the Trust could control, but asked what proportion of helicopters landing were from the coastguard versus standard helicopters from other services. Matt Overton replied that the coastguard helicopter had landed approximately once a month over the previous twelve months and informed the ARG CIC that NHSE had started a national lead to review all helipads and have asked for authorised manager details in advance of the review. The new ruling did not affect standard helicopters, which still land multiple times a week at HRI which Matt Overton understood to average one landing a day. Simon Parkes concluded that the scale of coastguard helicopter landings were therefore in the minority.

Jane Hawkard referred to the business continuity plans and the task and finish group now in place to gain additional assurance, and asked for the timescale on it. Matt Overton reported seeing an improvement month on month with an aim to be >90% by the end of March 2025. For those Care Groups were there was no evidence of improvement they would be written to by Matt Overton, to gain assurance on performance before the end of March 2025. Jane Hawkard asked for clarification around the compliance rates shown in the report and this was explained by Matt Overton. Last year HUTH was 18% compliant with the core standards, and there was an action plan in place for the remainder to achieve compliance. The previous update report in October 2024 showed that it had

increased to 85% compliance at HUTH. This year's score standards assessment was then completed but was now reported at 69%. Matt Overton explained this was due to the fact that there had been a series of exercises and also an audit completed by the Yorkshire Ambulance Service on HRI's CBRN and HAZMAT preparedness, resulting in some additional actions as some multiple core standards for HUTH aligned to the CBRN were now only partially compliant when they were full compliance previously. As a result, there is a detailed action plan around this for HUTH. The team were also looking at the expertise on the south bank, to work collaboratively in improving the CBRN and HAZMAT preparedness at HRI. The current compliance rate is 69% for HUTH.

Matt Overton explained the EPRR core standards assessment process commenced in August each year and was signed off at the end of December. The current action plan therefore runs through to next December, and will then be superseded by the outcome of the assessment which commences in August 2025.

Jane Hawkard was assured that there was a really good process in place, and thanked Matt Overton for his report.

Matt Overton left the meeting.

9.4 Group Procurement Update (including update on stock management / cost reduction)

Jane Hawkard advised that the ARG CiC had asked for an update on the position with stock management and asked Edd James to focus on the stock management slide in his report. Edd James advised of the aim to align his report with the HUTH internal audit report on stock management that had been expected at the meeting but was not ready and therefore in the interim this was a more high level update, with a more detailed report to be provided once the audit report was available. The report was an overview of how stock was managed around the Trusts. 61% of clinical areas are serviced by Procurement for stock management at HUTH and 80% at NLAG, with a big difference in the number of products covered suggesting a split between Procurement managed and self-managed.

Edd James also advised they had looked at the amount of stock being held. Nationally, it was agreed that two weeks' worth of stock being held was a sensible level. Most of the Group's deliveries were within three days of the order being placed, and NLAG were performing well against that in that at 19.2 days of stock as opposed to HUTH at 55 days of stock. At HUTH, there was a dual inventory management system in place (TAGNOS and EDC) whereas NLAG use the NHS Supply Chain EDC system only. York are also using EDC but are moving to the new solution across the collaborative, ELCOM.

Gill Ponder referred back to her earlier question at agenda item 5.2 around the high level of stock holding at HUTH and whether this corresponded to a high level of wastage. Edd James stated that out of date stock was not tracked as well as it should be, so the answer was probably yes but there is not the evidence to support it. The Scan for Safety team had seen and collated some out of date stock as part of their rollout work. Gill Ponder referred to the routine reporting of wastage at NLAG via the Losses and Compensations Reports, but nothing was reported for HUTH yet HUTH were holding more stock and therefore logic would suggest they would write off more stock. Edd James considered that it was a reporting issue

rather than a better management issue. Jane Hawkard asked whether this would be included in the internal audit work, and Laura Gough replied that this was included in the internal audit currently being performed and the team were working with management from the Scan for Safety and Procurement teams to agree the draft report, confirming there was an item on enhanced reporting on what wastage there is and why.

Jane Hawkard referred to the contract renewals reducing from £102m to £66m stating this was good to see, and asked if this was due to anything in particular. Edd James advised that this was predominantly related to data cleansing around one contract that had been entered incorrectly and had been updated. Jane Hawkard also referred to Procurement team staffing numbers and asked whether more savings could be made if there were more people in Procurement. Edd James advised that he had been at the Financial Performance Improvement Board (FPIB) meeting the previous week to present a paper around this and the Group Chief Executive had requested a paper be presented to the Group Cabinet that week, but was delayed to the following week, which would seek approval to commence recruitment into some of the vacancies.

Helen Wright thanked Edd James for the helpful report and noted in relation to Performance, Estates & Finance (PEF) CIC meeting in December 2024, that it was good to see the high confidence level around hitting the savings targets for the current year and questioned whether there an expectation to over deliver and if so to what extent. Edd James replied that he did not expect to over deliver this year, advising that suppliers were starting to ask to increase prices since the rise of the national minimum wage and National Insurance contributions, which was impacting the ability to deliver savings.

Jane Hawkard concluded that this report would now be better placed at the PEF CIC as the ARG CIC now had the assurance around the contract expiry reductions. The routine annual report on KPI's would still come to the ARG CiC in November each year. This was agreed by the ARG CiC, and the work plans for both CiC's are to be amended to reflect this.

Action: PEF CiC Chairs / Sally Stevenson

Edd James left the meeting.

9.5 Group HFMA Improving NHS Financial Sustainability Self-Assessment Checklist

Helen Wright noted the 1.5 score for Board reporting acknowledging the reason for this (financial papers taken to PEF CiC not the Boards in Common) and wanted to check that the ARG CIC were content with it staying with the PEF CIC, and also confirm what is the score for the papers going into PEF CiC. Emma Sayer responded that this was being discussed with the Finance team in terms of compliance with this question, and raised the question of whether the Boards-in-Common needed more enhanced / formal reporting on Group finances. Emma Sayner added that she was keen to work with the ARG CiC on this as necessary.

Gill Ponder referred to question B2 (budget sign off) and whether this needed to be earlier than June. Emma Sayner responded that the work is driven by NHSE timelines and it is sometimes impossible to do this, but knows that budget setting is going on in the background. However Emma Sayner suggested that she could look

at something with the Finance team to provide interim assurance. Gill Ponder acknowledged this and stated that more work could be done with the Care Groups in tightening controls on spending from the start of the financial year, to which Emma Sayner agreed there needed to be a cultural shift on how decisions were made on new items, things being stopped, etc. in order to live within our means. A monthly Business Case Review Group meeting had been implemented to ensure that there was a multi-disciplinary structure to the decision making process. Emma Sayner believed that the previous year had been affected by the new Group structure and late national planning guidance, but there was work underway with the Care Groups on addressing their in-year accruals to get a better grip on them.

Gill Ponder referred to question F1 (format of the reporting) and stated there had been a lot of discussion at the PEF CIC to agree the format of the report which used to go the Board, but then the view was taken that as the Group Chief Executive included a high level summary in his Board report and the Boards-in-Common received the PEF CiC Highlight Report it was not necessary to have another Finance report going to the Board. The ARG CiC then discussed as to whether the Finance report (that goes to the PEF CiC) could be included in the Board papers for information, with Jane Hawkard and David Sharif confirming that the IPR was already included, but not the Finance report. It was stated that the format of the Finance report was excellent. David Sharif advised that his team were in the process of reviewing the board reporting framework. Helen Wright commented that it is not about saying that the organisations don't have Board reporting, it's that the organisations are choosing to receive it at the PEF CiC and not the Boards-in-Common. Simon Parkes added that the Boards-in-Common had delegated the oversight of finance to the PEF CIC, and therefore in the context of the HFMA checklist it would be reasonable to consider PEF CiC as a substitute for the Boards-in-Common. However, the Boards-in-Common have been discussing finance much more because of the risks around finances and the delivery of CIP and therefore it is probably currently inadequate given the scale of the risk and therefore the Finance report should go as an appendix to the Board papers. Helen Wright commented that the report should be forward focussed and therefore needed some consideration as to what went to the Boards-in-Common.

Action: Emma Sayner

Simon Parkes also suggested that there be a provisional budget allocation for the Care Groups before the start of the financial year so that it was clear to them before there is any spend. Simon Parkes acknowledged however that there may be practical system issues that prevent this from being done, and if so it may need further discussion at the PEF CIC to demonstrate that financial control by the Care Groups is in place from April before budgets are signed off.

Action: Emma Sayner

Julie Beilby believed there was evidence of a cultural issue and questioned whether the Risk Registers were being used correctly and also thought that the Group needed to have multiyear planning in place as soon as possible which would prove to be a big cultural shift for the organisation. Emma Sayner agreed there was a clear need to work with Care Groups in looking ahead at large transformational pieces of work as opposed to small projects and the financial implications and also advised that she was meeting with Lindsay Cunningham to

look at the financial strategy from a medium term point of view. Emma Sayner stated that the size of the cultural challenge could not be underestimated.

The ARG CiC meeting paused for a 10 minute break at 11.10am.

9.6 Group Board Assurance Framework

David Sharif stated that it was the same report that had already been to the Boards-in-Common, which had resulted in a number of actions around some of the high scores, etc. As part of that challenge process there was to be a series of meetings with Executives looking at the BAF refresh as a whole and continuing the strategic focus in the use of the BAF and this would be seen at the next Boards-in-Common meeting. Simon Parkes commented that that work would be important, citing the example of the people risk and stating it was not credible the organisations are facing such a catastrophic risk that is likely to materialise based on the risk of not implementing compassionate leadership or poor working conditions, and there was a need to be more realistic and looked forward to seeing responses from Executive colleagues. Jane Hawkard reiterated the need to see evidence of more mitigations with a more mitigated score. David Sharif recognised there was a need to see the mitigated score post the actions described and this would be included in the next phase of work. Helen Wright suggested having tolerable scores and working backwards from there.

Jane Hawkard asked a question around the Group Risk Register (agenda item 9.7) and was concerned that some significant items had no evidence of any mitigations against them. David Sharif responded that this was part of the development of the processes going forward but wanted to assure the ARG CIC that as part of the performance and accountability meetings that were now being held with the Care Groups, this was an opportunity for them to be reminded of their responsibilities around risk management. However, David Sharif recognised that it was unfortunately not yet where it needed to be and there were clearly still cultural issues which would take time to overcome.

The ARG CiC discussed how the Risk Register may be being misused by managers to transfer responsibility for risks to someone else when there was no funding available. The number of high risks on the Risk Register was also a significant concern for the ARG CiC and how this could be overcome. Gill Ponder stated that it was important to use the correct language in the Risk Register in so far as to nominate an accountable officer who would be responsible for the management of that risk and mitigating it. It was noted that mitigating actions were missing for some high risks.

David Sharif suggested that the ARG CIC invite himself and Amanda Stanford, Group Chief Nurse, to give a specific update on the position regarding risks across the Care Groups at the next meeting. This was agreed.

Action: David Sharif / Amanda Stanford

Helen Wright questioned how the Group Cabinet gained comfort that risks are managed appropriately and are not catastrophic. David Sharif replied that this was made through the monthly GCRAC meetings at which all of the Group Executives

attend, and suggested that the ARG CiC concerns be brought to their attention as a matter of urgency with a request for an immediate response. This was agreed.

Action: David Sharif

Jane Hawkard advised that she would also write to the Group Chief Executive with the ARG CiC's extreme concern as discussed.

Action: Jane Hawkard

David Sharif added that the Risk and Compliance meetings with the Care Groups looked at their high and moderate risks and challenged every element of each one. The GCRAC meetings take a slightly different approach in looking at the risk profile overall. Julie Beilby questioned where the strategic risks were being addressed in more detail. Jane Hawkard stated they were in the BAF and David Sharif agreed, however as far as the Group wide (formerly corporate risks) risks were concerned, there was no strong framework as yet. GCRAC had been rightly concerned with other aspects of risks across the organisations, but essentially was the place for these risks to be channelled into.

Andy Haywood and Sue Meakin joined the meeting.

9.7 Group Risk Register

This was included in the discussions at item 9.6 above.

9.8 WISHH Charitable Funds Governance Arrangements

Jane Hawkard advised that she had asked for this report to gain clarification on the governance arrangements, which it gave. Gill Ponder noted that in the Charity objectives, there was no mention of staff benefits as there was at NLAG. Jane Hawkard, however, stated there was reference to staff benefits in the HUTH objectives. Gill Ponder also queried the fundraising and income for WISHH and whether there should be a strategic look at the best form of governance for the two Trusts fundraising efforts whilst minimising costs, etc. Tony Curry concurred and advised he had formally raised the same question at the HUTH charity committee recently, although it had not been answered as yet.

Emma Sayner clarified section 2.1 of the paper relating to the makeup of the WISHH Trustee Board and advised that she was not the replacement for Lee Bond, believing it to be David Sharif. Emma Sayner also advised that she needed to consider how this tracked into The Health Tree Foundation where she was a Trustee.

10. Policies for Review/Approval

10.1 Annual Review of Policy for Engagement of External Auditor for Non-Audit Work – Group

The newly merged Group policy was approved.

11. ARG CiC Governance Items

11.1 Results of ARG CiC Annual Self-Assessment Exercise 2025

Helen Wright questioned who the two nominated Vice Chairs for the ARG CiC were. Gill Ponder stated that she was the Vice Chair for NLAG but there was uncertainty for HUTH. David Sharif agreed to check with Linda Jackson.

Action: David Sharif

Gill Ponder referred to point 4.8 in that both the 'Yes' and 'No' boxes were ticked and Jane Hawkard felt this needed to be a 'Yes'. The ARG CiC approved the self-assessment exercise 2025 for submission to the Boards-in-Common.

Action: Sally Stevenson

11.2 Annual Review of ARG CiC Terms of Reference – NLAG

The ARG CiC approved the proposed adjustments to the NLAG ToR, subject to inclusion of wording around nomination of a Vice Chair for the ARG CiC. These will be submitted to the Boards-in-Common for ratification.

Action: Sally Stevenson

11.3 Annual Review of ARG CiC Terms of Reference – HUTH

The ARG CiC approved the proposed adjustments to the HUTH ToR, subject to inclusion of wording around nomination of a Vice Chair for the ARG CiC. These will be submitted to the Boards-in-Common for ratification.

Action: Sally Stevenson

11.4 Annual Review of ARG CiC Aligned Work Plan 2025/26

Jane Hawkard proposed there should be reference to having assurance around charitable funds governance arrangements for both The Health Tree Foundation (NLAG) and WISHH (HUTH) once a year. Jane Hawkard also proposed adding consideration of system risk into the risk management section of the workplan. Simon Parkes added that these needed to be aligned in the Terms of Reference also. Subject to these two adjustments the ARG CiC Aligned Work Plan for 2025/26 was approved.

Action: Sally Stevenson

12. Highlight Reports and Action Logs from Board Sub-Committees-in-Common

12.1 Performance, Estates & Finance CiC
12.2 Capital & Major Projects CiC
12.3 Quality & Safety CiC
12.4 Workforce, Education & Culture CiC
12.5 Health Tree Foundation Trustees' Committee

The above highlight reports and action logs were received for information. There were no issues raised.

13. Private Agenda Items

Items 13.1 to 13.3 were minuted as private agenda items.

14.

Any Other Urgent Business

There was no urgent business to discuss.

15.

Matters for Escalation to the Trust Boards-in-Common (Public/Private)

The following items of business were agreed to be highlighted to the public Trust Boards-in-Common:

- Group Internal Audit Update
- Freedom to Speak Up Arrangements Update
- Group Risk Register
- Approval of Group Policy for Engagement of External Auditor for Non-Audit Work
- ARG CiC Governance Documents (self-assessment exercise and adjustments to Membership and Terms of Reference documents)

16.

Matters to Highlight to other Trust Board CiC

- Referral to Quality & Safety CIC regarding assurance on EQIA's
- Referral to WEC CiC regarding triangulation of FSUG data and other workforce data.

17.

Review of the Meeting

Any feedback from the meeting to be forwarded to Sally Stevenson.

18.

Audit Services Items – Private

Items 18.1 and 18.2 were minuted as private agenda items.

19.

Date of the Next Meeting

The next full meeting of the Audit, Risk and Governance Committees-in-Common will be held on Thursday 24 April 2025 at 9.00am to 12.30pm in the Boardroom, HRI and via MS Teams.

The ARG CiC Chair closed the meeting at 12.36pm.

Schedule of Attendance at ARG CiC Meetings 2024/25

Member / Attendee	Apr-24	Jun24 HUTH only[1]	Jul-24	Aug24 NLAG only[2]	Oct24	Jan-25	Total
Members - NLAG:							
Simon Parkes – NED / ARG CiC Chair	Y	N[1]	Y	Y	Y	Y	5/5
Gill Ponder – NED	Y	N[1]	N[3]	N[3]	Y	Y	3/5
Kate Truscott – NED (to Aug 24)	Y	N[1]	N[3]	N[3]	-	-	1/3
Julie Beilby – NED (from Jan 25)	-	-	-	-	-	Y	1/1
Members - HUTH:							
Jane Hawkard – NED / ARG CiC Chair	Y	N	Y	N[2]	Y	Y	4/5
Mike Robson – NED (to Apr 24)	Y	-	-	-	-	-	1/1
Tony Curry – NED	Y	Y[4]	Y	N[2]	Y	Y	5/5
Helen Wright – NED (from Jun 24)	-	Y	N	N[2]	Y	Y	3/4
Regular Attendees:							
Lee Bond – Group CFO (to Aug 24)	Y	Y	Y	Y	-	-	4/4
Mark Brearley – Interim Group CFO	-	-	-	-	Y	-	1/1
Emma Sayner – Group CFO(from Jan 25)	-	-	-	-	-	Y	1/1
David Sharif – Group Director of Assurance	Y	Y	Y	N[6]	Y	Y	5/6
Rebecca Thompson – Deputy Director of Assurance - HUTH	Y	Y	Y	Y	N	Y	5/6
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	Y	N	5/6
Nicki Foley – Group Local Counter Fraud Specialist	Y	N[5]	Y	N[5]	Y	N	3/4
External Audit - NLAG (Sumer NI)	Y	N[1]	Y	Y	Y	Y	5/5
External Audit – HUTH (Forvis Mazars)	Y	Y	Y	N[2]	N	Y	4/5
Internal Audit - NLAG (Audit Yorkshire)	Y	N[1]	Y	Y	Y	Y	5/5
Internal Audit – HUTH – (RSM)	Y	Y	Y	N[2]	Y	Y	5/5
Group DPO / IG Lead (Sue Meakin)	Y	N[5]	Y	N[5]	Y	Y	4/4
NLAG Governor Observer (Various)	Y	N[1]	Y	N	Y	Y	4/4
Member / Attendee	**Apr-24**	**Jun24 HUTH only[1]**	**Jul-24**	**Aug24 NLAG only[2]**	**Oct24**	**Jan-25**	**Total**

Ad-hoc Attendees:							
Asst. DoF – Planning & Control (Nicola Parker)	Y	Y	-	Y	-	-	3
Deputy Director D2A Transformation (Rachel Kemp)	Y	-	-	-	-	-	1
Director of People Services (Helen Knowles)	Y	-	-	-	-	-	1
Group Chief Technology Officer (Tony Deal)	Y	-	-	-	-	-	1
Group Chief Digital Officer (Andy Hayward)	Y	-	-	-	Y	Y	3
Group Chair (Sean Lyons)	-	Y	-	Y	-	-	2
Group Chief Executive (Jonathan Lofthouse)	-	Y	-	Y	-	-	2
HUTH Vice Chair / NED (Stuart Hall)	-	Y	-	-	-	-	1
Non-Executive Director (Sue Liburd)	-	-	Y[3]	-	-	-	1
NLAG Vice Chair / NED (Linda Jackson)	-	-	Y[3]	Y[3]	-	-	2
Interim Group Director of Quality Governance (Rob Chidlow)	-	-	Y	-	-	-	1
Group Chief Delivery Officer (Paul Bytheway)	-	-	Y	-	Y	-	2
Group Operations Director EPRR (Matt Overton)	-	-	Y	-	Y	Y	3
Director of Procurement (Edd James)	-	-	Y	-	Y	Y	3
Group Director of IT Performance & Operations (Steve Mattern)	-	-	Y	-	-	-	1
Deputy Director of Assurance – NLAG (Alison Hurley)	-	-	-	Y	-	-	1
Group Deputy Director of Communications (Adrian Beddow)	-	-	-	Y	-	-	1
Deputy Group Chief Financial Officer (Philippa Russell)	-	-	-	-	Y	-	1
Senior Head of Finance - Cost Improvement & Efficiency (Mike Smith)	-	-	-	-	-	Y	1
HUTH Freedom to Speak Up Guardian (Fran Moverley)	-	-	-	-	-	Y	1
NLAG Freedom to Speak Up Guardian (Liz Houchin)	-	-	-	-	-	Y	1

Notes:
[1] HUTH audited accounts meeting only
[2] NLAG audited accounts meeting only
[3] Sue Liburd and / or Linda Jackson in attendance to ensure quoracy
[4] Tony Curry as Chair
[5] Not required to attend, audited accounts meeting only
[6] Alison Hurley deputising

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(25)121

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 June 2025
Director Lead	**Emma Sayner, Group Chief Financial Officer**
Contact Officer / Author	Philippa Russell, Deputy Director of Finance
Title of Report	**Group Finance Report – Month 1 – 2025/26**
Executive Summary	This report highlights the reported financial position of Month 1 of the 2025/26 reporting period.
Background Information and/or Supporting Document(s) (if applicable)	-
Prior Approval Process	-
Financial Implication(s) (if applicable)	Contained within the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Finance Report Month 1
April – 2025/26

Finance Overview

In-month I&E Performance – page 3

(£0.0m) The Group reported a (£2.5m) in-month deficit for month 1, marginally adverse to plan.

Year to Date I&E Performance – page 3

(£0.0m) The Group reported a (£2.5m) year to date deficit for month 1, marginally adverse to plan.
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I&E Forecast Outturn – page 4

(£40.6m) The Group is forecasting a deficit of (£66.9m) based on an adjusted straight-line projection. Mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£40.6m) across the Group.

YTD Cost Improvement Plan – page 5

(£2.6m) The Trust has delivered £5.2m in CIP against a YTD target of £7.8m, (£2.6m) behind target. Unidentified CIP of £47.7m and a risk adjusted forecast of £60.6m, (£69.4m) adverse to target.

Underlying I&E – page 6

(£119.8m) The Group's underlying position is estimated at a deficit of circa (£119.8m). Recurrent CIP delivery will be the key variable to the Group's underlying position.

System Performance – page 7

(£2.40m) The ICB reported a YTD deficit of (£5.90m), (£2.40m) adverse to plan. The ICS is forecasting a break-even position as planned.

Capital Expenditure – page 8

(£1.8m) The Group has spent £0.2m on capital expenditure against a plan of £2.0m plan, (£1.8m) behind plan.

Balance Sheet & Cash – pages 9 & 10

£81.7m The Group's cash balance at the end of month 1 was £81.7m. CIP delivery will be the key variable in determining if external cash support will be required in year. This will be monitored closely.

Elective Recovery Performance –

£0.0m The Group's ERF baselines and contractual arrangement for Elective Recovery Funding are still to be confirmed with the ICB. The Group have assumed no penalties for month 1.

Temporary Staffing – pages 11

(£0.1m) The Group has spent £5.5m on agency and bank pay YTD. This is (£0.1m) more than the same period in 2024/25.

Key Risks

- ❑ Unidentified CIP and reliance on Non-Recurrent schemes.
- ❑ ICS Risk share arrangement for CDC and HCDs growth.
- ❑ Winter pressures / unfunded Escalation Beds.
- ❑ Unidentified stretch income target
- ❑ Capital Expenditure profile
- ❑ Requirement for Revenue Cash Support if CIP not fully identified

Key Actions

- ❑ Reducing cost pressures: reliance on premium bank and agency; minimising escalation beds; and greater control of non-pay expenditure.
- ❑ Maximising planned care activity within core capacity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- ❑ Delivering a challenging CIP programme – conversion of non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target.
- ❑ Reduce underlying run rate spend within Care Groups.

Financial Performance Summary

The Group ended April with a year-to-date (YTD) deficit of (£2.5) which was marginally adverse to plan.

£million	HUTH £m						NLAG £m						Group £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.1	75.6	0.5	75.1	75.6	0.5	46.3	45.3	(1.0)	46.3	45.3	(1.0)	121.4	120.9	(0.5)	121.4	120.9	(0.5)
Other Income	6.0	7.0	1.0	6.0	7.0	1.0	5.9	4.5	(1.4)	5.9	4.5	(1.4)	11.8	11.4	(0.4)	11.8	11.4	(0.4)
Total Operating Income	**81.1**	**82.5**	**1.5**	**81.1**	**82.5**	**1.5**	**52.1**	**49.8**	**(2.3)**	**52.1**	**49.8**	**(2.3)**	**133.2**	**132.3**	**(0.9)**	**133.2**	**132.3**	**(0.9)**
Pay Costs																		
Clinical Pay	(38.7)	(40.3)	(1.7)	(38.7)	(40.3)	(1.7)	(27.8)	(27.5)	0.3	(27.8)	(27.5)	0.3	(66.5)	(67.8)	(1.3)	(66.5)	(67.8)	(1.3)
Other Pay	(8.1)	(8.3)	(0.2)	(8.1)	(8.3)	(0.2)	(7.2)	(7.0)	0.2	(7.2)	(7.0)	0.2	(15.3)	(15.3)	0.0	(15.3)	(15.3)	0.0
Total Pay Costs	**(46.8)**	**(48.6)**	**(1.8)**	**(46.8)**	**(48.6)**	**(1.8)**	**(35.0)**	**(34.5)**	**0.5**	**(35.0)**	**(34.5)**	**0.5**	**(81.8)**	**(83.1)**	**(1.3)**	**(81.8)**	**(83.1)**	**(1.3)**
Clinical Non Pay	(18.1)	(18.7)	(0.6)	(18.1)	(18.7)	(0.6)	(7.4)	(7.3)	0.1	(7.4)	(7.3)	0.1	(25.5)	(26.0)	(0.5)	(25.5)	(26.0)	(0.5)
Other Non Pay	(13.3)	(12.6)	0.7	(13.3)	(12.6)	0.7	(6.9)	(6.9)	(0.0)	(6.9)	(6.9)	(0.0)	(20.2)	(19.5)	0.6	(20.2)	(19.5)	0.6
Total Non Pay Costs	**(31.4)**	**(31.3)**	**0.1**	**(31.4)**	**(31.3)**	**0.1**	**(14.3)**	**(14.2)**	**0.1**	**(14.3)**	**(14.2)**	**0.1**	**(45.6)**	**(45.5)**	**0.2**	**(45.6)**	**(45.5)**	**0.2**
Total Operating Expenditure	**(78.2)**	**(79.9)**	**(1.7)**	**(78.2)**	**(79.9)**	**(1.7)**	**(49.3)**	**(48.7)**	**0.6**	**(49.3)**	**(48.7)**	**0.6**	**(127.5)**	**(128.6)**	**(1.2)**	**(127.5)**	**(128.6)**	**(1.2)**
EBITDA	**2.9**	**2.6**	**(0.3)**	**2.9**	**2.6**	**(0.3)**	**2.8**	**1.0**	**(1.8)**	**2.8**	**1.0**	**(1.8)**	**5.7**	**3.7**	**(2.1)**	**5.7**	**3.7**	**(2.1)**
Depreciation	(2.4)	(2.4)	0.0	(2.4)	(2.4)	0.0	(2.1)	(1.9)	0.1	(2.1)	(1.9)	0.1	(4.5)	(4.3)	0.1	(4.5)	(4.3)	0.1
Non Operating Items	(1.4)	(1.2)	0.2	(1.4)	(1.2)	0.2	(0.7)	(0.6)	0.0	(0.7)	(0.6)	0.0	(2.1)	(1.9)	0.2	(2.1)	(1.9)	0.2
Surplus/(Deficit)	**(0.9)**	**(1.1)**	**(0.1)**	**(0.9)**	**(1.1)**	**(0.1)**	**0.1**	**(1.5)**	**(1.6)**	**0.1**	**(1.5)**	**(1.6)**	**(0.8)**	**(2.6)**	**(1.7)**	**(0.8)**	**(2.6)**	**(1.7)**
NHSE Allowable Adjustments	(0.1)	0.0	0.1	(0.1)	0.0	0.1	(1.5)	0.1	1.6	(1.5)	0.1	1.6	(1.6)	0.1	1.7	(1.6)	0.1	1.7
Adjusted Surplus / (Deficit)	**(1.0)**	**(1.1)**	**(0.0)**	**(1.0)**	**(1.1)**	**(0.0)**	**(1.4)**	**(1.4)**	**(0.0)**	**(1.4)**	**(1.4)**	**(0.0)**	**(2.4)**	**(2.5)**	**(0.0)**	**(2.4)**	**(2.5)**	**(0.0)**

- **The Group reported a (£2.5m) deficit for April 2025, which is marginally adverse to plan. However, £2.1m of non-recurrent technical balance sheet was released in month to support the financial position.**
- The Group is behind on its CIP programme by (£2.6m),with £47.7m unidentified CIP and is forecasting a risk adjusted forecast adverse variance of (£69.4m).
- The Group cash balance increased by £14.2m in month to £81.7m (£48.6m HUTH / £33.1m NLAG). CIP delivery will be the key risk to cash flow for the remainder of the year and will be monitored closely.

See Appendix A on Page 17 to 18 for Detailed I&E Position

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£66.9m) based on an adjusted straight-line projection. Mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£40.6m) across the Group.

The Group is currently in line with plan at the end of month 1 but has been supported through non-recurrent technical support of £2.1m. The underlying adverse variance is largely driven by the shortfall in CIP delivery.

A straight-line forecast projects a potential deficit of (£29.8m) against a balanced plan.

This has been adjusted for non-recurrent balance sheet support, known seasonal variation in energy and drug costs, planned completion of Capital programme, increasing depreciation charges and anticipated investment in expansion of CDC and Daycase units resulting in an adjusted forecast deficit to plan of (£66.9m).

CIP delivery is forecast to increase on the current in month delivery by £19.1m.

In addition, there is an element of the risk share income agreed with the ICB that is not yet identified - £6.8m.

The above actions reduce the deficit leaving an unidentified gap of (£40.6m) adrift of a balanced plan.

The Group is formally reporting a plan compliant balanced forecast position.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	Group £'m
YTD deficit (M1)	(1.0)	(1.4)	(2.5)
Straight line forecast	**(12.6)**	**(17.2)**	**(29.8)**
Seasonality	(3.5)	(2.8)	(6.3)
CDC	(5.0)	-	(5.0)
Daycase Unit	(1.2)	-	(1.2)
Non Recurrent Flexibility in YTD position	(16.0)	(7.3)	(23.3)
Depreciation and Interest Received	-	(1.3)	(1.3)
Adjusted Run Rate	**(38.3)**	**(28.6)**	**(66.9)**
Forecast CIP delivery (improvement in run-rate)	13.7	5.5	19.1
Non recurrent mitigation	0.3	-	0.3
Income target	3.4	3.4	6.8
Unidentified Gap	20.9	19.7	40.6
Reported Forecast deficit	**(0.0)**	**(0.0)**	**(0.0)**
Plan	**-**	**-**	**-**
Variance	**(0.0)**	**(0.0)**	**(0.0)**

Financial Performance – CIP Planning Progress

The Group has identified £82.3m in CIP schemes at the end of month 1, leaving £47,7m still to be identified.

The Group and ICB are bound by the following conditions from NHSE as part of the plan sign off process:

- Nil unidentified by 31st May

Reported M1: £47.72m 37%

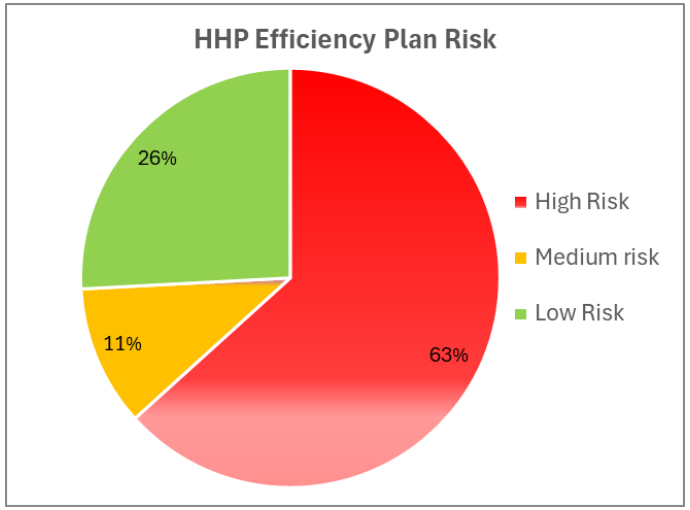
- No high-risk schemes by 30th June 2025

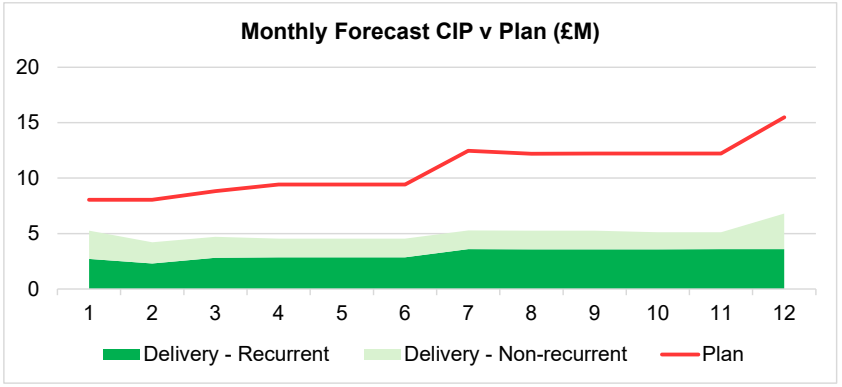
Reported M1: £82.3M (includes unidentified)

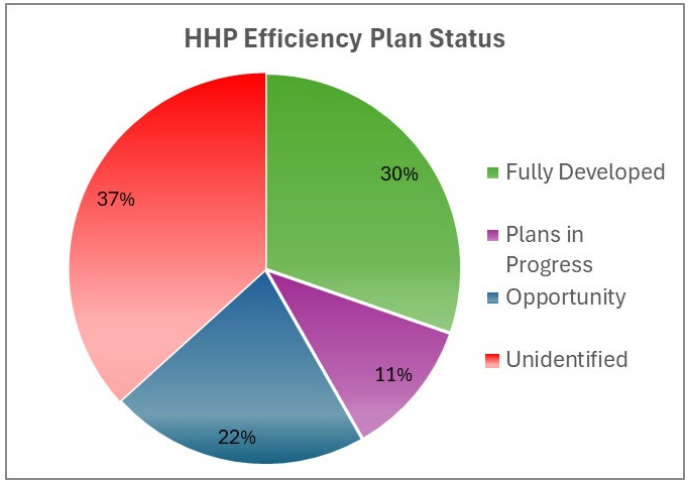
The £82.3m of identified schemes has a risk adjusted forecast value of £60.63m, of which only £37.8m is forecast to be delivered recurrently (62%). The risk-adjustment reflects the scheme development status and would be expected to increase as more schemes are progressed to Gateway 4 / Delivery

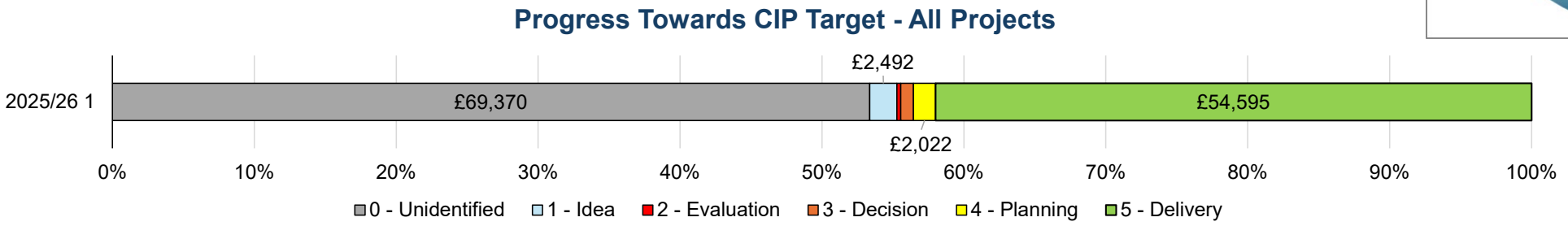
Efficiency Plan Risk	HUTH	NLAG	HHP
High Risk	42,263	40,030	82,293
Medium risk	11,944	2,171	14,115
Low Risk	14,113	19,479	33,592
TOTAL	**68,320**	**61,680**	**130,000**

Efficiency Plan Status	HUTH	NLAG	HHP
Fully Developed	18,975	20,421	39,396
Plans in Progress	12,017	2,843	14,860
Opportunity	13,568	14,459	28,027
Unidentified	23,760	23,958	47,718
TOTAL	**68,320**	**61,680**	**130,000**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£119.8m)

- The Groups estimated underlying deficit is estimated to be (£119.8m).
- Bridging from the balanced planned for 2025-26 the below are the main drivers:

1. The Group is in receipt of specific Non-Recurrent Income support totalling £21.0m.
2. Non-Recurrent Deficit funding received in 2025/26 of £28.2m.
3. The Group has historically relied on Non-Recurrent savings delivery to achieve its financial targets. This is forecast to be £22.8m within the current year's savings plan. The Group must look to convert non-recurrent savings schemes into recurrent schemes where possible.
4. In addition, the Group currently has unidentified CIP of £47.7M.

CIP delivery will be the key driver for the Trust's underlying financial position.

£million	NLAG	HUTH	Group
2025/26 - Surplus/(Deficit) Plan	**0.0**	**0.0**	**0.0**
Non-recurrent Adjustments			
NR Additional Stretch Income Support	(1.4)	(19.7)	(21.0)
NR 25/26 Deficit Funding	(14.9)	(13.4)	(28.2)
NR CIP (Forecast)	(10.6)	(12.2)	(22.8)
Undidentified CIP (Forecast)	(24.0)	(23.8)	(47.7)
Underlying Deficit	**(50.8)**	**(69.0)**	**(119.8)**

System Financial Performance – April 2025

The ICB reported a YTD deficit of (£5.90m), (£2.40m) adverse to plan. The ICS is forecasting a break-even position as planned.

System Surplus/(Deficit) including Non-Recurrent Deficit Funding	Expected Sign	SR_PLANYTD1_1	SR_PLANYTD2_1	SR_ACTYTD_1	SR_VARYTD_1	SR_PLANFOT1_1	SR_PLANFOT2_1
		Surplus / (Deficit) Plan 27th March Plan 30/04/2025 YTD £'000	Surplus / (Deficit) Plan 30th April Plan 30/04/2025 YTD £'000	Surplus / (Deficit) Actual 30/04/2025 YTD £'000	Surplus / (Deficit) Variance 30/04/2025 YTD £'000	Surplus / (Deficit) Plan 27th March Plan 31/03/2026 Year Ending £'000	Surplus / (Deficit) Plan 30th April Plan 31/03/2026 Year Ending £'000
Humber And North Yorkshire ICB	+/-	0	0	0	0	0	0
Harrogate And District NHS Foundation Trust	+/-	(274)	(274)	(1,719)	(1,445)	0	0
Hull University Teaching Hospitals NHS Trust	+/-	(1,046)	(1,046)	(1,049)	(3)	0	0
Humber Teaching NHS Foundation Trust	+/-	(308)	(312)	(312)	0	0	0
Northern Lincolnshire And Goole NHS Foundation Trust	+/-	(1,393)	(1,393)	(1,432)	(39)	0	0
York And Scarborough Teaching Hospitals NHS Foundation Trust	+/-	(476)	(476)	(1,386)	(910)	0	0
System Total	+/-	**(3,497)**	**(3,501)**	**(5,898)**	**(2,397)**	**0**	**0**

Capital Expenditure

The Group has spent £0.2m on capital expenditure against a plan of £2.0m plan, (£1.8m) behind plan.

£million	NLAG Year to Date			HUTH Year to Date			GROUP Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	0.0	0.0	0.0	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Day Surgery CHH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Theatres & IRT	0.0	0.0	0.0	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Community Diagnostic Centres	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NEEF 4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Estates Major Schemes	**0.0**	**0.0**	**0.0**	**0.4**	**0.0**	**(0.4)**	**0.4**	**0.0**	**(0.4)**
Other Estates Schemes	0.0	0.0	0.0			0.0	0.0	0.0	0.0
IM&T Programme	0.0	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1
EPR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Equipment Renewal	0.0	0.0	0.0	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Facilities Maintenance	0.1	0.0	(0.1)	0.0	0.1	0.0	0.1	0.1	(0.1)
Other Capital Expenditure	1.0	0.0	(1.0)	0.4	(0.0)	(0.4)	1.4	(0.0)	(1.4)
Total Capital Programme	**1.1**	**0.1**	**(1.0)**	**0.9**	**0.1**	**(0.8)**	**2.0**	**0.2**	**(1.8)**
Funded By:									
Internally Generated	0.1	0.1	0.0	0.5	0.1	(0.4)	0.6	0.2	(0.4)
PDC Funded	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated	1.0	0.0	(1.0)	0.1	0.0	(0.1)	1.1	0.0	(1.1)
IFRS16	0.0	0.0	0.0	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**1.1**	**0.1**	**(1.0)**	**0.9**	**0.1**	**(0.8)**	**2.0**	**0.2**	**(1.8)**

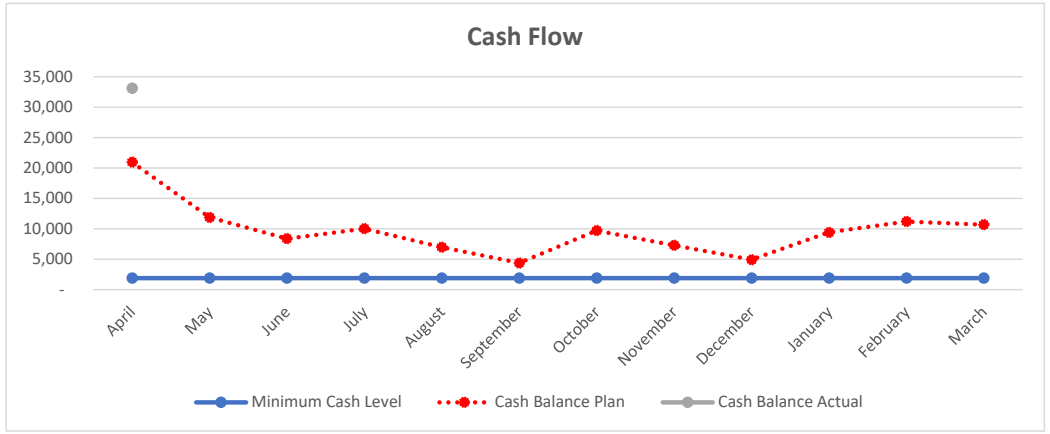
Balance Sheet

£ million	NLAG			HUTH			GROUP		
	Actual 31-Mar-25	Actual 30-Apr-25	In month movement	Actual 31-Mar-25	Actual 30-Apr-25	In month movement	Actual 31-Mar-25	Actual 30-Apr-25	In month movement
Fixed Assets	300.7	298.9	(1.8)	483.4	481.7	(1.7)	784.1	780.6	(3.5)
Other Investments			0.0	0.6	0.6	0.0	0.6	0.6	0.0
Current Assets									
Inventories	4.2	4.1	(0.1)	20.3	20.6	0.3	24.5	24.7	0.2
Trade and Other Debtors	20.3	20.4	0.1	40.5	32.3	(8.2)	60.8	52.7	(8.1)
Cash	32.6	33.1	0.5	34.9	48.6	13.7	67.5	81.7	14.2
Total Current Assets	**57.2**	**57.7**	**0.5**	**95.7**	**101.5**	**5.9**	**152.8**	**159.2**	**6.4**
Current Liabilities									
Trade and Other Creditors	(63.4)	(56.3)	7.1	(71.7)	(63.3)	8.4	(135.2)	(119.6)	15.6
Accruals	(14.5)	(18.2)	(3.7)	(54.6)	(63.4)	(8.8)	(69.1)	(81.6)	(12.6)
Other Current Liabilities	(4.7)	(8.7)	(4.0)	(15.6)	(19.5)	(3.9)	(20.4)	(28.3)	(7.9)
Total Current Liabilities	**(82.6)**	**(83.2)**	**(0.6)**	**(141.9)**	**(146.2)**	**(4.3)**	**(224.6)**	**(229.5)**	**(4.9)**
Net Current Liabilities	**(25.5)**	**(25.6)**	**(0.1)**	**(46.3)**	**(44.7)**	**1.6**	**(71.7)**	**(70.3)**	**1.4**
Debtors Due > 1 Year	0.8	0.8	0.0	2.3	2.3	0.0	3.0	3.0	0.0
Creditors Due > 1 Year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loans > 1 Year	(4.2)	(4.2)	0.0	(4.4)	(4.4)	0.0	(8.6)	(8.6)	0.0
Finance Lease Obligations > 1 Year	(8.6)	(8.2)	0.4	(74.3)	(74.2)	0.1	(82.8)	(82.3)	0.5
Provisions - Non Current	(3.6)	(3.6)	0.0	(2.3)	(2.3)	0.0	(5.9)	(5.9)	0.0
Total Assets/(Liabilities)	**259.6**	**258.0**	**(1.5)**	**359.0**	**359.0**	**(0.1)**	**618.6**	**617.0**	**(1.6)**
TOTAL CAPITAL & RESERVES	**259.6**	**258.0**	**(1.5)**	**359.0**	**359.0**	**(0.1)**	**618.6**	**617.0**	**(1.6)**

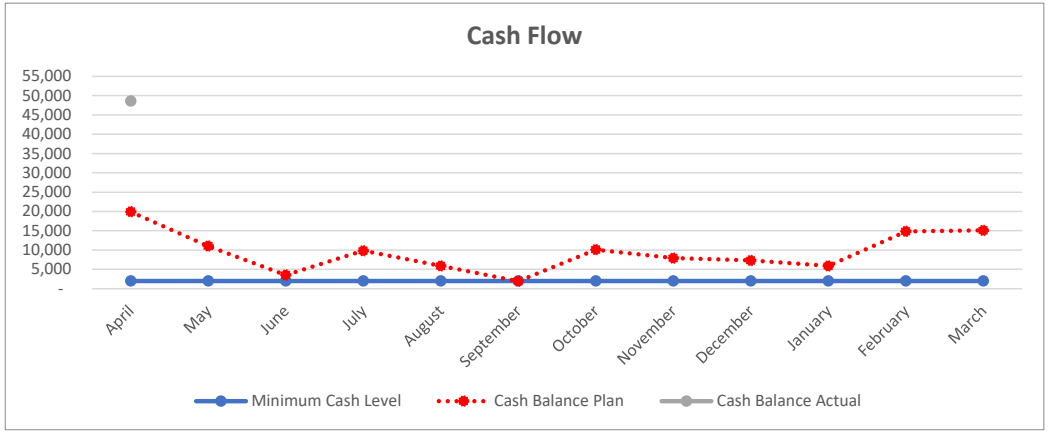
Cash Flow

The Group's cash balance at month 1 was £81.7m. CIP delivery will be the key variable in minimising any cash support requirements in year. The Group's cash position will be monitored closely each month.

NLAG



HUTH



Temporary Staffing Summary

The Group has spent £5.5m on agency and bank YTD. This is (£0.1m) more than the same period in 2024/25 and remains below the NHSE Target of 3.2% of total pay expenditure at 2.9%.

Agency & Bank Expenditure v's 2024/25

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Type	Subjective Sub category	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Agency	Medical Staff	664	783	(119)	1,054	1,128	(74)	1,718	1,911	(193)
	Nursing Staff	52	76	(24)	469	290	180	522	366	156
	Scientific, Therapeutic & Technical Staff	70	22	48	150	122	28	220	144	76
	Admin & Clerical Staff	46	(5)	51	35	4	31	81	(1)	82
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	0	13	(13)	0	0	0	0	13	(13)
Agency Total		**832**	**888**	**(56)**	**1,709**	**1,545**	**165**	**2,542**	**2,433**	**109**
Bank	Medical Staff	181	368	(187)	808	721	87	988	1,089	(101)
	Nursing Staff	436	353	83	987	978	10	1,423	1,330	93
	Scientific, Therapeutic & Technical Staff	30	53	(24)	84	106	(21)	114	159	(45)
	Admin & Clerical Staff	0	83	(83)	162	162	(0)	163	246	(83)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	6	12	(6)	170	199	(29)	176	211	(35)
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**653**	**869**	**(216)**	**2,212**	**2,165**	**46**	**2,864**	**3,035**	**(170)**
Grand Total		**1,485**	**1,758**	**(273)**	**3,921**	**3,710**	**211**	**5,406**	**5,468**	**(62)**

Agency Spend as % Total Pay (3.2% is the NHSE Target)	1.8%	4.5%	2.9%